STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST LAFAYETTE ALF OPERATIONS	3575 SENIOR PLACE, WEST LAFAYETTE, , 47906

(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 IN00464301. Intake IN00464301-State deficiencies related to the allegations are cited at R0053. Survey date: September 25, 2025. Facility number: 014094 Residential Census: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 2, 2025.	R 0000	Allegation of Substantial Compliance West Lafayette Assited Living has or will have substantially corrected the alleged deficiencies and achieved substantial compliance on or before the date specified herein. The Plan of Correction constitutes West Lafayette Assisted Living's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before November 15, 2025. The statements made on this plan of correction are to correct the deficiencies continue to remain in substantial compliance with Indiana state requirements for health facilities found at 410 IAC 16.2, West Lafayette Assisted Living (herein after referred to as "community") has taken or will take the actions set forth in this plan of correction	

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 ensure a resident was free from verbal abuse of a staff member for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: A facility reported incident, dated 8/22/25, indicated QMA 2 was found in Resident B's room. She had startled him. He called his sister, and she told QMA 2 to leave or they would call the police. Resident B went to the nursing station to report incident and QMA 2 yelled and screamed at the resident in front of another employee. The clinical record for Resident B was reviewed on 9/25/25 at 3:10 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, depression, anemia, and atrial fibrillation. Resident B's mini mental score indicated he was cognitively intact. An e-mail from Resident B to the Executive Director (ED),	R 0053	ED will review with all staff members the abuse and neglect policy and procedures form will all employees during all staff on 10/16/2025. Each employee will sign and acknowledge the form was reviewed. ED coordinated with Ombudsman to conduct an all-staff meeting held on November 6, 2025 at 3:30pm to go over the different abuses towards senior citizens that occur in the nursing home setting and how to report abuse to the supervisors. DON will give an in-service to all staff members in regard to abuse and neglect once a week for the next 4 weeks. Week 1- Oct 20, 2025 Week 2- Oct 27, 2025 Week 3- Nov 3, 2025	11/15/2025

	dated 8/22/25 at 7:33 p.m., indicated on 6/12/25, he and QMA 2 had a casual non-sexual relationship evolve. He indicated he had set boundaries with QMA 2 since she was a married woman. He was attracted to her, and she was to him. QMA 2 ignored the boundaries and continued to pursue him through e-mails and unwelcome visits to his room during the middle of the night. He stopped the relationship and told her to back off. Things were okay, until 8/21/25, when he received confusing emails from her. He confronted her, she started to yell at him, and he walked away. At 1:00 a.m., she entered his room unannounced and began arguing Resident B. He told her to leave and she would not leave. She finally left and then reappeared, at 3:30 a.m., at his bedside. She touched his arm, and he was startled awake. She started arguing and harassing him and she would not leave. He called his sister, and she witnessed what was happening. QMA 2 was swearing at Resident B and his sister when she left the room. He barricaded his door. At 7:00 a.m., he removed the barricade. At 7:30 a.m., QMA 2 came into his room and began arguing and harassing him again. He left the room and went to the nurse's station to report the incidents. QMA 2 continued to argue and berate him in front of QMA 5. He		Week 4- Nov 10, 2025	

left the area, went to his room, and made a formal complaint regarding QMA 2 and her verbal abuse.

In a facility documented interview, dated 8/22/25, QMA 2 indicated she and Resident B were emailing each other and she accused Resident B of liking another staff member. He told QMA 2 not to go to his room. She went to his room, around 3:00 a.m., to apologize for the email. Resident B said QMA 2 was arguing with him, but he was just mad at her. Resident B called his sister and threatened to call the police. At 7:00 a.m., Resident B refused his medication pass. QMA 2 told Resident B she was tired of his treats to call the police. QMA 2 tried to be professional and told Resident B she was going to block him. Resident B got out of bed and began to yell at her down the hallway saying he was going to get her fired.

In a facility documented interview, on 8/22/25, QMA 5 indicated, at 7:30 a.m., she heard Resident B come out of his room yelling at QMA 2. Resident B indicated QMA 2 would not have a job after he reported her. QMA 5 asked Resident B what was wrong, and he asked if the ED was in the facility. QMA 5 informed him, she was not in yet. QMA 2 was interrupting him and yelling

from down the hallway. QMA 2 and Resident B continued to yell at each other. QMA 2 told Resident B his sister was psycho which aggravated the resident.

In a facility documented interview, on 8/22/25, QMA 6 indicated Resident B had complained QMA 2 had overstepped her boundaries. Resident B indicated QMA 2 kept coming into his room and arguing with him about messing around with other staff members. Resident B indicated he was sleeping in his room, and QMA 2 woke him out of his sleep, at 3:30 a.m., by rubbing his arm. She began arguing with him and he asked her to leave his room. She did not leave so he called his sister. His sister asked if he wanted her to call the police and QMA 2 left. QMA 2 called Resident B and his sister names as she left the room. He took a chair and placed it under the doorknob to keep QMA 2 out of his room.

During an interview, on 9/25/25 at 2:50 p.m., Resident B indicated QMA 2 was told not to be in his room, talk to him, or be around him starting in July 2025. QMA 2 entered his room multiple times on 8/21/25. They were arguing regarding personal issues. QMA 2 and himself were in a relationship which included emailing, kissing and hugging.

The relationship started in June 2025. He had backed off the relationship because QMA 2 was married and wanted to divorce her husband and be with him. Resident B did not want the relationship to go that far and did not have sex with QMA 2. They had sent emails to each other since June, and some were ex-rated. On 8/22/2025, QMA 2 entered his room around 3:00 a.m., and was touching his arm while he was in bed. He was startled. He told QMA 2 to leave his room and she did not. She was yelling and screaming at him. He called his sister while QMA 2 was in the room. His sister told QMA 2 to leave, or she would call the police. Resident B went to the nurse's station to report the incident to QMA 5. When he was reporting the incident, QMA 2 interrupted him and began yelling and screaming at him. QMA 2 told QMA 5 Resident B was lying and making up stories about her. QMA 2 continued to yell and scream at Resident B. The incident was reported to the Executive Director, she called the police, and a police report was filed. Resident B felt he was verbally abused by QMA 2.

During an interview, on 9/25/25 at 3:46 p.m., Resident B's sister indicated her brother called on 8/22/25 at 3:40 a.m. He was upset and told her QMA 2 was yelling, cussing and verbally

abusive to him. She overheard the yelling from QMA 2, and it was loud and not very nice. QMA 2 was obsessed with her brother and would not leave him alone. She was jealous of other staff around him. She asked her brother, on 8/22/25, if he wanted her to call the police since QMA 2 would not leave his room. QMA 2 was calling her and Resident B names as she left the room. Her brother did not want a relationship with QMA 2. She indicated her brother had been verbally abused by QMA 2.

During an interview, on 9/25/25 at 3:55 p.m., QMA 5 indicated, on 8/22/25, Resident B and QMA 2 were arguing and yelling at each other at the nurse's station around 7:00 a.m. Resident B was upset and wanted to let someone know about QMA 2's actions toward him. He did not want QMA 2 to administer his medications, so QMA 5 administered them after QMA 2 left the facility. QMA 2 was verbally abusive to the resident, and she reported the incident to her supervisor.

During an interview, on 9/25/25 at 2:20 p.m., the ED indicated Resident B had reported the incident to her regarding QMA 2's verbally abusive behavior on 8/22/25. She was not aware of any relationship between QMA 2 and Resident B. QMA 2

denied any relationship. She indicated the staff member was suspended during the investigation, The staff member was terminated after the investigation was completed. The staff member was reported to the QMA board for verbal abuse activity with a resident. She indicated a police report had been filed for the resident.

A current facility policy, titled "Resident Abuse Prevention and Reporting Policy", not dated and received from the ED on 9/25/25 at 12:48 p.m., indicated "...Abuse: intentional or reckless act (or failure to act) that causes physical, emotional, sexual, or financial harm...."

This citation relates to Intake IN00464301.

Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse of a staff member for 1 of 3 residents reviewed for abuse. (Resident B)

Findings include:

A facility reported incident, dated 8/22/25, indicated QMA 2 was found in Resident B's room. She had startled him. He called his sister, and she told QMA 2 to leave or they would call the police. Resident B went to the nursing station to report incident and QMA 2 yelled and screamed at the resident in front

of another employee.

The clinical record for Resident B was reviewed on 9/25/25 at 3:10 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, depression, anemia, and atrial fibrillation.

Resident B's mini mental score indicated he was cognitively intact.

An e-mail from Resident B to the Executive Director (ED), dated 8/22/25 at 7:33 p.m., indicated on 6/12/25, he and QMA 2 had a casual non-sexual relationship evolve. He indicated he had set boundaries with QMA 2 since she was a married woman. He was attracted to her, and she was to him. QMA 2 ignored the boundaries and continued to pursue him through e-mails and unwelcome visits to his room during the middle of the night. He stopped the relationship and told her to back off. Things were okay, until 8/21/25, when he received confusing emails from her. He confronted her, she started to yell at him, and he walked away. At 1:00 a.m., she entered his room unannounced and began arguing Resident B. He told her to leave and she would not leave. She finally left and then reappeared, at 3:30 a.m., at his bedside. She touched his arm, and he was startled awake. She

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sister names as she left the room. He took a chair and placed it under the doorknob to keep QMA 2 out of his room.

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QMA 2 told QMA 5 Resident B was lying and making up stories about her. QMA 2 continued to yell and scream at Resident B. The incident was reported to the Executive Director, she called the police, and a police report was filed. Resident B felt he was verbally abused by QMA 2.

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correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREKristie Cottrell	TITLEExecutive Director	(X6) DATE10/14/2025