STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT HUNTER STATION	400 HUNTER STATION ROAD, SELLERSBURG, , 47172

(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 467170. Intake 467170 - State deficiencies related to the allegations are cited at R00349, R00352 and R00353. Survey date: February 3, 2026 Facility number: 013841 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 4, 2026.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statment of deficiencies. The statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of a revisit.	
R 0349	Clinical Records - Noncompliance 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	R 0349	**Corrective Action(s) for Residents Affected by the Deficient Practice** Residents D no longer resides at the community. Residents B and C's service plans were	02/27/2026

	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, observation, and interview, the facility failed to ensure a resident's behaviors envolving other residents were documented in the resident's clinical record for 1 of 3 residents reviewed Clinical Records. (Residents B) Findings include: 1.a.The record for Resident B was reviewed on 2/3/26 at 8:40 a.m. The resident's diagnosis included, but was not limited to, dementia (progressive decline in memory, thinking and behavior). The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., Resident D was wandering the halls looking for his apartment. He saw an open door to an apartment and attempted to enter Resident B's apartment. Resident B blocked his way and a tussle occurred between Residents B and D. Resident B indicated he hit the resident on the cheek and was		reviewed and updated to reflect residents' current needs by Memory Care Director on 2/12/2026. **Corrective Action(s) for Other Residents Potentially Affected** All other memory care residents have the potential to be affected by this deficient practice; however, none were affected. Residents who were identified with aggressive behaviors were reviewed and service plans and care plans were updated to reflect current interventions and needs. **Measures to Ensure the Deficient Practice Does Not Recur** Wellness Director, Memory Care Director and Unit Coordinator will be educated by Regional Nurse by 2/16/2026 to include incident documentation, monitoring, investigation and completion. Wellness Director and/or designated nurse will educate nurses on or before 2/26/2026 to include incident completion, appropriate documentation and monitoring, shift report and intervention documentation. Newly hired nurses will be educated during orientation ongoing. Wellness Director will review observations and incidents and will ensure incidents are entered, monitoring is initiated,	

	trying to keep Resident D from coming into the apartment. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D on 12/16/25. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between the two residents in Resident B's record. The LPN searched online records and the paper charting. During an interview, on 2/3/26 at 2:10 p.m., the Executive Director (ED) indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the resident. She indicated the residents should be monitored by staff for 72 hours after an incident, but this had not occurred. 1.b. During an observation, on 2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B and Resident C could be overheard raising their voices to each other. Resident B stepped out of Resident B's room. The note by Licensed Practical Nurse (LPN) 5 written in Resident C's record indicated,		observations are completed each shift, incidents are investigated with care plan updates and incident reports are completed timely. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Executive Director will complete an audit including incident report completion, monitoring and post incident documentation, care plan intervention review, and investigation completion. The audit will include 5 incidents per week for 4 weeks, then 3 incidents per week for 4 weeks, then 1 incident per week for 4 weeks. The Executive Director will review results of the audits at the monthly QA meeting. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

	on 1/7/26 at 5:30 a.m., Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had open areas to the right and left arms. The State Reportable, dated 1/7/26, indicated a nurse was alerted to the apartment of Resident C. Resident C indicated Resident B grabbed her arms. Both residents were placed on monitoring. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated Resident B and Resident C would argue a lot, but LPN 3 didn't feel that the interactions were physical. Resident B said aggressive things to Resident C, like, "I am going to kick your butt," during meals in the dining room. The LPN could not locate any documentation of the incidents occurring between Resident B and Resident C for Resident B's record. The LPN searched for the online record and the paper charting. During an interview, on 2/3/26 at 10:26 a.m., Certified Nurse Aide (CNA) 4 indicated Resident B had a history of raising his voice with Resident C. During an interview, on 2/3/26 at 9:15 a.m., the ED indicated Resident B had a history of verbal behaviors with Resident			

	C and both residents resided in the Memory Care Unit. At 2:10 p.m., the ED indicated the residents should have been monitored by staff for 72 hours after an incident, but this had not occurred. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident C; the behavior monitoring for 72 hours after the occurrence; and Resident B's behaviors or verbal altercations. During an interview, on 2/3/26 at 12:57 p.m., the ED indicated she had no policy for documentation by staff of resident needs. She also called her corporate office and they concurred. Cross Reference: R00352 This citation relates to Intake 467170. Based on record review, observation, and interview, the facility failed to ensure a resident's behaviors envolving other residents were documented in the resident's clinical record for 1 of 3 residents reviewed Clinical Records. (Residents B) Findings include: 1.a.The record for Resident B			

	was reviewed on 2/3/26 at 8:40 a.m. The resident's diagnosis included, but was not limited to, dementia (progressive decline in memory, thinking and behavior). The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., Resident D was wandering the halls looking for his apartment. He saw an open door to an apartment and attempted to enter Resident B's apartment. Resident B blocked his way and a tussle occurred between Residents B and D. Resident B indicated he hit the resident on the cheek and was trying to keep Resident D from coming into the apartment. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D on 12/16/25. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between the two residents in Resident B's record. The LPN searched online records and the paper charting. During an interview, on 2/3/26 at 2:10 p.m., the Executive Director (ED) indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the			

	resident. She indicated the residents should be monitored by staff for 72 hours after an incident, but this had not occurred. 1.b. During an observation, on 2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B and Resident C could be overheard raising their voices to each other. Resident B stepped out of Resident B's room. The note by Licensed Practical Nurse (LPN) 5 written in Resident C's record indicated, on 1/7/26 at 5:30 a.m., Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had open areas to the right and left arms. The State Reportable, dated 1/7/26, indicated a nurse was alerted to the apartment of Resident C. Resident C indicated Resident B grabbed her arms. Both residents were placed on monitoring. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated Resident B and Resident C would argue a lot, but LPN 3 didn't feel that the interactions were physical. Resident B said aggressive things to Resident C, like, "I am going to kick your butt," during meals in the dining			

	room. The LPN could not locate any documentation of the incidents occurring between Resident B and Resident C for Resident B's record. The LPN searched for the online record and the paper charting. During an interview, on 2/3/26 at 10:26 a.m., Certified Nurse Aide (CNA) 4 indicated Resident B had a history of raising his voice with Resident C. During an interview, on 2/3/26 at 9:15 a.m., the ED indicated Resident B had a history of verbal behaviors with Resident C and both residents resided in the Memory Care Unit. At 2:10 p.m., the ED indicated the residents should have been monitored by staff for 72 hours after an incident, but this had not occurred. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident C; the behavior monitoring for 72 hours after the occurrence; and Resident B's behaviors or verbal altercations. During an interview, on 2/3/26 at 12:57 p.m., the ED indicated she had no policy for documentation by staff of resident needs. She also called her corporate office and they concurred.			

	Cross Reference: R00352 This citation relates to Intake 467170.			
R 0352	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(e)(1-4) (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on observation, record review, and interview, the facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed for 3 of 3 residents reviewed for Clinical Records. (Residents B, C, and D) Findings include: 1. During an observation, on 2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B stepped out of Resident C's room. The record for Resident B was	R 0352	**Corrective Action(s) for Residents Affected by the Deficient Practice** Residents D no longer resides at the community. Residents B and C’s service plans were reviewed and updated to reflect residents’ current needs by Memory Care Director on 2/12/2026. **Corrective Action(s) for Other Residents Potentially Affected** All memory care residents have the potential to be affected by this deficient practice; however, none have been affected. Residents who were identified with aggressive behaviors were reviewed and service plans and care plans were updated to reflect current interventions and needs. **Measures to Ensure the Deficient Practice Does Not Recur**	02/27/2026

	reviewed on 2/3/26 at 8:40 a.m. The diagnoses included, but was not limited to, dementia (progressive decline in memory, thinking and behavior). The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., indicated a tussle occurred between Residents B and D. Resident B indicated he hit the resident on the cheek and was trying to keep Resident D from coming into the apartment. The State Reportable, dated 1/7/26, indicated Resident B grabbed REsident C's arms. Resident C had two open areas to her arms. Resident B was placed on monitoring. The documentation from Resident C's notes, dated 1/7/26 at 5:30 a.m., indicated Licensed Practical Nurse (LPN) 5 heard Resident C in her room yelling out for help. When the nurse entered the room, Resident C indicated that Resident B grabbed her arms. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D; or between Resident B and Resident C. The record lacked documentation of behavior monitoring for 72 hours, other		Wellness Director, Memory Care Director and Unit Coordinator will be educated by Regional Nurse by 2/16/2026 to include evaluation, service plan updates, incident report monitoring, investigation and completion**.** Wellness Director and/or designated nurse will educate nurses by 2/26/2026 to include incident completion, appropriate documentation and monitoring, shift report and intervention documentation. Newly hired nurses will be educated during orientation ongoing. Wellness Director will review observations and incidents and will ensure incidents are entered, monitoring is initiated, observations are completed each shift, incidents are investigated with care plan updates and incident reports are completed timely. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Executive Director will complete an audit including incident report completion, monitoring and post incident documentation, care plan intervention review, and investigation completion. The audit will include 5 incidents per week for 4 weeks, then 3 incidents per week for 4 weeks, then 1 incident per week for 4	

	than Resident B being taken to the nurse's station after the altercation with Resident C. The record lacked documentation of behaviors or verbal aggression in the care plan. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between Resident B and Resident D or between Resident B and Resident C. LPN 3 searched the online record and the paper charting. During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated Resident B had a history of verbal behaviors and resided in the Memory Care Unit. At 2:10 p.m., the ED indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred. 3. The record for Resident D was reviewed on 2/3/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder without psychotic features (a mental health condition) and dementia with behavioral		weeks. The Executive Director will review results of the audits at the monthly QA meeting. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

	disturbance. A nurse's note, dated 12/16/25 at 9:15 p.m., indicated a CNA called the nurse to assist the resident as he was on the floor in the hallway. Resident D was laying on his right side on floor with his head against the wall. Upon assessment, it was observed that the resident had a raised area on the right side of his forehead and was bleeding red blood from his nose. The resident had two abrasions on the top of his head. He remained alert to self with confusion. He was unable to state what happened. The NP was made aware and gave the order to send him to the emergency room.			

	An incident between Residents B and D, was reported to the State Agency on 12/16/25. The report indicated at around 9:08 p.m., a tussle occured between Resident D and Resident B. Resident D lost his balance and was found on the floor in the hallway with a hematoma to his forehead and nose. Resident D returned from the emergency room and neurological checks (assess for brain injury by evaluation mental status, consciousness level, pupillary response, motor strength in all extremities, sensation, and balance) were to be implemented. The record for Resident D lacked documentation related to the altercation with Resident B and the resident's neurological checks that were supposed to be completed after he returned from the emergency room. During an interview with the Dementia Unit Director, on 2/3/26 at 10:00 a.m., she indicated Resident D had a pattern where he would wander and it did not matter which hall he might have been on, if he saw an open door, he would try to walk in as he believed it was his apartment. He was in the wrong place at the wrong time that night. During an interview, on 2/3/26 at			

	12:57 p.m., the ED indicated she had no policy for documentation by staff of resident needs. She also called her corporate office and they concurred. Cross Reference: R00349 This citation relates to Intake 467170. 2. The record for Resident C was reviewed on 2/3/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, dementia. A nurse's note, dated 1/7/26 at 5:30 a.m., indicated Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had an open area to her right and left arms. First aid was applied to the open areas. A nurse's note, dated 1/8/26 at 4:33 p.m., indicated Resident C saw the nurse practitioner and new orders were received to cleanse her bilateral forearm skin tears with normal saline, apply triple antibiotic ointment (TAO) and then cover the open areas with bandaids until healed.			

	The resident's record lacked documentation of the 72-hour follow-up on Resident C's skin assessment. The service plan, dated 1/28/26, indicated the resident required safety checks. The interventions, dated 1/28/26, included, but were not limited to, the resident would be checked on a designated number of times throughout the day, eight times per day. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that she was unaware of any incidents between Resident C and Resident B. The residents were supposed to have a 72-hour follow-up after any incidents. The LPN could not find any follow-up documentation in the electronic medical record or in the paper chart related to the occurance on 1/7/26 for Resident C. Based on observation, record review, and interview, the facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed for 3 of 3 residents reviewed for Clinical Records. (Residents B, C, and D) Findings include: 1. During an observation, on			

	2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B stepped out of Resident C's room. The record for Resident B was reviewed on 2/3/26 at 8:40 a.m. The diagnoses included, but was not limited to, dementia (progressive decline in memory, thinking and behavior). The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., indicated a tussle occurred between Residents B and D. Resident B indicated he hit the resident on the cheek and was trying to keep Resident D from coming into the apartment. The State Reportable, dated 1/7/26, indicated Resident B grabbed REsident C's arms. Resident C had two open areas to her arms. Resident B was placed on monitoring. The documentation from Resident C's notes, dated 1/7/26 at 5:30 a.m., indicated Licensed Practical Nurse (LPN) 5 heard Resident C in her room yelling out for help. When the nurse entered the room, Resident C indicated that Resident B grabbed her arms. Resident B's record lacked documentation of the incident having occurred between			

	Resident B and Resident D; or between Resident B and Resident C. The record lacked documentation of behavior monitoring for 72 hours, other than Resident B being taken to the nurse's station after the altercation with Resident C. The record lacked documentation of behaviors or verbal aggression in the care plan. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between Resident B and Resident D or between Resident B and Resident C. LPN 3 searched the online record and the paper charting. During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated Resident B had a history of verbal behaviors and resided in the Memory Care Unit. At 2:10 p.m., the ED indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred. 3. The record for Resident D			

	was reviewed on 2/3/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder without psychotic features (a mental health condition) and dementia with behavioral disturbance. A nurse's note, dated 12/16/25 at 9:15 p.m., indicated a CNA called the nurse to assist the resident as he was on the floor in the hallway. Resident D was laying on his right side on floor with his head against the wall. Upon assessment, it was observed that the resident had a raised area on the right side of his forehead and was bleeding red blood from his nose. The resident had two abrasions on the top of his head. He remained alert to self with confusion. He was unable to state what happened. The NP was made aware and gave the order to send him to the emergency room. An incident between Residents B and D, was reported to the State Agency on 12/16/25. The report indicated at around 9:08 p.m., a tussle occured between Resident D and Resident B. Resident D lost his balance and was found on the floor in the hallway with a hematoma to his forehead and nose. Resident D returned from the emergency room and neurological checks			

	(assess for brain injury by evaluation mental status, consciousness level, pupillary response, motor strength in all extremities, sensation, and balance) were to be implemented. The record for Resident D lacked documentation related to the altercation with Resident B and the resident's neurological checks that were supposed to be completed after he returned from the emergency room. During an interview with the Dementia Unit Director, on 2/3/26 at 10:00 a.m., she indicated Resident D had a pattern where he would wander and it did not matter which hall he might have been on, if he saw an open door, he would try to walk in as he believed it was his apartment. He was in the wrong place at the wrong time that night. During an interview, on 2/3/26 at 12:57 p.m., the ED indicated she had no policy for documentation by staff of resident needs. She also called her corporate office and they concurred. Cross Reference: R00349 This citation relates to Intake 467170. 2. The record for Resident C			

	was reviewed on 2/3/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, dementia. A nurse's note, dated 1/7/26 at 5:30 a.m., indicated Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had an open area to her right and left arms. First aid was applied to the open areas. A nurse's note, dated 1/8/26 at 4:33 p.m., indicated Resident C saw the nurse practitioner and new orders were received to cleanse her bilateral forearm skin tears with normal saline, apply triple antibiotic ointment (TAO) and then cover the open areas with bandaids until healed. The resident's record lacked documentation of the 72-hour follow-up on Resident C's skin assessment. The service plan, dated 1/28/26, indicated the resident required safety checks. The interventions, dated 1/28/26, included, but were not limited to, the resident would be checked on a designated number of times throughout the day, eight times per day. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that			

	she was unaware of any incidents between Resident C and Resident B. The residents were supposed to have a 72-hour follow-up after any incidents. The LPN could not find any follow-up documentation in the electronic medical record or in the paper chart related to the occurance on 1/7/26 for Resident C. Based on observation, record review, and interview, the facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed for 3 of 3 residents reviewed for Clinical Records. (Residents B, C, and D) Findings include: 1. During an observation, on 2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B stepped out of Resident C's room. The record for Resident B was reviewed on 2/3/26 at 8:40 a.m. The diagnoses included, but was not limited to, dementia (progressive decline in memory, thinking and behavior). The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., indicated a tussle occurred between Residents B			

	and D. Resident B indicated he hit the resident on the cheek and was trying to keep Resident D from coming into the apartment. The State Reportable, dated 1/7/26, indicated Resident B grabbed REsident C's arms. Resident C had two open areas to her arms. Resident B was placed on monitoring. The documentation from Resident C's notes, dated 1/7/26 at 5:30 a.m., indicated Licensed Practical Nurse (LPN) 5 heard Resident C in her room yelling out for help. When the nurse entered the room, Resident C indicated that Resident B grabbed her arms. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D; or between Resident B and Resident C. The record lacked documentation of behavior monitoring for 72 hours, other than Resident B being taken to the nurse's station after the altercation with Resident C. The record lacked documentation of behaviors or verbal aggression in the care plan. During an interview, on 2/3/26 at			

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	Upon assessment, it was observed that the resident had a raised area on the right side of his forehead and was bleeding red blood from his nose. The resident had two abrasions on the top of his head. He remained alert to self with confusion. He was unable to state what happened. The NP was made aware and gave the order to send him to the emergency room. An incident between Residents B and D, was reported to the State Agency on 12/16/25. The report indicated at around 9:08 p.m., a tussle occured between Resident D and Resident B. Resident D lost his balance and was found on the floor in the hallway with a hematoma to his forehead and nose. Resident D returned from the emergency room and neurological checks (assess for brain injury by evaluation mental status, consciousness level, pupillary response, motor strength in all extremities, sensation, and balance) were to be implemented. The record for Resident D lacked documentation related to the altercation with Resident B and the resident's neurological checks that were supposed to be completed after he returned from the emergency room.			

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	Licensed Practical Nurse (LPN) 5 heard Resident C in her room yelling out for help. When the nurse entered the room, Resident C indicated that Resident B grabbed her arms. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D; or between Resident B and Resident C. The record lacked documentation of behavior monitoring for 72 hours, other than Resident B being taken to the nurse's station after the altercation with Resident C. The record lacked documentation of behaviors or verbal aggression in the care plan. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between Resident B and Resident D or between Resident B and Resident C. LPN 3 searched the online record and the paper charting. During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated Resident B had a history of verbal behaviors and resided in the Memory Care Unit. At 2:10 p.m.,			

	the ED indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred. 3. The record for Resident D was reviewed on 2/3/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder without psychotic features (a mental health condition) and dementia with behavioral disturbance. A nurse's note, dated 12/16/25 at 9:15 p.m., indicated a CNA called the nurse to assist the resident as he was on the floor in the hallway. Resident D was laying on his right side on floor with his head against the wall. Upon assessment, it was observed that the resident had a raised area on the right side of his forehead and was bleeding red blood from his nose. The resident had two abrasions on the top of his head. He remained alert to self with confusion. He was unable to state what happened. The NP was made aware and gave the order to send him to the emergency room. An incident between Residents B and D, was reported to the			

	State Agency on 12/16/25. The report indicated at around 9:08 p.m., a tussle occured between Resident D and Resident B. Resident D lost his balance and was found on the floor in the hallway with a hematoma to his forehead and nose. Resident D returned from the emergency room and neurological checks (assess for brain injury by evaluation mental status, consciousness level, pupillary response, motor strength in all extremities, sensation, and balance) were to be implemented. The record for Resident D lacked documentation related to the altercation with Resident B and the resident's neurological checks that were supposed to be completed after he returned from the emergency room. During an interview with the Dementia Unit Director, on 2/3/26 at 10:00 a.m., she indicated Resident D had a pattern where he would wander and it did not matter which hall he might have been on, if he saw an open door, he would try to walk in as he believed it was his apartment. He was in the wrong place at the wrong time that night. During an interview, on 2/3/26 at 12:57 p.m., the ED indicated she had no policy for			

	documentation by staff of resident needs. She also called her corporate office and they concurred. Cross Reference: R00349 This citation relates to Intake 467170. 2. The record for Resident C was reviewed on 2/3/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, dementia. A nurse's note, dated 1/7/26 at 5:30 a.m., indicated Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had an open area to her right and left arms. First aid was applied to the open areas. A nurse's note, dated 1/8/26 at 4:33 p.m., indicated Resident C saw the nurse practitioner and new orders were received to cleanse her bilateral forearm skin tears with normal saline, apply triple antibiotic ointment (TAO) and then cover the open areas with bandaids until healed. The resident's record lacked documentation of the 72-hour follow-up on Resident C's skin assessment. The service plan, dated 1/28/26,			

	indicated the resident required safety checks. The interventions, dated 1/28/26, included, but were not limited to, the resident would be checked on a designated number of times throughout the day, eight times per day. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that she was unaware of any incidents between Resident C and Resident B. The residents were supposed to have a 72-hour follow-up after any incidents. The LPN could not find any follow-up documentation in the electronic medical record or in the paper chart related to the occurance on 1/7/26 for Resident C. Based on observation, record review, and interview, the facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed for 3 of 3 residents reviewed for Clinical Records. (Residents B, C, and D) Findings include: 1. During an observation, on 2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B stepped out of Resident C's room.			

	The record for Resident B was reviewed on 2/3/26 at 8:40 a.m. The diagnoses included, but was not limited to, dementia (progressive decline in memory, thinking and behavior). The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., indicated a tussle occurred between Residents B and D. Resident B indicated he hit the resident on the cheek and was trying to keep Resident D from coming into the apartment. The State Reportable, dated 1/7/26, indicated Resident B grabbed REsident C's arms. Resident C had two open areas to her arms. Resident B was placed on monitoring. The documentation from Resident C's notes, dated 1/7/26 at 5:30 a.m., indicated Licensed Practical Nurse (LPN) 5 heard Resident C in her room yelling out for help. When the nurse entered the room, Resident C indicated that Resident B grabbed her arms. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D; or between Resident B and Resident C. The record lacked documentation of behavior			

	monitoring for 72 hours, other than Resident B being taken to the nurse's station after the altercation with Resident C. The record lacked documentation of behaviors or verbal aggression in the care plan. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between Resident B and Resident D or between Resident B and Resident C. LPN 3 searched the online record and the paper charting. During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated Resident B had a history of verbal behaviors and resided in the Memory Care Unit. At 2:10 p.m., the ED indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred. 3. The record for Resident D was reviewed on 2/3/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder without psychotic features (a mental health condition) and			

	dementia with behavioral disturbance. A nurse's note, dated 12/16/25 at 9:15 p.m., indicated a CNA called the nurse to assist the resident as he was on the floor in the hallway. Resident D was laying on his right side on floor with his head against the wall. Upon assessment, it was observed that the resident had a raised area on the right side of his forehead and was bleeding red blood from his nose. The resident had two abrasions on the top of his head. He remained alert to self with confusion. He was unable to state what happened. The NP was made aware and gave the order to send him to the emergency room. An incident between Residents B and D, was reported to the State Agency on 12/16/25. The report indicated at around 9:08 p.m., a tussle occured between Resident D and Resident B. Resident D lost his balance and was found on the floor in the hallway with a hematoma to his forehead and nose. Resident D returned from the emergency room and neurological checks (assess for brain injury by evaluation mental status, consciousness level, pupillary response, motor strength in all extremities, sensation, and balance) were to be			

	implemented. The record for Resident D lacked documentation related to the altercation with Resident B and the resident's neurological checks that were supposed to be completed after he returned from the emergency room. During an interview with the Dementia Unit Director, on 2/3/26 at 10:00 a.m., she indicated Resident D had a pattern where he would wander and it did not matter which hall he might have been on, if he saw an open door, he would try to walk in as he believed it was his apartment. He was in the wrong place at the wrong time that night. During an interview, on 2/3/26 at 12:57 p.m., the ED indicated she had no policy for documentation by staff of resident needs. She also called her corporate office and they concurred. Cross Reference: R00349 This citation relates to Intake 467170. 2. The record for Resident C was reviewed on 2/3/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, dementia. A nurse's note, dated 1/7/26 at			

	5:30 a.m., indicated Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had an open area to her right and left arms. First aid was applied to the open areas. A nurse's note, dated 1/8/26 at 4:33 p.m., indicated Resident C saw the nurse practitioner and new orders were received to cleanse her bilateral forearm skin tears with normal saline, apply triple antibiotic ointment (TAO) and then cover the open areas with bandaids until healed. The resident's record lacked documentation of the 72-hour follow-up on Resident C's skin assessment. The service plan, dated 1/28/26, indicated the resident required safety checks. The interventions, dated 1/28/26, included, but were not limited to, the resident would be checked on a designated number of times throughout the day, eight times per day. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that she was unaware of any incidents between Resident C and Resident B. The residents were supposed to have a 72-hour follow-up after any incidents. The LPN could not			

find any follow-up documentation in the electronic medical record or in the paper chart related to the occurance on 1/7/26 for Resident C.

Based on observation, record review, and interview, the facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed for 3 of 3 residents reviewed for Clinical Records. (Residents B, C, and D)

Findings include:

1. During an observation, on 2/3/26 at 10:30 a.m., Resident B answered the door to Resident C's apartment. Resident B stepped out of Resident C's room.

The record for Resident B was reviewed on 2/3/26 at 8:40 a.m. The diagnoses included, but was not limited to, dementia (progressive decline in memory, thinking and behavior).

The State Reportable, dated 12/16/25, indicated at around 9:08 p.m., indicated a tussle occurred between Residents B and D. Resident B indicated he hit the resident on the cheek and was trying to keep Resident D from coming into the apartment.

	The State Reportable, dated 1/7/26, indicated Resident B grabbed REsident C's arms. Resident C had two open areas to her arms. Resident B was placed on monitoring. The documentation from Resident C's notes, dated 1/7/26 at 5:30 a.m., indicated Licensed Practical Nurse (LPN) 5 heard Resident C in her room yelling out for help. When the nurse entered the room, Resident C indicated that Resident B grabbed her arms. Resident B's record lacked documentation of the incident having occurred between Resident B and Resident D; or between Resident B and Resident C. The record lacked documentation of behavior monitoring for 72 hours, other than Resident B being taken to the nurse's station after the altercation with Resident C. The record lacked documentation of behaviors or verbal aggression in the care plan. During an interview, on 2/3/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated they could not locate any documentation of the incidents occurring between Resident B and Resident D or between			

	Resident B and Resident C. LPN 3 searched the online record and the paper charting. During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated Resident B had a history of verbal behaviors and resided in the Memory Care Unit. At 2:10 p.m., the ED indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred. 3. The record for Resident D was reviewed on 2/3/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder without psychotic features (a mental health condition) and dementia with behavioral disturbance. A nurse's note, dated 12/16/25 at 9:15 p.m., indicated a CNA called the nurse to assist the resident as he was on the floor in the hallway. Resident D was laying on his right side on floor with his head against the wall. Upon assessment, it was observed that the resident had a raised area on the right side of his forehead and was bleeding red blood from his nose. The resident had two abrasions on			

	the top of his head. He remained alert to self with confusion. He was unable to state what happened. The NP was made aware and gave the order to send him to the emergency room. An incident between Residents B and D, was reported to the State Agency on 12/16/25. The report indicated at around 9:08 p.m., a tussle occured between Resident D and Resident B. Resident D lost his balance and was found on the floor in the hallway with a hematoma to his forehead and nose. Resident D returned from the emergency room and neurological checks (assess for brain injury by evaluation mental status, consciousness level, pupillary response, motor strength in all extremities, sensation, and balance) were to be implemented. The record for Resident D lacked documentation related to the altercation with Resident B and the resident's neurological checks that were supposed to be completed after he returned from the emergency room. During an interview with the Dementia Unit Director, on 2/3/26 at 10:00 a.m., she indicated Resident D had a pattern where he would wander and it did not matter which hall			

	he might have been on, if he saw an open door, he would try to walk in as he believed it was his apartment. He was in the wrong place at the wrong time that night. During an interview, on 2/3/26 at 12:57 p.m., the ED indicated she had no policy for documentation by staff of resident needs. She also called her corporate office and they concurred. Cross Reference: R00349 This citation relates to Intake 467170. 2. The record for Resident C was reviewed on 2/3/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, dementia. A nurse's note, dated 1/7/26 at 5:30 a.m., indicated Resident C was in her room yelling out for help. When the nurse entered the room, Resident C indicated Resident B grabbed her arms. Resident C had an open area to her right and left arms. First aid was applied to the open areas. A nurse's note, dated 1/8/26 at 4:33 p.m., indicated Resident C saw the nurse practitioner and new orders were received to cleanse her bilateral forearm skin tears with normal saline, apply triple antibiotic ointment			

	(TAO) and then cover the open areas with bandaids until healed. The resident's record lacked documentation of the 72-hour follow-up on Resident C's skin assessment. The service plan, dated 1/28/26, indicated the resident required safety checks. The interventions, dated 1/28/26, included, but were not limited to, the resident would be checked on a designated number of times throughout the day, eight times per day. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that she was unaware of any incidents between Resident C and Resident B. The residents were supposed to have a 72-hour follow-up after any incidents. The LPN could not find any follow-up documentation in the electronic medical record or in the paper chart related to the occurance on 1/7/26 for Resident C.			
R 0353	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(f) (f) The facility shall have a policy that ensures the staff has sufficient information to meet the residents ' needs.	R 0353	**Corrective Action(s) for Residents Affected by the Deficient Practice**	02/27/2026

	Based on record review and interview, the facility failed to ensure a policy was in place to ensure the staff had sufficent information to meet the residents needs for 3 of 3 resident records reviewed. This dificient practice had the potential to affect 110 of 110 residents residing in the facility. Findings include: The review of the records for Residents B, C, and D, lacked documentation of assessments involving resident aggression. The record for Resident B lacked documentation of the incidents between Resident B and D; and the incident between Resident B and C. During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred. During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that she was unaware of any incidents between Resident C and Resident B. Cross Reference: R0352 -The facility failed to ensure a		Residents D no longer resides at the community. Current change of condition policy obtained and reviewed. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice; however, none have been affected. **Measures to Ensure the Deficient Practice Does Not Recur** Wellness Director, Memory Care Director and Unit Coordinator will be educated by Regional Nurse by 2/16/2026 to include change of condition policy and procedure**.** Wellness Director and/or designated nurse will educate nurses on or before 2/26/2026 on change of condition policy and procedures. Newly hired nurses will be educated during orientation ongoing. Wellness Director will review observations and incidents and will ensure incidents are entered,	

	resident's behaviors envolving other residents were documented in the resident's clinical record. Cross Reference: R0349 -The facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed. During an interview, on 2/3/26 at 12:57 p.m., the Executive Director (ED) indicated she had no documentation policy for resident evaluations, monitoring, or needs. She called her corporate office and they concurred. This citation relates to Intake 467170. Based on record review and interview, the facility failed to ensure a policy was in place to ensure the staff had sufficent information to meet the residents needs for 3 of 3 resident records reviewed. This dificient practice had the potential to affect 110 of 110 residents residing in the facility. Findings include: The review of the records for Residents B, C, and D, lacked documentation of assessments involving resident aggression. The record for Resident B		monitoring is initiated, observations are completed each shift, incidents are investigated with care plan updates and incident reports are completed timely **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Executive Director will complete an audit including incident report completion, monitoring and post incident documentation, care plan intervention review, and investigation completion. The audit will include 5 incidents per week for 4 weeks, then 3 incidents per week for 4 weeks, then 1 incident per week for 4 weeks. The Executive Director will review results of the audits at the monthly QA meeting. The Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

lacked documentation of the incidents between Resident B and D; and the incident between Resident B and C.

During an interview, on 2/3/26 at 9:15 a.m., the Executive Director (ED) indicated she had worked on the incident between Resident B and Resident D, and she had not documented on the residents. The residents should have been monitored by staff for 72 hours after an incident, but that had not occurred.

During an interview, on 2/3/26 at 10:11 a.m., LPN 3 indicated that she was unaware of any incidents between Resident C and Resident B.

Cross Reference: R0352

-The facility failed to ensure a resident's behaviors envolving other residents were documented in the resident's clinical record.

Cross Reference: R0349

-The facility failed to ensure residents' clinical records contained sufficient information related to occurances and/or evalutions/follow-up needed.

During an interview, on 2/3/26 at 12:57 p.m., the Executive Director (ED) indicated she had no documentation policy for resident evaluations, monitoring,

	or needs. She called her corporate office and they concurred. This citation relates to Intake 467170.			

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 SIGNATUREKathy Jones	TITLEExecutive Director	(X6) DATE02/12/2026