STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD, GREENWOOD, , 46143

(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 465887. Intake 465887 - State deficiencies related to the allegations are cited at R0052, R0053, R0090, R0217, and R0349. Survey dates: November 18 and 19, 2025 Facility number: 014079 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 25, 2025.	R 0000	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with	12/17/2025

	(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 protect a resident's right to be free from sexual abuse for 1 of 3 residents reviewed for abuse. A cognitively impaired female resident exposed her breast and climbed into bed with a cognitively impaired male resident. (Resident B, Resident C) Findings include: During an interview on 11/18/25 at 7:27 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B (female resident) had shown an interest in and pursued Resident C (male resident). Resident B and Resident C were both confused and Resident C often had to be assisted to his apartment because he had gotten lost in the facility while walking the halls. During an interview on 11/18/25 at 7:36 a.m., QMA 2 indicated a few days ago, Resident B walked up to Resident C while		the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. **Corrective action taken for residents affected by the deficient practice:** • Both Resident B and Resident C wereassessed immediatelyfollowing discovery of the incident for any signs of physical injury or emotional distress. • Both residents wereseparated and placed under increased supervision. • Physician and responsible parties	

	he was sitting in the bistro, pulled up her shirt, and exposed her breast. Resident C showed no reaction. Resident C was confused and had to be assisted to his room at times. Resident B had been difficult to redirect when she looked for Resident C. At times, Resident B had been aggressive with staff when staff had attempted to redirect Resident B from Resident C. The Director of Nursing (DON) and Administrator were notified. During an interview on 11/18/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment and Resident B continued to climb into bed with Resident C. Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and were not touching inappropriately. The DON was made aware. The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A Brief Interview for Mental Status (BIMS) assessment, dated 6/18/25, indicated		were notified promptly. • Both residents received psychosocial follow-up and monitoring from the community team members. **Identification of other residents potentially affected by the same deficient practice:** • Residents withcognitive impairmentswere reviewed to ensure proper supervision levels are in place. • Care plans and supervision levelswere reviewed and updated as necessary for cognitively impaired residents to prevent similar events. **Systemic changes to ensure the deficient practice does not recur:**	

	Resident B was severely cognitively impaired. A Service Plan, dated 6/18/25, indicated Resident B was independent for dressing and undressing self. The Progress Notes included, but were not limited to: - On 10/9/25 at 6:00 a.m., Resident B had been continuously seeking out and making inappropriate advances toward Resident C. Staff made multiple attempts to redirect Resident B but were unable to do so. The DON had been made aware. - On 10/13/25 at 3:39 p.m., Resident B was seen wandering into Resident C's apartment. Resident C asked Resident B to leave his apartment multiple time. Then Resident C started yelling for help. Resident B got into bed with Resident C and when staff attempted to assist Resident B out of Resident C's bed, Resident B started to hit the staff and indicated leave her the f*** alone. - On 11/16/25 at 8:11 a.m., observed Resident B take off her bra in the front lobby with her breasts exposed and other residents in the lobby. Staff attempted to redirect Resident B to the restroom but Resident B indicated she was taking the bra off right then because it was too		• Staff receivedin-service educationon: • Definitions of sexual abuse and inappropriate sexual contact between residents • Proper supervision of cognitively impaired residents • Immediate interventions and reporting protocols • TheAbuse Prevention and Protection Policywas reviewed to clarify staff responsibilities when potential resident-to-resident sexual interactions occur. • TheHWD (Health and Wellness Director)or designee will conductrandom daily roundson all shifts for 4 weeks to ensure supervision and staff awareness. •	

	tight. The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy. A BIMS assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired. A service plan, dated 9/23/25, indicated Resident C functioned appropriately in social settings. A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired. On 11/19/25 at 5:45 a.m., observed Resident C sitting in the lobby watching a television. Resident C was pleasant, confused, and indicated he was not able to recall how long he had resided at the facility by approximately seven years. Resident C was not able to recall Resident B by name nor any inappropriate behaviors in the facility. On 11/18/25 at 9:00 a.m., the Administrator provided a copy of a facility policy, dated 9/28/23, titled Abuse and Neglect Reporting Policy, and indicated this was the current policy used by the facility. A review of the policy indicated the facility		Future incidents will trigger an immediate investigationby the facility's Administrator or designee and review will take place at IDT. **Monitoring to ensure the corrective action is sustained:** • TheHWD or designeewill review weekly for 4 weeks, then monthly for 3 months, to ensure compliance. • Results will be reviewed in the ED/HWD meetings monthly for at least 3 consecutive months. • Continued compliance will be monitored ongoing thereafter through the facility's IDT Meeting. **Completion Date:**	

	strived to provide an environment free from abuse. This citation relates to Intake 465887. Based on interview and record review, the facility failed to protect a resident's right to be free from sexual abuse for 1 of 3 residents reviewed for abuse. A cognitively impaired female resident exposed her breast and climbed into bed with a cognitively impaired male resident. (Resident B, Resident C) Findings include: During an interview on 11/18/25 at 7:27 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B (female resident) had shown an interest in and pursued Resident C (male resident). Resident B and Resident C were both confused and Resident C often had to be assisted to his apartment because he had gotten lost in the facility while walking the halls. During an interview on 11/18/25 at 7:36 a.m., QMA 2 indicated a few days ago, Resident B walked up to Resident C while he was sitting in the bistro, pulled up her shirt, and exposed her breast. Resident C showed no reaction. Resident C was confused and had to be assisted to his room at times.		12/17/2025	

	Resident B had been difficult to redirect when she looked for Resident C. At times, Resident B had been aggressive with staff when staff had attempted to redirect Resident B from Resident C. The Director of Nursing (DON) and Administrator were notified. During an interview on 11/18/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment and Resident B continued to climb into bed with Resident C. Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and were not touching inappropriately. The DON was made aware. The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A Brief Interview for Mental Status (BIMS) assessment, dated 6/18/25, indicated Resident B was severely cognitively impaired. A Service Plan, dated 6/18/25, indicated Resident B was independent for dressing and			

undressing self.

The Progress Notes included, but were not limited to:

- On 10/9/25 at 6:00 a.m., Resident B had been continuously seeking out and making inappropriate advances toward Resident C. Staff made multiple attempts to redirect Resident B but were unable to do so. The DON had been made aware.

- On 10/13/25 at 3:39 p.m., Resident B was seen wandering into Resident C's apartment. Resident C asked Resident B to leave his apartment multiple time. Then Resident C started yelling for help. Resident B got into bed with Resident C and when staff attempted to assist Resident B out of Resident C's bed, Resident B started to hit the staff and indicated leave her the f*** alone.

- On 11/16/25 at 8:11 a.m., observed Resident B take off her bra in the front lobby with her breasts exposed and other residents in the lobby. Staff attempted to redirect Resident B to the restroom but Resident B indicated she was taking the bra off right then because it was too tight.

The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to,

	Alzheimer's disease, dementia, and polyneuropathy. A BIMS assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired. A service plan, dated 9/23/25, indicated Resident C functioned appropriately in social settings. A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired. On 11/19/25 at 5:45 a.m., observed Resident C sitting in the lobby watching a television. Resident C was pleasant, confused, and indicated he was not able to recall how long he had resided at the facility by approximately seven years. Resident C was not able to recall Resident B by name nor any inappropriate behaviors in the facility. On 11/18/25 at 9:00 a.m., the Administrator provided a copy of a facility policy, dated 9/28/23, titled Abuse and Neglect Reporting Policy, and indicated this was the current policy used by the facility. A review of the policy indicated the facility strived to provide an environment free from abuse. This citation relates to Intake 465887.			

R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to protect a resident's right to be free from verbal abuse for 1 of 3 residents reviewed for abuse. A cognitively impaired female resident screamed in the face of a cognitively impaired male resident. (Resident B, Resident C) Findings include: During an interview on 11/18/25 at 7:36 a.m., Qualified Medication Aide (QMA) 2 indicated approximately two weeks ago Resident B walked into the bistro and screamed in Resident C's face. Resident B screamed why didn't Resident C want to talk to her. Resident C became tearful and left the bistro. The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A Brief Interview for Mental Status (BIMS) assessment, dated 6/18/25, indicated	R 0053	**Tag R053:** This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor’s findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. **Corrective Action Taken for Affected Residents:** -Staff immediately intervened and separated both residents to reduce further agitation. - Both residents were assessed	12/17/2025

	Resident B was severely cognitively impaired. A Service Plan, dated 6/18/25, indicated Resident B was independent for dressing and undressing self. The service plan lacked any information regarding behaviors/sexually inappropriate behaviors, nor mental health services. A progress note, dated 11/2/25 at 6:54 p.m., indicated earlier today at approximately 6:25 a.m., observed Resident B walk toward Resident C's apartment. Staff attempted to educate Resident B that Resident C did not want to talk at that time. Resident B became increasingly agitated and began yelling out for Resident C. Writer attempted to locate Resident C while another staff member redirected Resident B. Resident C was located in the laundry room hiding from Resident B. Once Resident B had been redirected, Resident C was escorted back to his apartment. Later observed Resident C sitting in the bistro reading a newspaper. Resident B entered the bistro and began yelling in Resident C's face asking why Resident C did not want to talk to her. Resident C became tearful and walked away. The Director of Nursing was notified. The clinical record for Resident C was reviewed on 11/18/25 at		by nursing for changes in mood or behavior and received emotional reassurance. - Both responsible parties and attending physicians were notified. **Identification of Other Residents Potentially Affected:** - Current residents with cognitive impairment or behavioral symptoms were reviewed to ensure care plans and supervision levels meet their needs. - Behavior monitoring logs were updated as appropriate. **Systemic Changes to Prevent Recurrence:** - Staff in-service training on recognizing and preventing verbal abuse, emphasizing respectful communication, de-escalation, and intervention strategies with cognitively impaired residents.	

	10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy. A BIMS assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired. A service plan, dated 9/23/25, indicated Resident C functioned appropriately in social settings. A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired. On 11/18/25 at 9:00 a.m., the Administrator provided a copy of a facility policy, dated 9/28/23, titled Abuse and Neglect Reporting Policy, and indicated this was the current policy used by the facility. A review of the policy indicated the facility strives to provide an environment free from abuse. This citation relates to Intake 465887. Based on interview and record review, the facility failed to protect a resident's right to be free from verbal abuse for 1 of 3 residents reviewed for abuse. A cognitively impaired female resident screamed in the face of a cognitively impaired male resident. (Resident B, Resident C)		- The facility's Abuse Prevention, Reporting, and Protection Policy was reviewed and revised to include guidance on resident-to-resident verbal aggression and immediate staff response. - Nursing and direct care staff were re-educated on behavioral cues, non-confrontational redirection, and appropriate staff reporting reaction. - The DON or designee now reviews all behavioral and verbal altercation incidents during daily stand-up meetings and follows up with care plan revisions as needed. **Monitoring to Ensure Ongoing Compliance:** - Unannounced Rounds: The DON or designee will conduct unannounced observations weekly for 4 weeks on different shifts to monitor staff response and resident interaction. - Behavioral Observation Logs:	

	Findings include: During an interview on 11/18/25 at 7:36 a.m., Qualified Medication Aide (QMA) 2 indicated approximately two weeks ago Resident B walked into the bistro and screamed in Resident C's face. Resident B screamed why didn't Resident C want to talk to her. Resident C became tearful and left the bistro. The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A Brief Interview for Mental Status (BIMS) assessment, dated 6/18/25, indicated Resident B was severely cognitively impaired. A Service Plan, dated 6/18/25, indicated Resident B was independent for dressing and undressing self. The service plan lacked any information regarding behaviors/sexually inappropriate behaviors, nor mental health services. A progress note, dated 11/2/25 at 6:54 p.m., indicated earlier today at approximately 6:25 a.m., observed Resident B walk toward Resident C's apartment. Staff attempted to educate Resident B that Resident C did not want to talk at that time.		Staff will document daily behaviors of residents identified with cognitive impairment; reviewed weekly by the HWD or designee. **Completion Date:** 12/17/2025	

Resident B became increasingly agitated and began yelling out for Resident C. Writer attempted to locate Resident C while another staff member redirected Resident B. Resident C was located in the laundry room hiding from Resident B. Once Resident B had been redirected, Resident C was escorted back to his apartment. Later observed Resident C sitting in the bistro reading a newspaper. Resident B entered the bistro and began yelling in Resident C's face asking why Resident C did not want to talk to her. Resident C became tearful and walked away. The Director of Nursing was notified.

The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy.

A BIMS assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired.

A service plan, dated 9/23/25, indicated Resident C functioned appropriately in social settings.

A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired.

On 11/18/25 at 9:00 a.m., the Administrator provided a copy of

	a facility policy, dated 9/28/23, titled Abuse and Neglect Reporting Policy, and indicated this was the current policy used by the facility. A review of the policy indicated the facility strives to provide an environment free from abuse. This citation relates to Intake 465887.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents.	R 0090	**Tag R090:** This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. **Corrective Action for the**	12/17/2025

	If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request A. Based on interview, and		**Deficient Practice:** - The administrator reviewed details of the event and ensured internal follow-up actions and resident safety were completed. - Residents involved were reassessed and care plans updated as needed. **Identification of Other Residents Potentially Affected:** - Incidents for the past 60 days were reviewed to ensure all reportable occurrences were submitted to the State agency within 24 hours as required. - No other reporting delays were identified. **Systemic Changes to Prevent Recurrence:** - The administrator and department heads were re-educated on state reporting timelines and	

	record review, the facility failed to report to the Indiana Department of Health allegations of sexual abuse when a cognitively impaired female resident made inappropriate advances toward, flashed her breast at, and climbed in bed with a cognitively impaired male resident; and the facility failed to report allegations of verbal abuse when a cognitively impaired female resident screamed in the face of a cognitively impaired male resident for 1 of 3 residents reviewed for abuse. (Resident B, Resident C) B. Based on observation, interview, and record review, the facility failed to report to the Indiana Department of Health when a cognitively impaired male resident walked out of the facility without staff knowledge for 1 of 3 residents reviewed for elopements. (Resident C) Findings include: A1. During an interview, on 11/18/25 at 10:16 a.m. Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment, but Resident B continued into Resident C's room and climb into bed with Resident C. Resident C continued to yell out for help.		documentation standards. - Backup reporting responsibility was assigned to the HWD or designee in the administrator's absence. **Monitoring for Sustained Compliance:** - The administrator or designee will review incident reports daily (Monday–Friday) to confirm whether state notification was required and completed within 24 hours. - A monthly audit of incident logs and state report confirmations will be conducted by the HWD/ED three consecutive months. - Discrepancies or delays will result in immediate re-education and corrective action. **Completion Date:** 12/17/2025	

Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and not touching inappropriately. The DON was made aware.

The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder.

The progress notes indicated:

- On 10/9/25 at 6:00 a.m., Resident B had been continuously seeking out and making inappropriate advances toward Resident C. Staff attempted to redirect Resident B multiple times but were unable to do so. The DON had been made aware.

- On 10/13/25 at 3:39 p.m., Resident B was seen wandering into Resident C's apartment. Resident C asked Resident B to leave his apartment multiple time. Then Resident C started yelling for help. Resident B got into bed with Resident C. When staff attempted to assist Resident B out of Resident C's bed, Resident B started to hit the staff and indicated leave her the f*** alone.

- On 11/16/25 at 8:11 a.m., observed Resident B take off her bra in the front lobby with her breasts exposed and other

	residents in the lobby. Staff attempted to redirect Resident B to the restroom but Resident B indicated she was taking the bra off right then because it was too tight. A2. During an interview on 11/18/25 at 7:36 a.m., Qualified Medication Aide (QMA) 2 indicated approximately two weeks ago Resident B walked into the bistro and screamed in Resident C's face asking why Resident C did not want to talk to her. Resident C became tearful and left the bistro. The clinical record for Resident B was reviewed, on 11/18/25 at 8:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A progress note, dated 11/2/25 at 6:54 p.m., indicated earlier today at approximately 6:25 a.m., observed Resident B walking toward Resident C's apartment. Writer attempted to educate Resident B that Resident C did not want to talk at that time. Resident B became increasingly agitated and began yelling out for Resident C. Writer attempted to locate Resident C while another staff member redirected Resident B. Resident C was located in the laundry room hiding from Resident B. Once Resident B had been redirected, Resident C was			

	escorted back to his apartment. Later observed Resident C sitting in the bistro reading a newspaper. Resident B entered the bistro and began yelling in Resident C's face asking why Resident C did not want to talk to her. Resident C became tearful and walked away. The Director of Nursing was notified. During an interview on 11/18/25 at 2:10 p.m., the Administrator indicated the allegations of sexual and verbal abuse should have been reported to the state health department. B1. During an interview on 11/19/25 at 5:32 a.m., QMA 4 indicated, on 10/13/25 at approximately 5:50 a.m., Resident C was walking down the long hall toward the back of the facility, as he normally does throughout the day. A few minutes later, a door alarm sounded and the staff immediately started checking doors and checking for residents. As we walked to the front of the building during the search, Resident C was knocking on the front door to get back in. The front door was locked until approximately 7:00 a.m., each morning. Resident C was confused, was wearing a t-shirt, pants, socks, and shoes. QMA 4 told Resident C he should have had a jacket on because it was cold outside. Resident C had a newspaper			

wrapped around his left forearm like it was a sleeve. From the time the door alarm sounded until Resident C was back inside the front door was approximately ten minutes. The DON was notified.

The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy.

A BIMS (Brief Interview for Mental Status) assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired.

A progress note, dated 10/13/25 at 6:01 a.m., indicated Resident C had left the building unwitnessed and by the time the exits were checked, resident was at the front door knocking to get back inside.

During an interview on 11/18/25 at 2:10 p.m., the Administrator indicated Resident C walking out of the facility without staff knowledge and it should have been reported to the state health department.

On 11/19/25 at 9:39 a.m., the DON provided a copy of the Long-Term Care Abuse and Incident Reporting Policy, dated 12/8/22. A review of the policy indicated the Administrator is responsible for reporting abuse

	or elopements to the Indiana Department of Health within 24 hours. This citation relates to Intake 465887. A. Based on interview, and record review, the facility failed to report to the Indiana Department of Health allegations of sexual abuse when a cognitively impaired female resident made inappropriate advances toward, flashed her breast at, and climbed in bed with a cognitively impaired male resident; and the facility failed to report allegations of verbal abuse when a cognitively impaired female resident screamed in the face of a cognitively impaired male resident for 1 of 3 residents reviewed for abuse. (Resident B, Resident C) B. Based on observation, interview, and record review, the facility failed to report to the Indiana Department of Health when a cognitively impaired male resident walked out of the facility without staff knowledge for 1 of 3 residents reviewed for elopements. (Resident C) Findings include: A1. During an interview, on 11/18/25 at 10:16 a.m. Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's			

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- On 11/16/25 at 8:11 a.m., observed Resident B take off her bra in the front lobby with her breasts exposed and other residents in the lobby. Staff attempted to redirect Resident B to the restroom but Resident B indicated she was taking the bra off right then because it was too tight.

A2. During an interview on 11/18/25 at 7:36 a.m., Qualified Medication Aide (QMA) 2 indicated approximately two weeks ago Resident B walked into the bistro and screamed in Resident C's face asking why Resident C did not want to talk to her. Resident C became tearful and left the bistro.

The clinical record for Resident B was reviewed, on 11/18/25 at 8:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder.

A progress note, dated 11/2/25 at 6:54 p.m., indicated earlier today at approximately 6:25 a.m., observed Resident B walking toward Resident C's apartment. Writer attempted to educate Resident B that Resident C did not want to talk at that time. Resident B became increasingly agitated and began

	yelling out for Resident C. Writer attempted to locate Resident C while another staff member redirected Resident B. Resident C was located in the laundry room hiding from Resident B. Once Resident B had been redirected, Resident C was escorted back to his apartment. Later observed Resident C sitting in the bistro reading a newspaper. Resident B entered the bistro and began yelling in Resident C's face asking why Resident C did not want to talk to her. Resident C became tearful and walked away. The Director of Nursing was notified. During an interview on 11/18/25 at 2:10 p.m., the Administrator indicated the allegations of sexual and verbal abuse should have been reported to the state health department. B1. During an interview on 11/19/25 at 5:32 a.m., QMA 4 indicated, on 10/13/25 at approximately 5:50 a.m., Resident C was walking down the long hall toward the back of the facility, as he normally does throughout the day. A few minutes later, a door alarm sounded and the staff immediately started checking doors and checking for residents. As we walked to the front of the building during the search, Resident C was knocking on the front door to get back in. The front door was			

	locked until approximately 7:00 a.m., each morning. Resident C was confused, was wearing a t-shirt, pants, socks, and shoes. QMA 4 told Resident C he should have had a jacket on because it was cold outside. Resident C had a newspaper wrapped around his left forearm like it was a sleeve. From the time the door alarm sounded until Resident C was back inside the front door was approximately ten minutes. The DON was notified. The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy. A BIMS (Brief Interview for Mental Status) assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired. A progress note, dated 10/13/25 at 6:01 a.m., indicated Resident C had left the building unwitnessed and by the time the exits were checked, resident was at the front door knocking to get back inside. During an interview on 11/18/25 at 2:10 p.m., the Administrator indicated Resident C walking out of the facility without staff knowledge and it should have been reported to the state			

	health department. On 11/19/25 at 9:39 a.m., the DON provided a copy of the Long-Term Care Abuse and Incident Reporting Policy, dated 12/8/22. A review of the policy indicated the Administrator is responsible for reporting abuse or elopements to the Indiana Department of Health within 24 hours. This citation relates to Intake 465887.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or	R 0217	**Tag R217:** This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	12/17/2025

	desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a service plan was updated when a cognitively impaired female resident started having inappropriate sexual behaviors toward other residents, verbally aggressive behaviors toward other residents, was being treated by a mental health professional, and was an elopement risk; and failed to ensure a service plan was updated for a cognitively impaired male resident that was at risk for elopement for 2 of 3 resident reviewed for service plans. (Resident B, Resident C)		**Corrective Action Taken for Affected Residents:** - Resident B's service plan was immediately reviewed and updated to include: • Documentation of sexually inappropriate and verbally aggressive behaviors. • Interventions for redirection, staff monitoring during social interactions, and elopement precautions. • Mental health treatment follow-up and communication plan. - Resident C's service plan was reviewed and updated to include elopement risk interventions and environmental safety measures. - Both residents were re-evaluated by the interdisciplinary team (IDT) to ensure that appropriate supports and	

	Findings include: 1. During an interview on 11/18/25 at 7:27 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B (female resident) had shown an interest in and pursued Resident C (male resident). Resident B and Resident C were both confused and Resident C often had to be assisted to his apartment because he had gotten lost in the facility while walking the halls. During an interview on 11/18/25 at 7:36 a.m., QMA 2 indicated approximately two weeks ago, Resident B walked into the bistro and screamed in Resident C's face. Resident B screamed why didn't Resident C want to talk to her. Resident C became tearful and left the bistro. Then, few days ago, Resident B walked up to Resident C while he was sitting in the bistro, pulled up her shirt, and exposed her breast. Resident C showed no reaction. Resident C was confused and had to be assisted to his room at times. Resident B had been difficult to redirect when she looked for Resident C. At times, Resident B had been aggressive with staff when staff had attempted to redirect Resident B from Resident C. The Director of Nursing (DON) and Administrator were notified.		supervision were in place. **Identification of Other Residents Potentially Affected:** - Residents with cognitive or behavioral changes in the past 60 days were reviewed to ensure their service plans appropriately reflect current needs, behaviors, and risks. - Discrepancies identified were corrected immediately. **Systemic Changes to Prevent Recurrence:** - The Service Plan and Evaluation Policy was reviewed to ensure timely updates following any noted change in condition, behavior, or treatment. - Nurses, QMA staff, care staff, and department heads were re-educated on: • Identifying when a resident’s	

	During an interview on 11/18/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment and Resident B continued to climb into bed with Resident C. Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and were not touching inappropriately. The DON was made aware. The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A Brief Interview for Mental Status (BIMS) assessment, dated 6/18/25, indicated Resident B was severely cognitively impaired. A Service Plan, dated 6/18/25, indicated Resident B was independent for dressing and undressing self. An initial psychiatric evaluation, dated 10/20/25 at 1:00 p.m. indicated nursing staff report concerns of Resident B being inappropriate with Resident C. Nursing reports Resident B fixates on Resident C by following Resident C around the		condition or behavior change requires immediate service plan review. • The process for initiating and documenting service plan updates. • The expectation that mental health changes, sexualized or aggressive behavior, and elopement risk trigger an immediate IDT meeting. - When staff report a new behavior or change, the nurse completes the form and notifies the HWD within 24 hours for review. - The HWD or designee will review incident reports and progress notes daily (Monday – Friday) for indicators that a service plan review may be needed. **Monitoring to Ensure Ongoing Compliance:** - The HWD or designee will audit five random service plans weekly for four weeks, then monthly for three months, to	

	facility, going to his room and continuously knocking on Resident C's door. These behaviors resulted in an admission to a acute behavioral hospital. A psychiatric progress note, dated 10/27/25 at 11:30 a.m., indicated nursing staff report Resident B continues to have sexually driven behaviors toward Resident C. Resident B was observed kissing another male resident while Resident B's husband was present. A psychiatric progress note, dated 11/10/25 at 1:30 p.m., indicated nursing shared concerns of increased impulsive behaviors and Resident B continued to seek out Resident C. The progress notes indicated: - On 10/9/25 at 6:00 a.m., Resident B had been continuously seeking out and making inappropriate advances toward Resident C. Staff made multiple attempts to redirect Resident B but were unable to do so. The DON had been made aware. - On 10/13/25 at 3:39 p.m. Resident B was seen wandering into Resident C's apartment. Resident C asked Resident B to leave his apartment multiple time. Then, Resident C started yelling for help. Resident B got		ensure all significant changes are incorporated into the care/service plan within 24 hours of identification. - Failure identified through monitoring will result in immediate re-education and corrective action for staff involved. **Completion Date:** 12/17/2025	

into bed with Resident C and when staff attempted to assist Resident B out of Resident C's bed, Resident B started to hit the staff and indicated leave her the f*** alone.

- On 11/16/25 at 8:11 a.m., observed Resident B take off her bra in the front lobby with her breasts exposed and other residents in the lobby. Staff attempted to redirect Resident B to the restroom but Resident B indicated she was taking the bra off right then because it was too tight.

Resident B's service plan, dated 6/18/25, lacked information regarding aggressive behaviors toward other residents, sexually inappropriate behaviors toward other residents, nor Resident B's elopement risk.

During a review of the facility elopement binder, on 11/19/25 at 9:08 a.m., observed Resident B's face sheet printed, on 8/20/25, with Resident B's picture and medical information. At that time, Resident B was in the lobby and indicated in a loud voice she wanted to go home. The receptionist attempted to redirect Resident B.

2. The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's

disease, dementia, and polyneuropathy.

A BIMS assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired.

A service plan, dated 9/23/25, indicated Resident C functioned appropriately in social settings.

A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired.

The progress notes indicated:

- On 10/13/25 at 6:01 a.m., indicated Resident C had left the building unwitnessed and by the time staff checked exit doors, Resident C was at the front door knocking to get back inside.

Resident C's service plan, dated 9/23/25, lacked information regarding Resident C's elopement risk.

During an interview on 11/19/25 at 5:32 a.m., QMA 4 indicated, on 10/13/25 at approximately 5:50 a.m., Resident C was walking down the long hall toward the back of the facility, as he normally does throughout the day. A few minutes later, a door alarm sounded and the staff immediately started checking doors and checking for residents. As the staff walked to

	the front of the building during the search, Resident C was knocking on the front door to get back in. The front door was locked until approximately 7:00 a.m., each morning. Resident C was confused, was wearing a t-shirt, pants, socks, and shoes. QMA 4 told Resident C he should have had a jacket on because it was cold outside. Resident C had a newspaper wrapped around his left forearm like it was a sleeve. From the time the door alarm sounded until Resident C was back inside the front door was approximately ten minutes. The DON was notified when this happened. On 11/19/25 at 5:45 a.m., observed Resident C sitting in the lobby watching a television. Resident C was pleasant, confused, and indicated he was not able to recall how long he had resided at the facility by approximately seven years. Resident C was not able to recall Resident B by name nor any inappropriate behaviors in the facility. During a review of the facility elopement binder, on 11/19/25 at 9:08 a.m., observed Resident C's face sheet printed, on 11/10/25 at 2:29 p.m., with Resident C's picture and medical information. During an interview, on 11/18/25			

at 2:10 p.m., the Administrator indicated Resident B's and Resident C's service plans should have been updated and accurate.

On 11/19/25 at 9:05 a.m., the Director of Nursing provided a copy of a facility policy, titled Evaluations, dated 1/9/25, and indicated this was the current policy used by the facility. A review of the policy indicated the facility strives to provide a comprehensive individualized service plan for each resident.

This citation relates to Intake 465887.

Based on interview and record review, the facility failed to ensure a service plan was updated when a cognitively impaired female resident started having inappropriate sexual behaviors toward other residents, verbally aggressive behaviors toward other residents, was being treated by a mental health professional, and was an elopement risk; and failed to ensure a service plan was updated for a cognitively impaired male resident that was at risk for elopement for 2 of 3 resident reviewed for service plans. (Resident B, Resident C)

Findings include:

1. During an interview on

	11/18/25 at 7:27 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B (female resident) had shown an interest in and pursued Resident C (male resident). Resident B and Resident C were both confused and Resident C often had to be assisted to his apartment because he had gotten lost in the facility while walking the halls. During an interview on 11/18/25 at 7:36 a.m., QMA 2 indicated approximately two weeks ago, Resident B walked into the bistro and screamed in Resident C's face. Resident B screamed why didn't Resident C want to talk to her. Resident C became tearful and left the bistro. Then, few days ago, Resident B walked up to Resident C while he was sitting in the bistro, pulled up her shirt, and exposed her breast. Resident C showed no reaction. Resident C was confused and had to be assisted to his room at times. Resident B had been difficult to redirect when she looked for Resident C. At times, Resident B had been aggressive with staff when staff had attempted to redirect Resident B from Resident C. The Director of Nursing (DON) and Administrator were notified. During an interview on 11/18/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 1			

	indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment and Resident B continued to climb into bed with Resident C. Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and were not touching inappropriately. The DON was made aware. The clinical record for Resident B was reviewed on 11/18/25 at 8:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety disorder. A Brief Interview for Mental Status (BIMS) assessment, dated 6/18/25, indicated Resident B was severely cognitively impaired. A Service Plan, dated 6/18/25, indicated Resident B was independent for dressing and undressing self. An initial psychiatric evaluation, dated 10/20/25 at 1:00 p.m. indicated nursing staff report concerns of Resident B being inappropriate with Resident C. Nursing reports Resident B fixates on Resident C by following Resident C around the facility, going to his room and continuously knocking on Resident C's door. These			

behaviors resulted in an admission to a acute behavioral hospital.

A psychiatric progress note, dated 10/27/25 at 11:30 a.m., indicated nursing staff report Resident B continues to have sexually driven behaviors toward Resident C. Resident B was observed kissing another male resident while Resident B's husband was present.

A psychiatric progress note, dated 11/10/25 at 1:30 p.m., indicated nursing shared concerns of increased impulsive behaviors and Resident B continued to seek out Resident C.

The progress notes indicated:

- On 10/9/25 at 6:00 a.m., Resident B had been continuously seeking out and making inappropriate advances toward Resident C. Staff made multiple attempts to redirect Resident B but were unable to do so. The DON had been made aware.

- On 10/13/25 at 3:39 p.m. Resident B was seen wandering into Resident C's apartment. Resident C asked Resident B to leave his apartment multiple time. Then, Resident C started yelling for help. Resident B got into bed with Resident C and when staff attempted to assist Resident B out of Resident C's

bed, Resident B started to hit the staff and indicated leave her the f*** alone.

- On 11/16/25 at 8:11 a.m., observed Resident B take off her bra in the front lobby with her breasts exposed and other residents in the lobby. Staff attempted to redirect Resident B to the restroom but Resident B indicated she was taking the bra off right then because it was too tight.

Resident B's service plan, dated 6/18/25, lacked information regarding aggressive behaviors toward other residents, sexually inappropriate behaviors toward other residents, nor Resident B's elopement risk.

During a review of the facility elopement binder, on 11/19/25 at 9:08 a.m., observed Resident B's face sheet printed, on 8/20/25, with Resident B's picture and medical information. At that time, Resident B was in the lobby and indicated in a loud voice she wanted to go home. The receptionist attempted to redirect Resident B.

2. The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy.

A BIMS assessment, dated

9/23/25, indicated Resident C was severely cognitively impaired.

A service plan, dated 9/23/25, indicated Resident C functioned appropriately in social settings.

A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired.

The progress notes indicated:

- On 10/13/25 at 6:01 a.m., indicated Resident C had left the building unwitnessed and by the time staff checked exit doors, Resident C was at the front door knocking to get back inside.

Resident C's service plan, dated 9/23/25, lacked information regarding Resident C's elopement risk.

During an interview on 11/19/25 at 5:32 a.m., QMA 4 indicated, on 10/13/25 at approximately 5:50 a.m., Resident C was walking down the long hall toward the back of the facility, as he normally does throughout the day. A few minutes later, a door alarm sounded and the staff immediately started checking doors and checking for residents. As the staff walked to the front of the building during the search, Resident C was knocking on the front door to get back in. The front door was

	locked until approximately 7:00 a.m., each morning. Resident C was confused, was wearing a t-shirt, pants, socks, and shoes. QMA 4 told Resident C he should have had a jacket on because it was cold outside. Resident C had a newspaper wrapped around his left forearm like it was a sleeve. From the time the door alarm sounded until Resident C was back inside the front door was approximately ten minutes. The DON was notified when this happened. On 11/19/25 at 5:45 a.m., observed Resident C sitting in the lobby watching a television. Resident C was pleasant, confused, and indicated he was not able to recall how long he had resided at the facility by approximately seven years. Resident C was not able to recall Resident B by name nor any inappropriate behaviors in the facility. During a review of the facility elopement binder, on 11/19/25 at 9:08 a.m., observed Resident C's face sheet printed, on 11/10/25 at 2:29 p.m., with Resident C's picture and medical information. During an interview, on 11/18/25 at 2:10 p.m., the Administrator indicated Resident B's and Resident C's service plans should have been updated and			

	accurate. On 11/19/25 at 9:05 a.m., the Director of Nursing provided a copy of a facility policy, titled Evaluations, dated 1/9/25, and indicated this was the current policy used by the facility. A review of the policy indicated the facility strives to provide a comprehensive individualized service plan for each resident. This citation relates to Intake 465887.			
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 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 interview and record review, the facility failed to ensure a resident's progress notes were complete and accurate when a cognitively impaired female resident made	R 0349	**Tag R349:** This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is	12/17/2025

verbally aggressive behaviors, inappropriate advances toward, flashed her breast at, and climbed in bed with a cognitively impaired male resident for 1 of 3 residents reviewed for complete and accurate records. (Resident C, Resident B)

Findings include:

During an interview on 11/18/25 at 7:27 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B (female resident) had shown an interest in and pursued Resident C (male resident). Resident B and Resident C were both confused and Resident C often had to be assisted to his apartment because he had gotten lost in the facility while walking the halls.

During an interview on 11/18/25 at 7:36 a.m., QMA 2 indicated approximately two weeks ago, Resident B walked into the bistro and screamed in Resident C's face. Resident B screamed why didn't Resident C want to talk to her. Resident C became tearful and left the bistro. Then, few days ago, Resident B walked up to Resident C while he was sitting in the bistro, pulled up her shirt, and exposed her breast. Resident C showed no reaction. Resident C was confused and had to be assisted to his room at times. Resident B had been difficult to

evidence of compliance.

Corrective Action Taken for the Affected Resident(s):

- Nursing staff involved were interviewed and counseled on the requirement for timely and factual documentation of all resident behaviors and incidents.

- The Health and Wellness Director reviewed all associated progress notes and ensured corresponding incident reports were filed and completed accurately.

Identification of Other Residents Potentially Affected:

- A facility-wide audit of progress notes and incident documentation for the past 30 days was completed to verify that all behaviors and significant events were accurately recorded.

redirect when she looked for Resident C. At times, Resident B had been aggressive with staff when staff had attempted to redirect Resident B from Resident C. The Director of Nursing (DON) and Administrator were notified.

During an interview on 11/18/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment, but Resident B continued into Resident C's room and climbed into bed with Resident C. Resident C continued to yell out for help. Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and not touching inappropriately. The DON was made aware.

The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy.

A BIMS (Brief Interview for Mental Status) assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired.

A service plan, dated 9/23/25 and current through 3/22/26,

- Any incomplete entries identified during this audit were corrected and verified by the DON or designee.

Systemic Changes to Prevent Recurrence:

- Nurses, QMAs, and CNAs were re-educated on:

• Regulatory requirements for complete and accurate documentation.

• Proper documentation of unusual behaviors, verbal or physical aggression, and resident-to-resident interactions.

• Definition of “significant change” requiring IDT and service plan review.

Monitoring to Ensure Ongoing Compliance:

- The HWD or designee will perform weekly audits of 5 random
resident records for 4 weeks, then monthly for 3 months.

	indicated Resident C functioned appropriately in social settings. A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired. Resident C's clinical record lacked documentation, on 10/13/25, when Resident B walking into his Resident C's apartment and got into his bed with him after Resident C told Resident B to leave his apartment and lacked documentation, on 11/2/25, when Resident B approached Resident C in the bistro and yelled in his face causing Resident C to become tearful and leave the bistro. During an interview on 11/18/25 at 2:10 p.m., the Administrator indicated Resident C's progress notes should have been complete and accurate. On 11/19/25 at 11:00 a.m., the facility was unable to provide a policy regarding complete and accurate documentation by the survey exit. This citation relates to Intake 465887. Based on interview and record review, the facility failed to ensure a resident's progress notes were complete and accurate when a cognitively impaired female resident made		- The IDT will review results of these audits monthly for a minimum of three months or until consistent compliance (100%) is sustained. - Incomplete or late documentation identified will result in immediate correction and individual staff re-education. **Completion Date:** 12/17/2025	

verbally aggressive behaviors, inappropriate advances toward, flashed her breast at, and climbed in bed with a cognitively impaired male resident for 1 of 3 residents reviewed for complete and accurate records. (Resident C, Resident B)

Findings include:

During an interview on 11/18/25 at 7:27 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B (female resident) had shown an interest in and pursued Resident C (male resident). Resident B and Resident C were both confused and Resident C often had to be assisted to his apartment because he had gotten lost in the facility while walking the halls.

During an interview on 11/18/25 at 7:36 a.m., QMA 2 indicated approximately two weeks ago, Resident B walked into the bistro and screamed in Resident C's face. Resident B screamed why didn't Resident C want to talk to her. Resident C became tearful and left the bistro. Then, few days ago, Resident B walked up to Resident C while he was sitting in the bistro, pulled up her shirt, and exposed her breast. Resident C showed no reaction. Resident C was confused and had to be assisted to his room at times. Resident B had been difficult to

redirect when she looked for Resident C. At times, Resident B had been aggressive with staff when staff had attempted to redirect Resident B from Resident C. The Director of Nursing (DON) and Administrator were notified.

During an interview on 11/18/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 1 indicated, on 10/13/25, Resident B entered Resident C's apartment. Resident C yelled for Resident B to leave his apartment, but Resident B continued into Resident C's room and climbed into bed with Resident C. Resident C continued to yell out for help. Resident B was difficult to redirect out of Resident C's bed and apartment. Both residents were fully clothed and not touching inappropriately. The DON was made aware.

The clinical record for Resident C was reviewed on 11/18/25 at 10:18 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and polyneuropathy.

A BIMS (Brief Interview for Mental Status) assessment, dated 9/23/25, indicated Resident C was severely cognitively impaired.

A service plan, dated 9/23/25 and current through 3/22/26,

indicated Resident C functioned appropriately in social settings.

A BIMS assessment, dated 11/7/25, indicated Resident C was severely cognitively impaired.

Resident C's clinical record lacked documentation, on 10/13/25, when Resident B walking into his Resident C's apartment and got into his bed with him after Resident C told Resident B to leave his apartment and lacked documentation, on 11/2/25, when Resident B approached Resident C in the bistro and yelled in his face causing Resident C to become tearful and leave the bistro.

During an interview on 11/18/25 at 2:10 p.m., the Administrator indicated Resident C's progress notes should have been complete and accurate.

On 11/19/25 at 11:00 a.m., the facility was unable to provide a policy regarding complete and accurate documentation by the survey exit.

This citation relates to Intake 465887.

SIGNATURERhiannon		