STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT HARRISON ALF OPERATIONS	8025 DOUBLEDAY DRIVE, INDIANAPOLIS, , 46216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 466783, 466691, 466191, 466160 and 466026. Intake 466026 - No deficiencies related to the allegations are cited. Intake 466160 - State deficiencies related to the allegations are cited at R0036 and R0349. Intake 466191 - State deficiencies related to the allegations are cited at R0297, R0349 and R0357. Intake 466691 - State deficiencies related to the allegations are cited at R0053, and R0091. Intake 466783 - State deficiencies related to the allegations are cited at R0053 and R0091. Survey dates: January 14, 15	R 0000		

	and 16, 2026 Facility number: 014109 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 28, 2026.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify a resident's legal representative of a resident's discharge to the hospital for 1 of 3 residents reviewed for Resident Rights. (Resident C) Findings include:	R 0036	**1. Immediate actions taken for those residents identified.** Education with QMAs, including Resident Rights policy and transfer/discharge policy. **2. How the facility identified other residents.** Any residents residing in the facility had the potential to be affected. **3. Measures put into place and/or system changes.** Transfer/discharge audit for proper documentation and proper contact notifications to be completed by HWD/designee weekly for 4 weeks, then 3 times weekly thereafter. Audits were start January 30, 2026. **4. How the corrective actions will be monitored.** The HWD/designee will be responsible for conducting	01/30/2026

	The clinical record for Resident C was reviewed on 1/14/25 at 2:30 p.m. The resident's diagnosis included, but was not limited to, lupus (autoimmune disease). A nursing progress note, dated 11/17/25, indicated Resident C had returned from the hospital with no new orders. The resident was hospitalized for an elevated blood pressure. The resident's legal representative was notified via phone she had arrived back at the facility. Resident C's medical chart lacked documentation of the notification to the resident's legal representative when the resident was transferred to hospital on 11/15/25. An interview was conducted with the Director of Nursing on 1/15/26 at 3:25 p.m. She indicated Resident C was sent out on 11/15/25 with complaints of a headache and elevated blood pressure. The staff notified a family member the resident was being transferred to the hospital, but did not notify Resident C's Legal Representative. The facesheet had the legal representative as the first contact, but the staff called the person they were more familiar with. Resident C's Legal Representative had discussed with staff he would like to be notified first prior to		audits and compliance. Any issues identified will be immediately addressed.	

	the incident. A resident rights policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...3. Medical and physical care and treatment. Every resident shall have the right to:...G. The individual and/or sponsor will be allowed to participate in the planning of his or her care..." The citation is related to Intake 466160. Based on interview and record review, the facility failed to notify a resident's legal representative of a resident's discharge to the hospital for 1 of 3 residents reviewed for Resident Rights. (Resident C) Findings include: The clinical record for Resident C was reviewed on 1/14/25 at 2:30 p.m. The resident's diagnosis included, but was not limited to, lupus (autoimmune disease). A nursing progress note, dated 11/17/25, indicated Resident C had returned from the hospital with no new orders. The resident was hospitalized for an elevated blood pressure. The resident's legal representative was notified via phone she had arrived back at the facility. Resident C's medical chart lacked documentation of the			

	notification to the resident's legal representative when the resident was transferred to hospital on 11/15/25. An interview was conducted with the Director of Nursing on 1/15/26 at 3:25 p.m. She indicated Resident C was sent out on 11/15/25 with complaints of a headache and elevated blood pressure. The staff notified a family member the resident was being transferred to the hospital, but did not notify Resident C's Legal Representative. The facesheet had the legal representative as the first contact, but the staff called the person they were more familiar with. Resident C's Legal Representative had discussed with staff he would like to be notified first prior to the incident. A resident rights policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...3. Medical and physical care and treatment. Every resident shall have the right to:...G. The individual and/or sponsor will be allowed to participate in the planning of his or her care..." The citation is related to Intake 466160.			

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 of verbal abuse by a staff member for 2 of 4 residents reviewed for Resident Rights. (Resident E and Resident S) Findings include: An interview was conducted with Resident L on 1/14/26 at 3:16 p.m. She indicated she had witnessed the verbal altercation between Resident E and QMA 1 a couple of weeks ago. The incident had occurred on the first floor while leaving the dining room. They both were shouting and cussing at each other. At that time, Resident L had demonstrated the close proximity of Resident E and QMA 1 during the altercation. Resident L indicated they (Resident E and QMA 1) were "chest to chest and in each others face " She had not observed any physical touching between the two besides QMA 1's foot was sitting on top of Resident E's foot. During the argument, QMA 1 had balled up her fist and was hitting her balled fist on the palm of her other hand as she was	R 0053	the facility failed to ensure a resident was free of verbal abuse by staff • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Provide **mandatory and education**for all staff on: • Indiana resident rights, including freedom from verbal abuse. • Abuse identification, prevention, and reporting procedures. • Communication and de-escalation techniques.	02/09/2026

	"screaming" at Resident E. Resident E was "giving it right back to her." A male resident had approached QMA 1 and Resident E during the exchange. He had asked to be let in his room, because he locked himself out. QMA 1 did not stop arguing with Resident E. She had reached in her pocket and gave Certified Nursing Aide (CNA) 2 her keys who had been observing the argument. CNA 2 had assisted the male resident with unlocking his door. An interview was conducted with Resident E on 1/15/26 at 9:57 a.m. She indicated she had gotten in a verbal altercation with QMA 1. She and QMA 1 was yelling and cussing at each other on the first floor outside of the dining room. An incident had occurred the day before in the dining room during a meal service. Resident S had expressed frustration and was loud about missing some tops after QMA 1 had completed her laundry. Resident S had felt QMA 1 had stolen the tops and was upset about it. QMA 1 had made rude comments toward Resident S, rolled her eyes and stood behind Resident S's chair. Resident S noticed her standing behind her chair and would then turn around and tell QMA 1 to move on. It was like QMA 1 was antagonizing Resident S. Resident E had witnessed the		• Reinforce **zero-tolerance abuse policy** facility-wide. • Increase leadership oversight and monitoring of staff–resident interactions. • Conduct periodic audits of staff compliance and training effectiveness. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

	incident. She was Resident S's tablemate. Resident E had stated to QMA 1 that day, "don't be like that." QMA 1 responded, "I am a grown a** woman." After the exchange that day, QMA 1 had exited the dining area through the kitchen area. The following day, Resident E and Resident L were leaving the dining room and QMA 1 came "rushing" down the stairs and stated to Resident E to "stay out of her business." The conversation had become aggressive they were chest to chest making loud statements that included cussing at eachother. QMA 1 stated, "You don't know me outside of this building. "Get the f*** out of my face." During the argument, a male resident had requested QMA 1 to unlock his apartment. QMA 1 never stopped yelling at her. She reached out with her keys in her hand and gave them to CNA 2 that had been present at the time of the verbal argument between them. CNA 2 did not intervene. He took the keys from QMA 1 and unlocked the resident's apartment door. It was a "very heated" and "aggressive" verbal argument. "I was very upset about it." An interview was conducted with Executive Director on 1/15/26 at 1:54 p.m. She indicated the incident between QMA 1 and Resident E's verbal altercation that included		• Any resident identified as potentially affected will receive an **immediate assessment of emotional well-being**. • Emotional support and reassurance will be provided as needed. • Resident care plans will be reviewed and updated to ensure protection of resident rights and safety • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? • Review and revise the facility's **Abuse Prevention and Resident Rights policies** to reinforce zero tolerance for verbal abuse.	

	shouting and cussing at one another after leaving the dining room had been investigated. It had taken place in a common area on the first floor. Verbal abuse education had been provided to all staff, and QMA 1 was addressed. An interview was conducted with Resident S on 1/15/26 at 2:00 p.m. She indicated QMA 1 had returned her completed clean laundry. There were some tops that were missing. Resident S had told QMA 1 in the dining room she needed her tops. That was it. QMA 1 had become disrespectful and started talking her "garbage." Resident S was bigger than that. She had not "paid her any attention" with a response. "I am too old." She had not witnessed the incident between one of her tablemates, Resident E and QMA 1 that had occurred the following day. She goes down to the dining room to eat her meals, and then returns to her room right after. She does not like "drama." QMA 1 and CNA 2 was not available for interviews. A written statement by QMA 1, dated 12/6/25, indicated the QMA, Resident L and Resident E were all talking when Resident E became upset because "I [QMA 1] told her [Resident E] that I was grown		• Ensure policies clearly define verbal abuse and outline disciplinary consequences. • Require staff acknowledgment of policies upon hire and annually. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • the Administrator and DON will conduct **routine and unannounced observations** of staff–resident interactions on all shifts. • Supervisory staff will complete **weekly monitoring logs** documenting	

	and I don't need people to tell me what to do if I'm not talking or interacting. It's because I stay away from negative energy...She walked up to me and pushed me with her big chest. I said Ms. [Resident E] watch out your pushing me. She pushed me again. Ms. [Resident L] got up and said come on yall. I said she's ok Ms. [Resident L] I just won't say anything to her to be fair. She said ok, ok, ok that 's fine...I said ok Ms. [Resident E] let me go cause this is crazy and I don't have time for none of this." An email statement by Resident L, dated 12/6/25, indicated, between Resident E and QMA 1, "..Bad names was called chest pumping out was going on. I try to get in between them but I was moved out of the way. [Resident E] was telling [QMA 1] she do not have to act like that...[QMA 1] told her she's a grown woman and she can act like she want to act...A lot of harsh words came out of both women's mouth. While I was siting down I noticed [QMA 1]'s foot was on top of [Resident E]'s shoe. One of the resident who lived on the first floor was asking [QMA]1 that he locked himself out of his door and he need her key to open to his door but she was (sic) kept on arguing with [Resident E] so I asked [QMA 1]. Please help the guy to unlock his door. So she		observations, staff behavior, and any corrective actions taken. • Any concerns identified will be addressed immediately through counseling, retraining, or disciplinary action as appropriate.	

	gave her key to [CNA 2] to the (sic) open his door..." A written statement by Resident E, dated 12/6/25, indicated "....I was...told what to say and do or not to say and do by an aggressive employee [QMA 1]. Said employee was headed up the stairs when (Resident L] and I were leaving the dining room. [Resident L] called out to speak to [QMA 1]...and when she saw me standing next to [Resident L] she said oh yeah and came to tell me she didn't appreciate what I said to her yesterday morning. She said I needed to mind my business all the while she was walking up on me real aggressive. I told her all I said was don't act like that and her response was I am grown and I said we all are..." An abuse policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...Policy Overview: Fort Harrison Assisted Living is committed to maintaining a safe environment for each resident, visitor and employee. Instances and allegations of abuse, neglect, or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...5. Investigation: a) Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation,			

	the Executive Director, or designee, should conduct a confidential internal investigation of the incident. b)...1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community...d.) Investigation Record. The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being questioned and an impartial report of facts..." This citation relates to Intakes 466783 and 466691. Based on interview and record review, the facility failed to ensure a resident was free of verbal abuse by a staff member for 2 of 4 residents reviewed for Resident Rights. (Resident E and Resident S) Findings include: An interview was conducted with Resident L on 1/14/26 at 3:16 p.m. She indicated she had witnessed the verbal altercation between Resident E and QMA 1 a couple of weeks ago. The incident had occurred on the first floor while leaving the			

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An interview was conducted with Executive Director on 1/15/26 at 1:54 p.m. She indicated the incident between QMA 1 and Resident E's verbal altercation that included shouting and cussing at one another after leaving the dining room had been investigated. It had taken place in a common area on the first floor. Verbal abuse education had been provided to all staff, and QMA 1 was addressed.

An interview was conducted with Resident S on 1/15/26 at 2:00 p.m. She indicated QMA 1 had returned her completed clean laundry. There were some tops that were missing. Resident S had told QMA 1 in the dining room she needed her tops. That was it. QMA 1 had become disrespectful and started talking her "garbage." Resident S was bigger than that. She had not "paid her any attention" with a response. "I am too old." She had not witnessed the incident between one of her

	tablemates, Resident E and QMA 1 that had occurred the following day. She goes down to the dining room to eat her meals, and then returns to her room right after. She does not like "drama." QMA 1 and CNA 2 was not available for interviews. A written statement by QMA 1, dated 12/6/25, indicated the QMA, Resident L and Resident E were all talking when Resident E became upset because "I [QMA 1] told her [Resident E] that I was grown and I don't need people to tell me what to do if I'm not talking or interacting. It's because I stay away from negative energy...She walked up to me and pushed me with her big chest. I said Ms. [Resident E] watch out your pushing me. She pushed me again. Ms. [Resident L] got up and said come on yall. I said she's ok Ms. [Resident L] I just won't say anything to her to be fair. She said ok, ok, ok that 's fine...I said ok Ms. [Resident E] let me go cause this is crazy and I don't have time for none of this." An email statement by Resident L, dated 12/6/25, indicated, between Resident E and QMA 1, "..Bad names was called chest pumping out was going on. I try to get in between them but I was moved out of the way.			

	[Resident E] was telling [QMA 1] she do not have to act like that...[QMA 1] told her she's a grown woman and she can act like she want to act...A lot of harsh words came out of both women's mouth. While I was siting down I noticed [QMA 1]'s foot was on top of [Resident E]'s shoe. One of the resident who lived on the first floor was asking [QMA]1 that he locked himself out of his door and he need her key to open to his door but she was (sic) kept on arguing with [Resident E] so I asked [QMA 1]. Please help the guy to unlock his door. So she gave her key to [CNA 2] to the (sic) open his door..." A written statement by Resident E, dated 12/6/25, indicated "....I was...told what to say and do or not to say and do by an aggressive employee [QMA 1]. Said employee was headed up the stairs when (Resident L] and I were leaving the dining room. [Resident L] called out to speak to [QMA 1]...and when she saw me standing next to [Resident L] she said oh yeah and came to tell me she didn't appreciate what I said to her yesterday morning. She said I needed to mind my business all the while she was walking up on me real aggressive. I told her all I said was don't act like that and her response was I am grown and I said we all are..."			

	An abuse policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...Policy Overview: Fort Harrison Assisted Living is committed to maintaining a safe environment for each resident, visitor and employee. Instances and allegations of abuse, neglect, or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...5. Investigation: a) Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or designee, should conduct a confidential internal investigation of the incident. b)...1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community...d.) Investigation Record. The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being questioned and an impartial report of facts..." This citation relates to Intakes 466783 and 466691.			

R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure reporting and thorough investigations were conducted for 4 of 4 reportable incidents reviewed (Residents D, E, F, P), and ensure residents that are in relationships have the involvement of a medical provider, a plan in place, and updated service plans per the intimate policy for 2 of 2 residents reviewed for intimate relationship (Residents Q and P). Findings include: 1. The clinical record for Resident D was reviewed on	R 0091	the facility failed to ensure reporting and thorough investigations were conducted • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For residents in intimate relationships (Residents Q and P), the facility has taken the following actions to ensure compliance with the **Intimate Relationships policy**: • **Medical Provider Involvement** •	02/09/2026

	1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain. A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed. A physician's order, dated 10/28/25, indicated Resident D was to self-administer oxycontin ER (Extended Release) 10 mg tablets take 1 tablet by mouth twice daily at 8:00 a.m. and 4:00 p.m. A Packing Slip from the facility pharmacy, dated 11/12/25, indicated Resident D had received 120 tablets of Oxycodone 10 mg. During an interview on 1/15/26 at 9:57 a.m., Resident D indicated that on November 24, 2025, she had reported to the Director of Nursing (DON) and the Executive Director (ED) that she had 120 tablets of oxycodone which was missing. Resident D indicated she was in the process of organizing her apartment and had placed the oxycodone in her dresser drawer the evening before when her children were visiting, the next morning it was not in the		• A medical provider has been consulted for each resident to assess safety, appropriateness, and any potential health risks associated with the relationship. • **Individualized Plan Development** • An individualized plan has been created for each resident to address safety, support, and resident rights, while respecting the relationship. •	

	dresser drawer. Resident D called the DON and reported the missing oxycodone. The DON came to her apartment and went through Resident D's dresser drawers and called Resident D's family to talk about the missing oxycodone. Resident D had gone to the ED to report the missing oxycodone and the 120 tablets of oxycodone had never been found. During an interview on 1/15/26 at 12:04 p.m., the ED and the DON indicated Resident D never had 120 OxyContin's missing. The DON indicated the pharmacy was notified and 120 OxyContin were never delivered to the facility. During an interview on 1/15/26 at 3:11 p.m., the ED indicated she had not reported to the alleged missing oxycontin to the Indiana Department of Health. The ED would have normally reported the missing narcotics, but after investigating and finding out that the pharmacy had never sent 120 OxyContin, the ED did not think she had to report the incident. During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets		**Service Plan Updates** • Resident service plans have been updated to reflect: • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The facility will review and assess all residents who could be impacted by the same deficient practices: • **Reporting & Investigation Deficiency:** • Review all incident reports,	

	and took 2 tablets to equal 10 mg which she took as needed. She also had oxycontin 10 mg tablets which she took routinely. When Resident D moved from the first floor to the second floor, she thought that her oxycodone 5 mg were missing (120 tabs). Resident D had 120 tablets of oxycontin 10 mg. Resident D did not have a prescription for oxycodone 5 mg but had received a refill oxycontin 10 mg (120 pills). The facility had contacted the pharmacy to confirm no oxycodone 5 mg had been delivered. Nurse Practitioner was informed that Resident D needed oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg, which was delivered. The DON had educated Resident D on the change of oxycodone from 5 mg tablet to a 10 mg tablet and provided a lock box and blank narc sheets for Resident D to use to keep a running count for herself. During an interview on 1/16/26 at 10:50 a.m., Pharmacy Technician (PT) 21 indicated Resident D had a prescription on file for Oxycodone IR 10 mg take one tablet every 6 hours as needed. The pharmacy had filled the prescription on November 10, 2025, and 120 tablets had been sent to the facility.		grievances, and complaints from the past 90 days for any signs of staff verbal abuse or failure to investigate properly. • Interview residents cared for by involved staff and others on the same unit/shift to determine if similar concerns exist. • Observe staff-resident interactions to identify any potential risk of abuse or reporting failures. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; • Review and revise	

	During an interview on 1/16/26 at 2:03 p.m., PT 22 indicated that on November 11, 2025, the pharmacy had sent 14 Oxycontin ER 10 mg tablets to the facility for Resident D. On 11/28/25, the pharmacy had sent 14 tablets of oxycontin ER for Resident D. During an interview on 1/16/26 at 2:16 p.m., Resident D indicated the oxycodone instant release medications were the medication that were missing. She had received 120 tablets and had maybe taken 2 or 3 tablets before they came up missing. She had reported the missing oxycodone instant release medications missing to the DON and the ED on 11/24/25. The ED had told her that the police were going to be called and an investigation started. Resident D had told the ED to go ahead and start an investigation. 2. A reportable incident to the Indiana Department of Health for Resident E, dated 12/8/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated Resident E and Qualified Medication Aide (QMA) 1 had approached Resident E as she was walking out of the dining area on the first floor. QMA 1 had told Resident E to "mind her		facility policies to clarify: • Mandatory reporting requirements and timelines for suspected abuse • Step-by-step procedures for conducting thorough investigations • Intimate Relationships policy requirements, including medical involvement, individualized plans, and service plan documentation	

	own business." The conversation between QMA 1 and Resident E were in close proximity of face to face escalated to screaming and using foul language between each other in the common area. The facility's action taken was QMA 1 was "sent home." Director of Nursing (DON) started investigation of the incident, ensure no injury to the resident, and provide verbal abuse and neglect in-service training to the staff. The incident investigation between QMA 1 and Resident E included the following statements: A written statement, dated 12/6/25, indicated, "Myself [QMA 1], [Resident L], [Resident E] was all talking [Resident E] got upset because I told her that I was grown and I don't need people to tell me what to do if I'm not talking or interacting. It's because I stay away from negative energy. I'm not trying to be rude or anything I just won't talk to you, so she says well yesterday you didn't have to look the way you did. I said Ms. [Resident E] once again if somethings just w/o (without) being said then me and you wouldn't be standing her talking. I said [Resident S' room number] has behaviors that I don't feed into so for you to tell me not to look a certain way		• Require all staff to **acknowledge understanding** of updated policies **2. Staff Education & Training** • Provide **mandatory training** for all staff on: • Resident rights and abuse prevention • Mandatory reporting and investigation procedures	

	when you should had just said nothing due to it not being nothing by this time. She walked up to me and pushed me with her big chest. I said Ms. [Resident E], Ms. [Resident E] watch out your pushing me. She pushed me again. Ms. [Resident L] got up and said come on yall. I said she's ok Ms. [Resident L] I just won't say anything to her to be fair. She said ok, ok, ok that is fine. Ima (sic) still speak. I said ok Ms. [Resident E] let me go cause this is crazy and I don't have time for none of this." An email statement by Resident L, dated 12/6/25, indicated, "This was between [Resident E] and [QMA 1]...(I'm not sure why. [QMA 1] came on down but maybe her and [Resident E] were going to say something. I'm not for sure of who even called her down cuz (sic) she was going up the steps to the second floor speaking with [resident name]. Bad names was called chest pumping out was going on. I try to get in between them but I was moved out of the way. [Resident E] was telling [QMA 1] she do not have to act like that, (this talk was about Resident S I think!) [QMA 1] told her she's a grown woman and she can act like she want to act. [Resident E] stated she can do the same. [QMA 1] ask [Resident E], why she getting upset about her friend who came to me like that. I only been		• Intimate Relationships policy and service plan documentation requirements • Validate staff competency post-training; include in new hire orientation • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; • Supervisors and leadership will conduct **routine and unannounced observations** of staff-resident interactions on all shifts.	

	here since October. A lot of harsh words came out of both women's mouth. While I was sitting down I noticed [QMA 1]'s foot was on top of [Resident E]'s shoe. One of the resident [Resident K] who lived on the first floor was asking [QMA]1 that he locked himself out of his door and he need her key to open to his door but she was (sic) kept on arguing with [Resident E] so I asked [QMA 1]. Please help the guy to unlock his door. So she gave her key to [CNA 2] to the (sic) open his door..." A written statement by Resident E, dated 12/6/25, indicated "....I was...told what to say and do or not to say and do by an aggressive employee [QMA 1]. Said employee was headed up the stairs when (Resident L] and I were leaving the dining room. [Resident L] called out to speak to [QMA 1]...and when she saw me standing next to [Resident L] she said oh yeah and came to tell me she didn't appreciate what I said to her yesterday morning. She said I needed to mind my business all the while she was walking up on me real aggressive. I told her all I said was don't act like that and her response was I am grown and I said we all are. This conversation occurred on (sic) yesterday morning 12/5/25. There is a situation that went on between Ms. [Resident S] and		• Observations will focus on: • Proper communication and adherence to abuse prevention policies • Compliance with reporting and investigation procedures • Support of residents in intimate relationships per individualized plans • Weekly review of all incident reports, complaints, and grievances related to abuse or resident intimate relationships.	

	QMA 1 I have heard the story twice. Yesterday [QMA 1] came in spoke to [another resident] and then spoke to everyone at our table while standing behind Ms. [Resident S] at which point Ms. [Resident S] got upset and told the story for the second time very loudly. Now while this was unfolding [QMA 1] looks down at [Resident S] and then at me and made a face then began to walk away and I still looking her in her eyes said don't be like that. Which evidently p***** her off and she said s*** I am grown my reply was we all are. She didn't come back our way she went out another way. So this morning when she hurried back down the stairs and approached me I was attempting to keep the peace and she was all up in my face and loud....That is when I got p***** off. She told me I didn't know and I don't her because she is a very different person outside of here. I told her she don't know me and I don't give a f*** about all that she don't know me and all this is crazy. The little old man [Resident K] came and asked her to let him in his apartment. She was more interested in attempting to threaten me. So funny. I told her she is tripping and we as women black women really don't need to acting like that. She said don't tell her what to say or do. My response was well then don't tell me she was		• Service plans for residents in intimate relationships will be audited to ensure:	

	better than she was acting and she told me she wasn't and I don't know her. I told her that's cool and I see her no harm no foul. Then she said again moving forward don't say s*** to her and she won't say S*** to me. I told her I was going speak because it ain't that deep. She was like something was funny and looking up and down like ok. She funny till she ain't. She told me to go on somewhere. I told her I live here you go on somewhere do your job. CNA 2 came and let the little man in his apartment but he stayed there watching the whole thing everywhere (sic). I moved, she kept walking up on me. Then [QMA 1] tried to hold a conversation with [Resident L] about [Resident S] being bipolar...I have nothing do with any of that or what she may have stolen from [Resident S]. All I care about is how we treat eachother and talk to one another..." The investigation did not include statements by Resident K, Resident S and CNA 2 or any other staff or residents that had witnessed the incident. An interview was conducted with the ED on 1/15/26 at 1:54 p.m. She indicated she was unable to get interviews from Resident K, Resident S and CNA 2. Resident S and CNA 2 had refused to be interviewed			

	about the incident. Resident S had indicated she did not want to get involved, and CNA 2 does not speak good of English and refused to write a statement. Resident K was not interviewable. After review of the statements in the investigation she had not noticed QMA 1 had not signed her statement. During and interview with Resident S on 1/15/26 at 2:00 p.m., she indicated she had not been asked to provide a statement about what happened to her in the dining room with QMA 1, nor the incident between Resident E and QMA 1 that had occurred the following day. 3. The clinical record for Resident F was reviewed on 1/14/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, posterior reverse encephalopathy syndrome (a condition with the brain that causes headaches, vision changes and seizures.) A reportable incident to the Indiana Department of Health, dated 12/12/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated "Resident [F] was going to dining room area with her dog. When resident was			

	trying to get off her dog ran off her scooter to see another resident. When she ran off the leash got tangled under resident's scooter. Nurse [Qualified Medication Aide (QMA) 3] asked resident if she needed help when resident started crying and getting emotional. Resident started yelling at staff and staff asked resident to stop yelling at her. Staff tried to get the dog untangled but the resident continued to yell and indicate that the staff member is being mean. Staff continued to try and assist with untangling the dog, but the resident continued to yell and cry. Staff was able to get the dog untangled but the resident continued to cry and yell. Resident went to her room and was still very emotional. The facility's action taken was offered to resident to go out for an eval (evaluation) but the resident and family said no. They did not her to go out...DON (Director of Nursing) ask staff to continue to check on resident throughout the day. Resident went on outing to Walmart and was not c/o (complaints of) any discomfort..." The incident investigation between Resident F and QMA 3 included the following: A typed statement with no name nor dated, indicated "Resident			

	[F] came down to speak with ED about a situation that happened with her and a staff member [QMA 3]. Resident stated that she was getting off the elevator and the staff member was getting on. Resident had her dog sitting on her scooter when she was trying to take him out to potty. Another resident came up to see resident dog. The dog ran off her scooter, and the nurse tried to catch her before running to the other resident. The dog's leash got tangled up under her scooter. Resident tried to move; nurse told her to stop she almost ran over her dog. Resident stated the nurse raised her voice at her." A written statement by QMA 3 not dated, indicated "[Resident F] and I were on the first floor, I had my medication cart but wasn't quite finish with the resident I was assisting. Once I was finished I was trying to get on the elevator. I asked [Resident F] to let me through she said you have to wait I have to get my dog. But when she's just sitting there blocking the area her dog is wrapping the dog leash around her wheelchair. I said [Resident F] just scoot up so I can get by; she starts screaming that I need to wait. I'm always being rude so I push her chair up so I can get passed. She starts yelling I hate you. I hate this place several times. I never said			

anything else I just got on the elevator and finished my med [medication] pass."

The investigation did not include any other resident statements nor any other staff member statements that had witnessed the incident.

An interview was conducted with the ED on 1/15/26 at 3:11 p.m. She indicated she had not noticed the statements in the investigations for Resident F, Resident P and Resident E some statements did not include names, dates and signatures who had written the statements. She did not have any additional interviews from staff or residents that she had conducted during the investigation.

An abuse policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...Policy Overview: Fort Harrison Assisted Living is committed to maintaining a safe environment for each resident, visitor and employee. Instances and allegations of abuse, neglect, or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...1. Definitions...c. 'Misappropriation' is defined in Indian as depriving, defrauding or otherwise obtaining real or personal property of a resident

	by any means prohibited by law including robbery, theft, burglary, or fraud... 5. Investigation: a) Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or designee, should conduct a confidential internal investigation of the incident. b) Manner of Conducting Investigation. The investigation should be conducted confidentially and in a manner that is least disruptive to the on-going delivery of services and daily routine of the community. 1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community...c) Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of the incident. d.) Investigation Record. The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being questioned and an impartial report of facts...6. External Reporting/ Notification...c) Report to the Department of Health 1) The executive Director or designee, in consultation with the Regional			

	Director of Operations, should report known or suspected abuse, neglect or misappropriation and all allegations of abuse, neglect or misappropriation to the Director of Health..." 4. The clinical record for Resident Q was reviewed on 1/15/25 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, altered mental status, and cognitive communication deficit. A service plan, dated 12/30/25, indicated the resident had mild impairment of orientation. She "has current and/or history of disorientation to person, place, time or situation. Requires some direction and reminding from others." A Mini Mental assessment, dated 1/2/26, indicated the resident scored a 26 on the exam. The resident's score was in the category of "degree of impairment: questionably significant." That category indicated "if clinical signs of cognitive impairment are present, formal assessment of cognition may be valuable. May have clinically significant but mild deficits. Likely to affect only most demanding activities of daily living." A summary of the meeting with			

	Resident Q's Legal Representative, dated 12/21/25, indicated "ED and BOM had a meeting with [Resident Q's Legal Representative] which was requested by [Resident Q's Legal Representative] on her concern how her [family member] is pushing her away. [Resident Q's Legal Representative] mentioned to both ED and BOM that at first she was ok with the relationship between Resident P and Resident Q but now she feels that [Resident Q] is being taken advantage of due to her not wanting to spend anytime with her anymore...She also stated [Resident Q] will come around when she needs something." Resident Q was not available for interview. 5.a. A reportable incident to the Indiana Department of Health for Resident E and Resident P, dated 12/11/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated "Resident [Q] brought her laundry out of her room and placed it in front of another resident's door. Resident [E] got upset and moved it back in front of the resident [Q]'s door asking are you messing with me or do you have a problem with me. Resident [Q] called her significant other [Resident P]			

	and he intervened by cursing and yelling and then situation escalated to residents verbally aggressive." The facility's action taken was the separation of the residents. ED and Director of Nursing (DON) provided education to Resident P and Resident E to bring unresolved concerns to ED and DON immediately. The incident investigation between Resident E and Resident P included the following: A statement written by Resident P, dated 12/11/25, indicated, "I was walking down the hall and she stepped up to me talking crazy and yelling. I thought we was cool. She wouldn't get out of my face. I spit on her and she spit on me. She said she is calling her [family member]. I'm not scared. I don't play that, She was coming at me." A statement written (no name or date), indicated "Resident [E] stated she noticed laundry basket from next door was close to her apartment. [Resident E] knocked on resident door and asked why she [Resident Q] placed her basket near her door. Residents exchanged words started spit on eachother." An incident report for Resident P, dated 12/11/25, indicated			

	Resident P and Resident E had a "verbally aggressive conversation" that included foul language and saliva in the hallway. The residents were separated by staff and they did not have any other physical contact. The resident statement: "Resident stated that the other resident [E] approached him and his friend [Resident Q] yelling and shouting about a laundry basket. Resident stated that the other resident [Resident E] got into his face and they spit on each other...Witnesses: Employee 5 and Employee 6..." The investigation did not include statements by Resident Q, Employee 5, Employee 6 nor any other residents or staff members that witnessed the incident. 5.b. The clinical record for Resident P was reviewed on 1/15/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to, chronic viral hepatitis C and hepatitis B, alcohol abuse, and liver cell carcinoma. A service plan, dated 1/4/26, indicated the resident makes his own decisions. Resident P does have "confrontational behaviors toward peers." A Mini Mental assessment, dated 11/21/25, indicated Resident P scored a 30 on the			

	exam. The resident's score was in the category of "degree of impairment: questionably significant." That category indicated "if clinical signs of cognitive impairment are present, formal assessment of cognition may be valuable. May have clinically significant but mild deficits. Likely to affect only most demanding activities of daily living." An email from Resident P's Legal Representative to the ED, dated 12/21/25, indicated, "I was wondering if I could have a meeting with you and [Business Office Manager (BOM)]? [Resident P] has spent all her money for the month in 3 weeks time..." This had happened twice since Resident Q had been in the picture. Resident P was now telling the Legal Representative she wanted a full bed. "... I feel she is being taken advantage of..." During an interview with Resident L on 1/14/26 at 3:16 p.m., she indicated there were two residents that reside in the same apartment. Resident P and Resident Q. "They are in a relationship". During an interview with Resident E on 1/15/26 at 9:57 a.m. She indicated Resident P and Resident Q are in a relationship. Resident P's apartment was down the hall,			

	but he resides with his "girlfriend" (Resident Q) in her apartment. An interview was conducted with Resident P on 1/15/26 at 11:56 a.m. He indicated he was in a relationship with Resident Q. An interview was conducted with ED on 1/16/26 at 11:05 a.m. She indicated she was aware of Resident P and Resident Q's relationship. Resident P does have his own apartment, and he does go back-n-forth from her apartment to his own apartment during the day. She had not observed nor had been told by staff Resident P was sleeping in Resident Q's apartment. Both residents' cognitive function are "high," and they both deny having a sexual relationship. Resident Q's Legal Representative did have concerns. The ED indicated she had not discussed the relationship between Resident P nor Resident Q with any medical providers nor provided education for sexual transmitted diseases. She had not put a plan or an agreement in place how to address or monitor the relationship between the residents nor updated their service plans. A intimacy policy was provided by ED 1/15/26 at 2:08 p.m. It indicated, "...The intent of this			

	guideline is to honor resident rights, while taking into consideration the cognitive status of the residents...If one or both of the older adults engaged in a physically intimate relationship/act are cognitively impaired as previously determined by a licensed healthcare provider or have a documented diagnosis of dementia, and there is not documented plan/agreement about this relationship, associates should take measures to respectfully separate the individuals, in as discrete of a manner possible maintaining dignity. Additionally, if associates have reason to believe one or more of the participants have recently exhibited behaviors indicative of dementia, the associates should treat the incident as if one or both have a diagnosis of dementia although the formal diagnosis has not yet been made. The associates should promptly report the incident to the Executive Director (ED), Health and Wellness Director (HWD) or supervisor in charge so that the ED may begin an investigation as soon as possible. The investigation should include contacting the resident's legal responsible party/involved family and physician. An incident report should be completed. Associates have an important obligation to protect the			

vulnerable and must notify the ED or supervisor in charge so that the legally responsible party/involved family for residents can be fully informed of physically intimate relationships...As indicated and agreed upon by...the physician, the cognitively impaired resident's Personal Service Plan (PSP) should be updated to reflect the outcome of the ED's discussion with the involved parties. Associates should be informed of the plan..."

This citation relates to Intakes 466783 and 466691.

Based on interview and record review, the facility failed to ensure reporting and thorough investigations were conducted for 4 of 4 reportable incidents reviewed (Residents D, E, F, P), and ensure residents that are in relationships have the involvement of a medical provider, a plan in place, and updated service plans per the intimate policy for 2 of 2 residents reviewed for intimate relationship (Residents Q and P).

Findings include:

1. The clinical record for Resident D was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain.

	A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed. A physician's order, dated 10/28/25, indicated Resident D was to self-administer oxycontin ER (Extended Release) 10 mg tablets take 1 tablet by mouth twice daily at 8:00 a.m. and 4:00 p.m. A Packing Slip from the facility pharmacy, dated 11/12/25, indicated Resident D had received 120 tablets of Oxycodone 10 mg. During an interview on 1/15/26 at 9:57 a.m., Resident D indicated that on November 24, 2025, she had reported to the Director of Nursing (DON) and the Executive Director (ED) that she had 120 tablets of oxycodone which was missing. Resident D indicated she was in the process of organizing her apartment and had placed the oxycodone in her dresser drawer the evening before when her children were visiting, the next morning it was not in the dresser drawer. Resident D called the DON and reported the missing oxycodone. The DON came to her apartment and went through Resident D's dresser			

	drawers and called Resident D's family to talk about the missing oxycodone. Resident D had gone to the ED to report the missing oxycodone and the 120 tablets of oxycodone had never been found. During an interview on 1/15/26 at 12:04 p.m., the ED and the DON indicated Resident D never had 120 OxyContin's missing. The DON indicated the pharmacy was notified and 120 OxyContin were never delivered to the facility. During an interview on 1/15/26 at 3:11 p.m., the ED indicated she had not reported to the alleged missing oxycontin to the Indiana Department of Health. The ED would have normally reported the missing narcotics, but after investigating and finding out that the pharmacy had never sent 120 OxyContin, the ED did not think she had to report the incident. During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. She also had oxycontin 10 mg tablets which she took routinely. When Resident D moved from			

	the first floor to the second floor, she thought that her oxycodone 5 mg were missing (120 tabs). Resident D had 120 tablets of oxycontin 10 mg. Resident D did not have a prescription for oxycodone 5 mg but had received a refill oxycontin 10 mg (120 pills). The facility had contacted the pharmacy to confirm no oxycodone 5 mg had been delivered. Nurse Practitioner was informed that Resident D needed oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg, which was delivered. The DON had educated Resident D on the change of oxycodone from 5 mg tablet to a 10 mg tablet and provided a lock box and blank narc sheets for Resident D to use to keep a running count for herself. During an interview on 1/16/26 at 10:50 a.m., Pharmacy Technician (PT) 21 indicated Resident D had a prescription on file for Oxycodone IR 10 mg take one tablet every 6 hours as needed. The pharmacy had filled the prescription on November 10, 2025, and 120 tablets had been sent to the facility. During an interview on 1/16/26 at 2:03 p.m., PT 22 indicated that on November 11, 2025, the pharmacy had sent 14 Oxycontin ER 10 mg tablets to			

	the facility for Resident D. On 11/28/25, the pharmacy had sent 14 tablets of oxycontin ER for Resident D. During an interview on 1/16/26 at 2:16 p.m., Resident D indicated the oxycodone instant release medications were the medication that were missing. She had received 120 tablets and had maybe taken 2 or 3 tablets before they came up missing. She had reported the missing oxycodone instant release medications missing to the DON and the ED on 11/24/25. The ED had told her that the police were going to be called and an investigation started. Resident D had told the ED to go ahead and start an investigation. 2. A reportable incident to the Indiana Department of Health for Resident E, dated 12/8/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated Resident E and Qualified Medication Aide (QMA) 1 had approached Resident E as she was walking out of the dining area on the first floor. QMA 1 had told Resident E to "mind her own business." The conversation between QMA 1 and Resident E were in close proximity of face to face escalated to screaming and			

using foul language between each other in the common area. The facility's action taken was QMA 1 was "sent home." Director of Nursing (DON) started investigation of the incident, ensure no injury to the resident, and provide verbal abuse and neglect in-service training to the staff.

The incident investigation between QMA 1 and Resident E included the following statements:

A written statement, dated 12/6/25, indicated, "Myself [QMA 1], [Resident L], [Resident E] was all talking [Resident E] got upset because I told her that I was grown and I don't need people to tell me what to do if I'm not talking or interacting. It's because I stay away from negative energy. I'm not trying to be rude or anything I just won't talk to you, so she says well yesterday you didn't have to look the way you did. I said Ms. [Resident E] once again if somethings just w/o (without) being said then me and you wouldn't be standing her talking. I said [Resident S' room number] has behaviors that I don't feed into so for you to tell me not to look a certain way when you should had just said nothing due to it not being nothing by this time. She walked up to me and pushed me with her big chest. I said Ms.

	[Resident E], Ms. [Resident E] watch out your pushing me. She pushed me again. Ms. [Resident L] got up and said come on yall. I said she's ok Ms. [Resident L] I just won't say anything to her to be fair. She said ok, ok, ok that is fine. Ima (sic) still speak. I said ok Ms. [Resident E] let me go cause this is crazy and I don't have time for none of this." An email statement by Resident L, dated 12/6/25, indicated, "This was between [Resident E] and [QMA 1]...(I'm not sure why. [QMA 1] came on down but maybe her and [Resident E] were going to say something. I'm not for sure of who even called her down cuz (sic) she was going up the steps to the second floor speaking with [resident name]. Bad names was called chest pumping out was going on. I try to get in between them but I was moved out of the way. [Resident E] was telling [QMA 1] she do not have to act like that, (this talk was about Resident S I think!) [QMA 1] told her she's a grown woman and she can act like she want to act. [Resident E] stated she can do the same. [QMA 1] ask [Resident E], why she getting upset about her friend who came to me like that. I only been here since October. A lot of harsh words came out of both women's mouth. While I was sitting down I noticed [QMA 1]'s foot was on top of [Resident E]'s			

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	Resident K was not interviewable. After review of the statements in the investigation she had not noticed QMA 1 had not signed her statement. During and interview with Resident S on 1/15/26 at 2:00 p.m., she indicated she had not been asked to provide a statement about what happened to her in the dining room with QMA 1, nor the incident between Resident E and QMA 1 that had occurred the following day. 3. The clinical record for Resident F was reviewed on 1/14/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, posterior reverse encephalopathy syndrome (a condition with the brain that causes headaches, vision changes and seizures.) A reportable incident to the Indiana Department of Health, dated 12/12/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated "Resident [F] was going to dining room area with her dog. When resident was trying to get off her dog ran off her scooter to see another resident. When she ran off the leash got tangled under resident's scooter. Nurse			

	[Qualified Medication Aide (QMA) 3] asked resident if she needed help when resident started crying and getting emotional. Resident started yelling at staff and staff asked resident to stop yelling at her. Staff tried to get the dog untangled but the resident continued to yell and indicate that the staff member is being mean. Staff continued to try and assist with untangling the dog, but the resident continued to yell and cry. Staff was able to get the dog untangled but the resident continued to cry and yell. Resident went to her room and was still very emotional. The facility's action taken was offered to resident to go out for an eval (evaluation) but the resident and family said no. They did not her to go out...DON (Director of Nursing) ask staff to continue to check on resident throughout the day. Resident went on outing to Walmart and was not c/o (complaints of) any discomfort..." The incident investigation between Resident F and QMA 3 included the following: A typed statement with no name nor dated, indicated "Resident [F] came down to speak with ED about a situation that happened with her and a staff member [QMA 3]. Resident stated that she was getting off the elevator			

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	any other resident statements nor any other staff member statements that had witnessed the incident. An interview was conducted with the ED on 1/15/26 at 3:11 p.m. She indicated she had not noticed the statements in the investigations for Resident F, Resident P and Resident E some statements did not include names, dates and signatures who had written the statements. She did not have any additional interviews from staff or residents that she had conducted during the investigation. An abuse policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...Policy Overview: Fort Harrison Assisted Living is committed to maintaining a safe environment for each resident, visitor and employee. Instances and allegations of abuse, neglect, or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...1. Definitions...c. 'Misappropriation' is defined in Indian as depriving, defrauding or otherwise obtaining real or personal property of a resident by any means prohibited by law including robbery, theft, burglary, or fraud... 5. Investigation: a) Internal Investigation. Upon receipt of an			

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	was requested by [Resident Q's Legal Representative] on her concern how her [family member] is pushing her away. [Resident Q's Legal Representative] mentioned to both ED and BOM that at first she was ok with the relationship between Resident P and Resident Q but now she feels that [Resident Q] is being taken advantage of due to her not wanting to spend anytime with her anymore...She also stated [Resident Q] will come around when she needs something." Resident Q was not available for interview. 5.a. A reportable incident to the Indiana Department of Health for Resident E and Resident P, dated 12/11/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated "Resident [Q] brought her laundry out of her room and placed it in front of another resident's door. Resident [E] got upset and moved it back in front of the resident [Q]'s door asking are you messing with me or do you have a problem with me. Resident [Q] called her significant other [Resident P] and he intervened by cursing and yelling and then situation escalated to residents verbally aggressive." The facility's action taken was the separation of the			

residents. ED and Director of Nursing (DON) provided education to Resident P and Resident E to bring unresolved concerns to ED and DON immediately.

The incident investigation between Resident E and Resident P included the following:

A statement written by Resident P, dated 12/11/25, indicated, "I was walking down the hall and she stepped up to me talking crazy and yelling. I thought we was cool. She wouldn't get out of my face. I spit on her and she spit on me. She said she is calling her [family member]. I'm not scared. I don't play that, She was coming at me."

A statement written (no name or date), indicated "Resident [E] stated she noticed laundry basket from next door was close to her apartment. [Resident E] knocked on resident door and asked why she [Resident Q] placed her basket near her door. Residents exchanged words started spit on eachother."

An incident report for Resident P, dated 12/11/25, indicated Resident P and Resident E had a "verbally aggressive conversation" that included foul language and saliva in the hallway. The residents were

	separated by staff and they did not have any other physical contact. The resident statement: "Resident stated that the other resident [E] approached him and his friend [Resident Q] yelling and shouting about a laundry basket. Resident stated that the other resident [Resident E] got into his face and they spit on each other...Witnesses: Employee 5 and Employee 6..." The investigation did not include statements by Resident Q, Employee 5, Employee 6 nor any other residents or staff members that witnessed the incident. 5.b. The clinical record for Resident P was reviewed on 1/15/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to, chronic viral hepatitis C and hepatitis B, alcohol abuse, and liver cell carcinoma. A service plan, dated 1/4/26, indicated the resident makes his own decisions. Resident P does have "confrontational behaviors toward peers." A Mini Mental assessment, dated 11/21/25, indicated Resident P scored a 30 on the exam. The resident's score was in the category of "degree of impairment: questionably significant." That category indicated "if clinical signs of			

	cognitive impairment are present, formal assessment of cognition may be valuable. May have clinically significant but mild deficits. Likely to affect only most demanding activities of daily living." An email from Resident P's Legal Representative to the ED, dated 12/21/25, indicated, "I was wondering if I could have a meeting with you and [Business Office Manager (BOM)]? [Resident P] has spent all her money for the month in 3 weeks time..." This had happened twice since Resident Q had been in the picture. Resident P was now telling the Legal Representative she wanted a full bed. "... I feel she is being taken advantage of..." During an interview with Resident L on 1/14/26 at 3:16 p.m., she indicated there were two residents that reside in the same apartment. Resident P and Resident Q. "They are in a relationship". During an interview with Resident E on 1/15/26 at 9:57 a.m. She indicated Resident P and Resident Q are in a relationship. Resident P's apartment was down the hall, but he resides with his "girlfriend" (Resident Q) in her apartment. An interview was conducted			

	with Resident P on 1/15/26 at 11:56 a.m. He indicated he was in a relationship with Resident Q. An interview was conducted with ED on 1/16/26 at 11:05 a.m. She indicated she was aware of Resident P and Resident Q's relationship. Resident P does have his own apartment, and he does go back-n-forth from her apartment to his own apartment during the day. She had not observed nor had been told by staff Resident P was sleeping in Resident Q's apartment. Both residents' cognitive function are "high," and they both deny having a sexual relationship. Resident Q's Legal Representative did have concerns. The ED indicated she had not discussed the relationship between Resident P nor Resident Q with any medical providers nor provided education for sexual transmitted diseases. She had not put a plan or an agreement in place how to address or monitor the relationship between the residents nor updated their service plans. A intimacy policy was provided by ED 1/15/26 at 2:08 p.m. It indicated, "...The intent of this guideline is to honor resident rights, while taking into consideration the cognitive status of the residents...If one or both of the older adults engaged			

	in a physically intimate relationship/act are cognitively impaired as previously determined by a licensed healthcare provider or have a documented diagnosis of dementia, and there is not documented plan/agreement about this relationship, associates should take measures to respectfully separate the individuals, in as discrete of a manner possible maintaining dignity. Additionally, if associates have reason to believe one or more of the participants have recently exhibited behaviors indicative of dementia, the associates should treat the incident as if one or both have a diagnosis of dementia although the formal diagnosis has not yet been made. The associates should promptly report the incident to the Executive Director (ED), Health and Wellness Director (HWD) or supervisor in charge so that the ED may begin an investigation as soon as possible. The investigation should include contacting the resident's legal responsible party/involved family and physician. An incident report should be completed. Associates have an important obligation to protect the vulnerable and must notify the ED or supervisor in charge so that the legally responsible party/involved family for residents can be fully informed			

of physically intimate relationships...As indicated and agreed upon by...the physician, the cognitively impaired resident's Personal Service Plan (PSP) should be updated to reflect the outcome of the ED's discussion with the involved parties. Associates should be informed of the plan..."

This citation relates to Intakes 466783 and 466691.

Based on interview and record review, the facility failed to ensure reporting and thorough investigations were conducted for 4 of 4 reportable incidents reviewed (Residents D, E, F, P), and ensure residents that are in relationships have the involvement of a medical provider, a plan in place, and updated service plans per the intimate policy for 2 of 2 residents reviewed for intimate relationship (Residents Q and P).

Findings include:

1. The clinical record for Resident D was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain.

A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5

	milligram (mg) take two tablets (10 mg) by mouth every six hours as needed. A physician's order, dated 10/28/25, indicated Resident D was to self-administer oxycontin ER (Extended Release) 10 mg tablets take 1 tablet by mouth twice daily at 8:00 a.m. and 4:00 p.m. A Packing Slip from the facility pharmacy, dated 11/12/25, indicated Resident D had received 120 tablets of Oxycodone 10 mg. During an interview on 1/15/26 at 9:57 a.m., Resident D indicated that on November 24, 2025, she had reported to the Director of Nursing (DON) and the Executive Director (ED) that she had 120 tablets of oxycodone which was missing. Resident D indicated she was in the process of organizing her apartment and had placed the oxycodone in her dresser drawer the evening before when her children were visiting, the next morning it was not in the dresser drawer. Resident D called the DON and reported the missing oxycodone. The DON came to her apartment and went through Resident D's dresser drawers and called Resident D's family to talk about the missing oxycodone. Resident D had gone to the ED to report the missing oxycodone and the 120			

	tablets of oxycodone had never been found. During an interview on 1/15/26 at 12:04 p.m., the ED and the DON indicated Resident D never had 120 OxyContin's missing. The DON indicated the pharmacy was notified and 120 OxyContin were never delivered to the facility. During an interview on 1/15/26 at 3:11 p.m., the ED indicated she had not reported to the alleged missing oxycontin to the Indiana Department of Health. The ED would have normally reported the missing narcotics, but after investigating and finding out that the pharmacy had never sent 120 OxyContin, the ED did not think she had to report the incident. During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. She also had oxycontin 10 mg tablets which she took routinely. When Resident D moved from the first floor to the second floor, she thought that her oxycodone 5 mg were missing (120 tabs). Resident D had 120 tablets of oxycontin 10 mg. Resident D did			

	not have a prescription for oxycodone 5 mg but had received a refill oxycontin 10 mg (120 pills). The facility had contacted the pharmacy to confirm no oxycodone 5 mg had been delivered. Nurse Practitioner was informed that Resident D needed oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg, which was delivered. The DON had educated Resident D on the change of oxycodone from 5 mg tablet to a 10 mg tablet and provided a lock box and blank narc sheets for Resident D to use to keep a running count for herself. During an interview on 1/16/26 at 10:50 a.m., Pharmacy Technician (PT) 21 indicated Resident D had a prescription on file for Oxycodone IR 10 mg take one tablet every 6 hours as needed. The pharmacy had filled the prescription on November 10, 2025, and 120 tablets had been sent to the facility. During an interview on 1/16/26 at 2:03 p.m., PT 22 indicated that on November 11, 2025, the pharmacy had sent 14 Oxycontin ER 10 mg tablets to the facility for Resident D. On 11/28/25, the pharmacy had sent 14 tablets of oxycontin ER for Resident D.			

	During an interview on 1/16/26 at 2:16 p.m., Resident D indicated the oxycodone instant release medications were the medication that were missing. She had received 120 tablets and had maybe taken 2 or 3 tablets before they came up missing. She had reported the missing oxycodone instant release medications missing to the DON and the ED on 11/24/25. The ED had told her that the police were going to be called and an investigation started. Resident D had told the ED to go ahead and start an investigation. 2. A reportable incident to the Indiana Department of Health for Resident E, dated 12/8/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated Resident E and Qualified Medication Aide (QMA) 1 had approached Resident E as she was walking out of the dining area on the first floor. QMA 1 had told Resident E to "mind her own business." The conversation between QMA 1 and Resident E were in close proximity of face to face escalated to screaming and using foul language between each other in the common area. The facility's action taken was QMA 1 was "sent home." Director of Nursing (DON)			

started investigation of the incident, ensure no injury to the resident, and provide verbal abuse and neglect in-service training to the staff.

The incident investigation between QMA 1 and Resident E included the following statements:

A written statement, dated 12/6/25, indicated, "Myself [QMA 1], [Resident L], [Resident E] was all talking [Resident E] got upset because I told her that I was grown and I don't need people to tell me what to do if I'm not talking or interacting. It's because I stay away from negative energy. I'm not trying to be rude or anything I just won't talk to you, so she says well yesterday you didn't have to look the way you did. I said Ms. [Resident E] once again if somethings just w/o (without) being said then me and you wouldn't be standing her talking. I said [Resident S' room number] has behaviors that I don't feed into so for you to tell me not to look a certain way when you should had just said nothing due to it not being nothing by this time. She walked up to me and pushed me with her big chest. I said Ms. [Resident E], Ms. [Resident E] watch out your pushing me. She pushed me again. Ms. [Resident L] got up and said come on yall. I said she's ok Ms. [Resident L] I

	just won't say anything to her to be fair. She said ok, ok, ok that is fine. Ima (sic) still speak. I said ok Ms. [Resident E] let me go cause this is crazy and I don't have time for none of this." An email statement by Resident L, dated 12/6/25, indicated, "This was between [Resident E] and [QMA 1]...(I'm not sure why. [QMA 1] came on down but maybe her and [Resident E] were going to say something. I'm not for sure of who even called her down cuz (sic) she was going up the steps to the second floor speaking with [resident name]. Bad names was called chest pumping out was going on. I try to get in between them but I was moved out of the way. [Resident E] was telling [QMA 1] she do not have to act like that, (this talk was about Resident S I think!) [QMA 1] told her she's a grown woman and she can act like she want to act. [Resident E] stated she can do the same. [QMA 1] ask [Resident E], why she getting upset about her friend who came to me like that. I only been here since October. A lot of harsh words came out of both women's mouth. While I was sitting down I noticed [QMA 1]'s foot was on top of [Resident E]'s shoe. One of the resident [Resident K] who lived on the first floor was asking [QMA]1 that he locked himself out of his door and he need her key to			

	open to his door but she was (sic) kept on arguing with [Resident E] so I asked [QMA 1]. Please help the guy to unlock his door. So she gave her key to [CNA 2] to the (sic) open his door..." A written statement by Resident E, dated 12/6/25, indicated "....I was...told what to say and do or not to say and do by an aggressive employee [QMA 1]. Said employee was headed up the stairs when (Resident L] and I were leaving the dining room. [Resident L] called out to speak to [QMA 1]...and when she saw me standing next to [Resident L] she said oh yeah and came to tell me she didn't appreciate what I said to her yesterday morning. She said I needed to mind my business all the while she was walking up on me real aggressive. I told her all I said was don't act like that and her response was I am grown and I said we all are. This conversation occurred on (sic) yesterday morning 12/5/25. There is a situation that went on between Ms. [Resident S] and QMA 1 I have heard the story twice. Yesterday [QMA 1] came in spoke to [another resident] and then spoke to everyone at our table while standing behind Ms. [Resident S] at which point Ms. [Resident S] got upset and told the story for the second time very loudly. Now while this was unfolding [QMA 1] looks			

	down at [Resident S] and then at me and made a face then began to walk away and I still looking her in her eyes said don't be like that. Which evidently p***** her off and she said s*** I am grown my reply was we all are. She didn't come back our way she went out another way. So this morning when she hurried back down the stairs and approached me I was attempting to keep the peace and she was all up in my face and loud....That is when I got p***** off. She told me I didn't know and I don't her because she is a very different person outside of here. I told her she don't know me and I don't give a f*** about all that she don't know me and all this is crazy. The little old man [Resident K] came and asked her to let him in his apartment. She was more interested in attempting to threaten me. So funny. I told her she is tripping and we as women black women really don't need to acting like that. She said don't tell her what to say or do. My response was well then don't tell me she was better than she was acting and she told me she wasn't and I don't know her. I told her that's cool and I see her no harm no foul. Then she said again moving forward don't say s*** to her and she won't say S*** to me. I told her I was going speak because it ain't that deep. She was like something was funny			

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3. The clinical record for Resident F was reviewed on 1/14/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, posterior reverse encephalopathy syndrome (a condition with the brain that causes headaches, vision changes and seizures.)

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The incident investigation between Resident E and Resident P included the following:

A statement written by Resident P, dated 12/11/25, indicated, "I was walking down the hall and she stepped up to me talking crazy and yelling. I thought we was cool. She wouldn't get out of my face. I spit on her and she spit on me. She said she is calling her [family member]. I'm not scared. I don't play that, She was coming at me."

A statement written (no name or date), indicated "Resident [E] stated she noticed laundry basket from next door was close to her apartment. [Resident E] knocked on resident door and asked why she [Resident Q] placed her basket near her door. Residents exchanged words started spit on eachother."

An incident report for Resident P, dated 12/11/25, indicated Resident P and Resident E had a "verbally aggressive conversation" that included foul language and saliva in the hallway. The residents were separated by staff and they did not have any other physical contact. The resident statement: "Resident stated that the other resident [E] approached him

	and his friend [Resident Q] yelling and shouting about a laundry basket. Resident stated that the other resident [Resident E] got into his face and they spit on each other...Witnesses: Employee 5 and Employee 6..." The investigation did not include statements by Resident Q, Employee 5, Employee 6 nor any other residents or staff members that witnessed the incident. 5.b. The clinical record for Resident P was reviewed on 1/15/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to, chronic viral hepatitis C and hepatitis B, alcohol abuse, and liver cell carcinoma. A service plan, dated 1/4/26, indicated the resident makes his own decisions. Resident P does have "confrontational behaviors toward peers." A Mini Mental assessment, dated 11/21/25, indicated Resident P scored a 30 on the exam. The resident's score was in the category of "degree of impairment: questionably significant." That category indicated "if clinical signs of cognitive impairment are present, formal assessment of cognition may be valuable. May have clinically significant but mild deficits. Likely to affect only			

most demanding activities of daily living."

An email from Resident P's Legal Representative to the ED, dated 12/21/25, indicated, "I was wondering if I could have a meeting with you and [Business Office Manager (BOM)]? [Resident P] has spent all her money for the month in 3 weeks time..." This had happened twice since Resident Q had been in the picture. Resident P was now telling the Legal Representative she wanted a full bed. "... I feel she is being taken advantage of..."

During an interview with Resident L on 1/14/26 at 3:16 p.m., she indicated there were two residents that reside in the same apartment. Resident P and Resident Q. "They are in a relationship".

During an interview with Resident E on 1/15/26 at 9:57 a.m. She indicated Resident P and Resident Q are in a relationship. Resident P's apartment was down the hall, but he resides with his "girlfriend" (Resident Q) in her apartment.

An interview was conducted with Resident P on 1/15/26 at 11:56 a.m. He indicated he was in a relationship with Resident Q.

An interview was conducted

	with ED on 1/16/26 at 11:05 a.m. She indicated she was aware of Resident P and Resident Q's relationship. Resident P does have his own apartment, and he does go back-n-forth from her apartment to his own apartment during the day. She had not observed nor had been told by staff Resident P was sleeping in Resident Q's apartment. Both residents' cognitive function are "high," and they both deny having a sexual relationship. Resident Q's Legal Representative did have concerns. The ED indicated she had not discussed the relationship between Resident P nor Resident Q with any medical providers nor provided education for sexual transmitted diseases. She had not put a plan or an agreement in place how to address or monitor the relationship between the residents nor updated their service plans. A intimacy policy was provided by ED 1/15/26 at 2:08 p.m. It indicated, "...The intent of this guideline is to honor resident rights, while taking into consideration the cognitive status of the residents...If one or both of the older adults engaged in a physically intimate relationship/act are cognitively impaired as previously determined by a licensed healthcare provider or have a documented diagnosis of			

	dementia, and there is not documented plan/agreement about this relationship, associates should take measures to respectfully separate the individuals, in as discrete of a manner possible maintaining dignity. Additionally, if associates have reason to believe one or more of the participants have recently exhibited behaviors indicative of dementia, the associates should treat the incident as if one or both have a diagnosis of dementia although the formal diagnosis has not yet been made. The associates should promptly report the incident to the Executive Director (ED), Health and Wellness Director (HWD) or supervisor in charge so that the ED may begin an investigation as soon as possible. The investigation should include contacting the resident's legal responsible party/involved family and physician. An incident report should be completed. Associates have an important obligation to protect the vulnerable and must notify the ED or supervisor in charge so that the legally responsible party/involved family for residents can be fully informed of physically intimate relationships...As indicated and agreed upon by...the physician, the cognitively impaired resident's Personal Service Plan (PSP) should be updated to			

reflect the outcome of the ED's discussion with the involved parties. Associates should be informed of the plan..."

This citation relates to Intakes 466783 and 466691.

Based on interview and record review, the facility failed to ensure reporting and thorough investigations were conducted for 4 of 4 reportable incidents reviewed (Residents D, E, F, P), and ensure residents that are in relationships have the involvement of a medical provider, a plan in place, and updated service plans per the intimate policy for 2 of 2 residents reviewed for intimate relationship (Residents Q and P).

Findings include:

1. The clinical record for Resident D was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain.

A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed.

A physician's order, dated 10/28/25, indicated Resident D

	was to self-administer oxycontin ER (Extended Release) 10 mg tablets take 1 tablet by mouth twice daily at 8:00 a.m. and 4:00 p.m. A Packing Slip from the facility pharmacy, dated 11/12/25, indicated Resident D had received 120 tablets of Oxycodone 10 mg. During an interview on 1/15/26 at 9:57 a.m., Resident D indicated that on November 24, 2025, she had reported to the Director of Nursing (DON) and the Executive Director (ED) that she had 120 tablets of oxycodone which was missing. Resident D indicated she was in the process of organizing her apartment and had placed the oxycodone in her dresser drawer the evening before when her children were visiting, the next morning it was not in the dresser drawer. Resident D called the DON and reported the missing oxycodone. The DON came to her apartment and went through Resident D's dresser drawers and called Resident D's family to talk about the missing oxycodone. Resident D had gone to the ED to report the missing oxycodone and the 120 tablets of oxycodone had never been found. During an interview on 1/15/26 at 12:04 p.m., the ED and the DON indicated Resident D			

	never had 120 OxyContin's missing. The DON indicated the pharmacy was notified and 120 OxyContin were never delivered to the facility. During an interview on 1/15/26 at 3:11 p.m., the ED indicated she had not reported to the alleged missing oxycontin to the Indiana Department of Health. The ED would have normally reported the missing narcotics, but after investigating and finding out that the pharmacy had never sent 120 OxyContin, the ED did not think she had to report the incident. During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. She also had oxycontin 10 mg tablets which she took routinely. When Resident D moved from the first floor to the second floor, she thought that her oxycodone 5 mg were missing (120 tabs). Resident D had 120 tablets of oxycontin 10 mg. Resident D did not have a prescription for oxycodone 5 mg but had received a refill oxycontin 10 mg (120 pills). The facility had contacted the pharmacy to confirm no oxycodone 5 mg had			

	been delivered. Nurse Practitioner was informed that Resident D needed oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg, which was delivered. The DON had educated Resident D on the change of oxycodone from 5 mg tablet to a 10 mg tablet and provided a lock box and blank narc sheets for Resident D to use to keep a running count for herself. During an interview on 1/16/26 at 10:50 a.m., Pharmacy Technician (PT) 21 indicated Resident D had a prescription on file for Oxycodone IR 10 mg take one tablet every 6 hours as needed. The pharmacy had filled the prescription on November 10, 2025, and 120 tablets had been sent to the facility. During an interview on 1/16/26 at 2:03 p.m., PT 22 indicated that on November 11, 2025, the pharmacy had sent 14 Oxycontin ER 10 mg tablets to the facility for Resident D. On 11/28/25, the pharmacy had sent 14 tablets of oxycontin ER for Resident D. During an interview on 1/16/26 at 2:16 p.m., Resident D indicated the oxycodone instant release medications were the medication that were missing. She had received 120 tablets			

	and had maybe taken 2 or 3 tablets before they came up missing. She had reported the missing oxycodone instant release medications missing to the DON and the ED on 11/24/25. The ED had told her that the police were going to be called and an investigation started. Resident D had told the ED to go ahead and start an investigation. 2. A reportable incident to the Indiana Department of Health for Resident E, dated 12/8/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated Resident E and Qualified Medication Aide (QMA) 1 had approached Resident E as she was walking out of the dining area on the first floor. QMA 1 had told Resident E to "mind her own business." The conversation between QMA 1 and Resident E were in close proximity of face to face escalated to screaming and using foul language between each other in the common area. The facility's action taken was QMA 1 was "sent home." Director of Nursing (DON) started investigation of the incident, ensure no injury to the resident, and provide verbal abuse and neglect in-service training to the staff.			

	The incident investigation between QMA 1 and Resident E included the following statements:			

	A written statement, dated 12/6/25, indicated, "Myself [QMA 1], [Resident L], [Resident E] was all talking [Resident E] got upset because I told her that I was grown and I don't need people to tell me what to do if I'm not talking or interacting. It's because I stay away from negative energy. I'm not trying to be rude or anything I just won't talk to you, so she says well yesterday you didn't have to look the way you did. I said Ms. [Resident E] once again if somethings just w/o (without) being said then me and you wouldn't be standing her talking. I said [Resident S' room number] has behaviors that I don't feed into so for you to tell me not to look a certain way when you should had just said nothing due to it not being nothing by this time. She walked up to me and pushed me with her big chest. I said Ms. [Resident E], Ms. [Resident E] watch out your pushing me. She pushed me again. Ms. [Resident L] got up and said come on yall. I said she's ok Ms. [Resident L] I just won't say anything to her to be fair. She said ok, ok, ok that is fine. Ima (sic) still speak. I said ok Ms. [Resident E] let me go cause this is crazy and I don't have time for none of this." An email statement by Resident L, dated 12/6/25, indicated, "This was between [Resident E] and [QMA 1]...(I'm not sure why.			

	[QMA 1] came on down but maybe her and [Resident E] were going to say something. I'm not for sure of who even called her down cuz (sic) she was going up the steps to the second floor speaking with [resident name]. Bad names was called chest pumping out was going on. I try to get in between them but I was moved out of the way. [Resident E] was telling [QMA 1] she do not have to act like that, (this talk was about Resident S I think!) [QMA 1] told her she's a grown woman and she can act like she want to act. [Resident E] stated she can do the same. [QMA 1] ask [Resident E], why she getting upset about her friend who came to me like that. I only been here since October. A lot of harsh words came out of both women's mouth. While I was sitting down I noticed [QMA 1]'s foot was on top of [Resident E]'s shoe. One of the resident [Resident K] who lived on the first floor was asking [QMA]1 that he locked himself out of his door and he need her key to open to his door but she was (sic) kept on arguing with [Resident E] so I asked [QMA 1]. Please help the guy to unlock his door. So she gave her key to [CNA 2] to the (sic) open his door..." A written statement by Resident E, dated 12/6/25, indicated "....I was...told what to say and do or			

	not to say and do by an aggressive employee [QMA 1]. Said employee was headed up the stairs when (Resident L] and I were leaving the dining room. [Resident L] called out to speak to [QMA 1]...and when she saw me standing next to [Resident L] she said oh yeah and came to tell me she didn't appreciate what I said to her yesterday morning. She said I needed to mind my business all the while she was walking up on me real aggressive. I told her all I said was don't act like that and her response was I am grown and I said we all are. This conversation occurred on (sic) yesterday morning 12/5/25. There is a situation that went on between Ms. [Resident S] and QMA 1 I have heard the story twice. Yesterday [QMA 1] came in spoke to [another resident] and then spoke to everyone at our table while standing behind Ms. [Resident S] at which point Ms. [Resident S] got upset and told the story for the second time very loudly. Now while this was unfolding [QMA 1] looks down at [Resident S] and then at me and made a face then began to walk away and I still looking her in her eyes said don't be like that. Which evidently p***** her off and she said s*** I am grown my reply was we all are. She didn't come back our way she went out another way. So this morning when she hurried back down the			

	stairs and approached me I was attempting to keep the peace and she was all up in my face and loud....That is when I got p***** off. She told me I didn't know and I don't her because she is a very different person outside of here. I told her she don't know me and I don't give a f*** about all that she don't know me and all this is crazy. The little old man [Resident K] came and asked her to let him in his apartment. She was more interested in attempting to threaten me. So funny. I told her she is tripping and we as women black women really don't need to acting like that. She said don't tell her what to say or do. My response was well then don't tell me she was better than she was acting and she told me she wasn't and I don't know her. I told her that's cool and I see her no harm no foul. Then she said again moving forward don't say s*** to her and she won't say S*** to me. I told her I was going speak because it ain't that deep. She was like something was funny and looking up and down like ok. She funny till she ain't. She told me to go on somewhere. I told her I live here you go on somewhere do your job. CNA 2 came and let the little man in his apartment but he stayed there watching the whole thing everywhere (sic). I moved, she kept walking up on me. Then [QMA 1] tried to hold a			

	conversation with [Resident L] about [Resident S] being bipolar...I have nothing do with any of that or what she may have stolen from [Resident S]. All I care about is how we treat eachother and talk to one another..." The investigation did not include statements by Resident K, Resident S and CNA 2 or any other staff or residents that had witnessed the incident. An interview was conducted with the ED on 1/15/26 at 1:54 p.m. She indicated she was unable to get interviews from Resident K, Resident S and CNA 2. Resident S and CNA 2 had refused to be interviewed about the incident. Resident S had indicated she did not want to get involved, and CNA 2 does not speak good of English and refused to write a statement. Resident K was not interviewable. After review of the statements in the investigation she had not noticed QMA 1 had not signed her statement. During and interview with Resident S on 1/15/26 at 2:00 p.m., she indicated she had not been asked to provide a statement about what happened to her in the dining room with QMA 1, nor the incident between Resident E and QMA 1 that had occurred the following			

	day. 3. The clinical record for Resident F was reviewed on 1/14/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, posterior reverse encephalopathy syndrome (a condition with the brain that causes headaches, vision changes and seizures.) A reportable incident to the Indiana Department of Health, dated 12/12/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated "Resident [F] was going to dining room area with her dog. When resident was trying to get off her dog ran off her scooter to see another resident. When she ran off the leash got tangled under resident's scooter. Nurse [Qualified Medication Aide (QMA) 3] asked resident if she needed help when resident started crying and getting emotional. Resident started yelling at staff and staff asked resident to stop yelling at her. Staff tried to get the dog untangled but the resident continued to yell and indicate that the staff member is being mean. Staff continued to try and assist with untangling the dog, but the resident continued to yell and cry. Staff was able to get the dog untangled but the			

	resident continued to cry and yell. Resident went to her room and was still very emotional. The facility's action taken was offered to resident to go out for an eval (evaluation) but the resident and family said no. They did not her to go out...DON (Director of Nursing) ask staff to continue to check on resident throughout the day. Resident went on outing to Walmart and was not c/o (complaints of) any discomfort..." The incident investigation between Resident F and QMA 3 included the following: A typed statement with no name nor dated, indicated "Resident [F] came down to speak with ED about a situation that happened with her and a staff member [QMA 3]. Resident stated that she was getting off the elevator and the staff member was getting on. Resident had her dog sitting on her scooter when she was trying to take him out to potty. Another resident came up to see resident dog. The dog ran off her scooter, and the nurse tried to catch her before running to the other resident. The dog's leash got tangled up under her scooter. Resident tried to move; nurse told her to stop she almost ran over her dog. Resident stated the nurse raised her voice at her."			

	A written statement by QMA 3 not dated, indicated "[Resident F] and I were on the first floor, I had my medication cart but wasn't quite finish with the resident I was assisting. Once I was finished I was trying to get on the elevator. I asked [Resident F] to let me through she said you have to wait I have to get my dog. But when she's just sitting there blocking the area her dog is wrapping the dog leash around her wheelchair. I said [Resident F] just scoot up so I can get by; she starts screaming that I need to wait. I'm always being rude so I push her chair up so I can get passed. She starts yelling I hate you. I hate this place several times. I never said anything else I just got on the elevator and finished my med [medication] pass." The investigation did not include any other resident statements nor any other staff member statements that had witnessed the incident. An interview was conducted with the ED on 1/15/26 at 3:11 p.m. She indicated she had not noticed the statements in the investigations for Resident F, Resident P and Resident E some statements did not include names, dates and signatures who had written the statements. She did not have any additional interviews from staff or residents			

	that she had conducted during the investigation. An abuse policy was provided by the ED on 1/14/26 at 1:00 p.m. It indicated, "...Policy Overview: Fort Harrison Assisted Living is committed to maintaining a safe environment for each resident, visitor and employee. Instances and allegations of abuse, neglect, or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...1. Definitions...c. 'Misappropriation' is defined in Indian as depriving, defrauding or otherwise obtaining real or personal property of a resident by any means prohibited by law including robbery, theft, burglary, or fraud... 5. Investigation: a) Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Executive Director, or designee, should conduct a confidential internal investigation of the incident. b) Manner of Conducting Investigation. The investigation should be conducted confidentially and in a manner that is least disruptive to the on-going delivery of services and daily routine of the community. 1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator,			

	the alleged victim, associates, other residents and visitors to the community...c) Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of the incident. d.) Investigation Record. The Executive Director or designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being questioned and an impartial report of facts...6. External Reporting/ Notification...c) Report to the Department of Health 1) The executive Director or designee, in consultation with the Regional Director of Operations, should report known or suspected abuse, neglect or misappropriation and all allegations of abuse, neglect or misappropriation to the Director of Health..." 4. The clinical record for Resident Q was reviewed on 1/15/25 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, altered mental status, and cognitive communication deficit. A service plan, dated 12/30/25, indicated the resident had mild impairment of orientation. She "has current and/or history of			

	disorientation to person, place, time or situation. Requires some direction and reminding from others." A Mini Mental assessment, dated 1/2/26, indicated the resident scored a 26 on the exam. The resident's score was in the category of "degree of impairment: questionably significant." That category indicated "if clinical signs of cognitive impairment are present, formal assessment of cognition may be valuable. May have clinically significant but mild deficits. Likely to affect only most demanding activities of daily living."			

	A summary of the meeting with Resident Q's Legal Representative, dated 12/21/25, indicated "ED and BOM had a meeting with [Resident Q's Legal Representative] which was requested by [Resident Q's Legal Representative] on her concern how her [family member] is pushing her away. [Resident Q's Legal Representative] mentioned to both ED and BOM that at first she was ok with the relationship between Resident P and Resident Q but now she feels that [Resident Q] is being taken advantage of due to her not wanting to spend anytime with her anymore...She also stated [Resident Q] will come around when she needs something." Resident Q was not available for interview. 5.a. A reportable incident to the Indiana Department of Health for Resident E and Resident P, dated 12/11/25, and the investigation to the incident was provided by the Executive Director (ED) on 1/15/26 at 1:45 p.m. The reportable incident indicated "Resident [Q] brought her laundry out of her room and placed it in front of another resident's door. Resident [E] got upset and moved it back in front of the resident [Q]'s door asking are you messing with me or do you have a problem with me. Resident [Q] called her			

	significant other [Resident P] and he intervened by cursing and yelling and then situation escalated to residents verbally aggressive." The facility's action taken was the separation of the residents. ED and Director of Nursing (DON) provided education to Resident P and Resident E to bring unresolved concerns to ED and DON immediately. The incident investigation between Resident E and Resident P included the following: A statement written by Resident P, dated 12/11/25, indicated, "I was walking down the hall and she stepped up to me talking crazy and yelling. I thought we was cool. She wouldn't get out of my face. I spit on her and she spit on me. She said she is calling her [family member]. I'm not scared. I don't play that, She was coming at me." A statement written (no name or date), indicated "Resident [E] stated she noticed laundry basket from next door was close to her apartment. [Resident E] knocked on resident door and asked why she [Resident Q] placed her basket near her door. Residents exchanged words started spit on eachother." An incident report for Resident			

	P, dated 12/11/25, indicated Resident P and Resident E had a "verbally aggressive conversation" that included foul language and saliva in the hallway. The residents were separated by staff and they did not have any other physical contact. The resident statement: "Resident stated that the other resident [E] approached him and his friend [Resident Q] yelling and shouting about a laundry basket. Resident stated that the other resident [Resident E] got into his face and they spit on each other...Witnesses: Employee 5 and Employee 6..." The investigation did not include statements by Resident Q, Employee 5, Employee 6 nor any other residents or staff members that witnessed the incident. 5.b. The clinical record for Resident P was reviewed on 1/15/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to, chronic viral hepatitis C and hepatitis B, alcohol abuse, and liver cell carcinoma. A service plan, dated 1/4/26, indicated the resident makes his own decisions. Resident P does have "confrontational behaviors toward peers." A Mini Mental assessment, dated 11/21/25, indicated			

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	obligation to protect the vulnerable and must notify the ED or supervisor in charge so that the legally responsible party/involved family for residents can be fully informed of physically intimate relationships...As indicated and agreed upon by...the physician, the cognitively impaired resident's Personal Service Plan (PSP) should be updated to reflect the outcome of the ED's discussion with the involved parties. Associates should be informed of the plan..." This citation relates to Intakes 466783 and 466691.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure an as needed medication was available for use for 1 of 3 residents reviewed for pharmacy services	R 0297	**1. Immediate actions taken for those residents identified.** Education with QMAs, including availability of as needed medications (prn) **2. How the facility identified other residents.** Any residents residing in the facility had the potential to be affected. **3. Measures put into place and/or system changes.** As needed (PRN) medication audit to be completed by HWD/designee, to ensure that as needed medications are available at the facility for	01/30/2026

	(Resident D). Findings include: The clinical record for Resident D was reviewed on 1/16/26 at 9:45 a.m. The resident's diagnosis included, but was not limited to, lung cancer. A physician's order, dated 9/10/15, indicated Resident D was to receive Atropine 1% drops (medication used when placed under the tongue or orally to reduce noisy respiratory secretions at the end of life) place 5 drops under the tongue every 2 hours as needed for secretions. A Delivery Manifest indicated the pharmacy had delivered Atropine 1% drops for Resident D on 9/10/25. A progress note, dated 9/11/25, indicated Resident D had been visited by hospice services. Resident D was at the beginning stages of actively transitioning (end of life). A progress note, dated 9/14/25 at 5:45 a.m., indicated that Resident D's family member had contacted the Director of Nursing (DON) due to the facility staff not being able to locate the Atropine drops for use during the night. Resident D had passed away, and Resident D's family member was not satisfied with the care received during		administration. Audits will be completed weekly for 4 weeks, then twice monthly thereafter. Audits were start January 30, 2026. **4. How the corrective actions will be monitored.** The HWD/designee will be responsible for conducting audits and compliance. Any issues identified will be immediately addressed.	

	the night shift. During an interview on 1/15/26 at 11:30 a.m., Family Member (FM) 20 indicated that she had been with Resident D the night she passed away. The facility staff had not been able to find the Atropine drops. Resident D had gurgling (death rattle) breathing during the night, and the Atropine should have been given. FM 20 was upset that Resident D had passed away like that and it had been awful to listen to. Resident D should have received the Atropine drops to help alleviate the increased secretions. During an interview on 1/16/26 at 9:50 a.m., the DON indicated the Atropine 1% drops for Resident D had been delivered to the facility on 9/10/25 and she had received a dose of Atropine on 9/11/25. The facility staff had been unable to locate the atropine on 9/14/25. The Atropine drops had been reordered from the pharmacy when the staff were unable to find them but were not received before Resident D had passed away. The DON was unsure where the Atropine drops had gone, and they had not been located. This citation is related to Intake 466191. Based on interview and record			

review, the facility failed to ensure an as needed medication was available for use for 1 of 3 residents reviewed for pharmacy services (Resident D).

Findings include:

The clinical record for Resident D was reviewed on 1/16/26 at 9:45 a.m. The resident's diagnosis included, but was not limited to, lung cancer.

A physician's order, dated 9/10/15, indicated Resident D was to receive Atropine 1% drops (medication used when placed under the tongue or orally to reduce noisy respiratory secretions at the end of life) place 5 drops under the tongue every 2 hours as needed for secretions.

A Delivery Manifest indicated the pharmacy had delivered Atropine 1% drops for Resident D on 9/10/25.

A progress note, dated 9/11/25, indicated Resident D had been visited by hospice services. Resident D was at the beginning stages of actively transitioning (end of life).

A progress note, dated 9/14/25 at 5:45 a.m., indicated that Resident D's family member had contacted the Director of Nursing (DON) due to the facility staff not being able to locate the

	Atropine drops for use during the night. Resident D had passed away, and Resident D's family member was not satisfied with the care received during the night shift. During an interview on 1/15/26 at 11:30 a.m., Family Member (FM) 20 indicated that she had been with Resident D the night she passed away. The facility staff had not been able to find the Atropine drops. Resident D had gurgling (death rattle) breathing during the night, and the Atropine should have been given. FM 20 was upset that Resident D had passed away like that and it had been awful to listen to. Resident D should have received the Atropine drops to help alleviate the increased secretions.			

	During an interview on 1/16/26 at 9:50 a.m., the DON indicated the Atropine 1% drops for Resident D had been delivered to the facility on 9/10/25 and she had received a dose of Atropine on 9/11/25. The facility staff had been unable to locate the atropine on 9/14/25. The Atropine drops had been reordered from the pharmacy when the staff were unable to find them but were not received before Resident D had passed away. The DON was unsure where the Atropine drops had gone, and they had not been located. This citation is related to Intake 466191.			
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. 2. The clinical record for	R 0349	**1. Immediate actions taken for those residents identified.** Education with QMAs, including Resident Rights policy, change of condition documentation, update medication orders, and transfer/discharge policy. **2. How the facility identified other residents.** Any residents residing in the facility had the potential to be affected. **3. Measures put into place and/or system changes.** Transfer/discharge/change of	01/30/2026

	Resident E was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain. A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed. During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. The Nurse Practitioner was informed that Resident D needed an oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg 1 tablet every 6 hours as needed, which was delivered. Resident D's clinical record did not include a physician's order for oxycodone IR 10 mg tablets take 1 tablet every 6 hours as needed. The citation is related to Intake 466160 and 466191. Based on interview and record		condition audit for proper documentation and proper contact notifications to be completed by HWD/designee weekly for 4 weeks, then 3 times weekly thereafter. HWD will audit resident medication orders for accuracy weekly for 4 weeks, then monthly thereafter. Audits were start January 30, 2026. **4. How the corrective actions will be monitored.** The HWD/designee will be responsible for conducting audits and compliance. Any issues identified will be immediately addressed.	

review, the facility failed to ensure residents' medical chart was complete that included documentation of a resident's change of condition and transfer to the hospital for 1 of 3 residents reviewed for hospitalization, and an accurate physician's order for narcotic pain medications were present in the clinical record for 1 of 15 resident clinical records reviewed. (Resident C and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 1/14/25 at 2:30 p.m. The resident's diagnoses included, but were not limited to, lupus (autoimmune disease).

A nursing progress note, dated 11/17/25, indicated Resident C had returned from the hospital with no new orders. The resident was hospitalized for elevated blood pressure. The resident's legal representative was notified via phone she had arrived back to the facility.

Resident C's medical chart did not include documentation the resident had a change of condition or when she was transferred to the hospital on 11/15/25.

An interview was conducted with the Director of Nursing on 1/15/26 at 3:25 p.m. She

	indicated she was unable to provide documentation in the medical chart the staff had documented Resident C's change of condition, notification of the medical provider and transfer of the resident to the hospital on 11/17/25. 2. The clinical record for Resident E was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain. A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed.			

	During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. The Nurse Practitioner was informed that Resident D needed an oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg 1 tablet every 6 hours as needed, which was delivered. Resident D's clinical record did not include a physician's order for oxycodone IR 10 mg tablets take 1 tablet every 6 hours as needed. The citation is related to Intake 466160 and 466191.			

Based on interview and record review, the facility failed to ensure residents' medical chart was complete that included documentation of a resident's change of condition and transfer to the hospital for 1 of 3 residents reviewed for hospitalization, and an accurate physician's order for narcotic pain medications were present in the clinical record for 1 of 15 resident clinical records reviewed. (Resident C and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 1/14/25 at 2:30 p.m. The resident's diagnoses included, but were not limited to, lupus (autoimmune disease).

A nursing progress note, dated 11/17/25, indicated Resident C had returned from the hospital with no new orders. The resident was hospitalized for elevated blood pressure. The resident's legal representative was notified via phone she had arrived back to the facility.

Resident C's medical chart did not include documentation the resident had a change of condition or when she was transferred to the hospital on 11/15/25.

An interview was conducted with the Director of Nursing on

	1/15/26 at 3:25 p.m. She indicated she was unable to provide documentation in the medical chart the staff had documented Resident C's change of condition, notification of the medical provider and transfer of the resident to the hospital on 11/17/25. 2. The clinical record for Resident E was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain. A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed. During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. The Nurse Practitioner was informed that Resident D needed an oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg 1 tablet every 6 hours as needed,			

which was delivered.

Resident D's clinical record did not include a physician's order for oxycodone IR 10 mg tablets take 1 tablet every 6 hours as needed.

The citation is related to Intake 466160 and 466191.

Based on interview and record review, the facility failed to ensure residents' medical chart was complete that included documentation of a resident's change of condition and transfer to the hospital for 1 of 3 residents reviewed for hospitalization, and an accurate physician's order for narcotic pain medications were present in the clinical record for 1 of 15 resident clinical records reviewed. (Resident C and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 1/14/25 at 2:30 p.m. The resident's diagnoses included, but were not limited to, lupus (autoimmune disease).

A nursing progress note, dated 11/17/25, indicated Resident C had returned from the hospital with no new orders. The resident was hospitalized for elevated blood pressure. The resident's legal representative was notified via phone she had

arrived back to the facility.

Resident C's medical chart did not include documentation the resident had a change of condition or when she was transferred to the hospital on 11/15/25.

An interview was conducted with the Director of Nursing on 1/15/26 at 3:25 p.m. She indicated she was unable to provide documentation in the medical chart the staff had documented Resident C's change of condition, notification of the medical provider and transfer of the resident to the hospital on 11/17/25.

2. The clinical record for Resident E was reviewed on 1/1/526 at 9:57 a.m. The resident's diagnosis included, but was not limited to, chronic pain.

A physician's order, dated 10/28/25, indicated Resident D was to self-administer Oxycodone HCL IR (Instant Release pain medication) 5 milligram (mg) take two tablets (10 mg) by mouth every six hours as needed.

During an interview on 1/16/26 at 10:14 a.m., the DON indicated Resident D had moved into the facility in October 2025. Resident D had been admitted with medications from her previous facility. She

had oxycodone IR 5 mg tablets and took 2 tablets to equal 10 mg which she took as needed. The Nurse Practitioner was informed that Resident D needed an oxycodone script and since she was taking two 5 mg tablets, the NP wrote the script for oxycodone 10 mg 1 tablet every 6 hours as needed, which was delivered.

Resident D's clinical record did not include a physician's order for oxycodone IR 10 mg tablets take 1 tablet every 6 hours as needed.

The citation is related to Intake 466160 and 466191.

Based on interview and record review, the facility failed to ensure residents' medical chart was complete that included documentation of a resident's change of condition and transfer to the hospital for 1 of 3 residents reviewed for hospitalization, and an accurate physician's order for narcotic pain medications were present in the clinical record for 1 of 15 resident clinical records reviewed. (Resident C and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 1/14/25 at 2:30 p.m. The resident's diagnoses included, but were not limited to, lupus

	(autoimmune disease). A nursing progress note, dated 11/17/25, indicated Resident C had returned from the hospital with no new orders. The resident was hospitalized for elevated blood pressure. The resident's legal representative was notified via phone she had arrived back to the facility. Resident C's medical chart did not include documentation the resident had a change of condition or when she was transferred to the hospital on 11/15/25. An interview was conducted with the Director of Nursing on 1/15/26 at 3:25 p.m. She indicated she was unable to provide documentation in the medical chart the staff had documented Resident C's change of condition, notification of the medical provider and transfer of the resident to the hospital on 11/17/25.			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative.	R 0357	**1. Immediate actions taken for those residents identified.** Education with QMAs, including death of a resident policy. All QMAs must complete death of a resident training during new hire orientation. All current QMAs must complete training immediately. Training will include but not limited to:	01/30/2026

	(2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to include in the resident's medical chart the required documentation that included: residents' vitals and condition prior to death, and the disposition of the resident's body and possessions for residents' that are transitioning to death or has deceased for 3 of 3 residents reviewed for death. (Residents' D, G, and H) Findings include: 1. The clinical record for Resident D was reviewed on 1/14/25 at 2:45 p.m. The resident's diagnosis included, but weas not limited to, lung cancer. A nursing progress note, dated 9/11/25 at 11:00 a.m., indicated, "Hospice visited resident. Resident is at the beginning stages of actively transitioning [end of life]..."		ensuring the body is appropriate presented for when family comes in, notify the doctor, obtain an order to release the body to the funeral home, and ensure all charting up to death is completed. **2. How the facility identified other residents.** Any residents residing in the facility had the potential to be affected. **3. Measures put into place and/or system changes.** Hospice/transitioning resident/death of a resident audit for proper documentation and proper contact notifications to be completed by HWD/designee weekly for 4 weeks, then 3 times weekly thereafter. Audits were start January 30, 2026. **4. How the corrective actions will be monitored.** The HWD/designee will be responsible for conducting audits and compliance. Any issues identified will be immediately addressed.	

A nursing progress note, dated 9/14/25 at 5:45 a.m., indicated, "...Hospice Nurse assisted with coordinating with Funeral Home to pick up residents body.

A discharge progress note, dated 10/6/25, indicated the resident was discharged, because deceased.

Resident D's clinical record did not include resident's assessment, resident's condition prior to death, and disposition of the resident's body or possessions.

2. The clinical record for Resident G was reviewed on 1/14/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, respiratory failure.

A nursing progress note for Resident G, dated 10/30/25 at 8:45 a.m., indicated the resident appeared to be sleeping and comfortable. The resident's vitals were "...100/72 [blood pressure], 106 [heart rate], temp [temperature] 99.5 Res [respirations] 14 and spo2 [oxygen saturations] 92."

A nursing progress note, dated 10/30/25 at 6:30 p.m., indicated Resident G had deceased. The resident's representative and hospice were notified.

A discharge progress note, dated 11/11/25, indicated

Resident G had been discharged due to death.

Resident G's medical record did not include the resident's condition prior to death and disposition of the resident's body or possessions.

3. The clinical record for Resident H was reviewed on 1/14/25 at 3:15 p.m. The resident's diagnosis included, but was not limited to, heart failure.

A nursing progress note, dated 12/19/25 at 8:45 p.m., indicated the resident was resting in bed with eyes closed. The resident's vitals were "...v/s [vitals] B/P [blood pressure] 73/47, T [Temperature] 97.3, P [pulse] 80, R [respirations] 16. Writer not able to an O2 stat [oxygen saturation]."

A nursing progress note, dated 12/20/25 at 6:15 a.m., indicated the resident's respirations have ceased in the early hours of the shift. The Coroner had still not arrived but the paperwork was ready.

Resident H's medical record did not include the resident's condition prior to death and disposition of the resident's body or possessions.

An interview was conducted with the DON on 1/16/26 at 9:50 a.m. She was unable to provide

additional documentation that was charted in the medical chart that indicated residents' vitals, condition prior to death and disposition of the residents' body and possessions for Residents' D, G, and H.

A death of a resident policy was provided by the Executive Director on 1/14/26 at 1:00 p.m. It indicated, "How to death of a resident...2. Instruct the RCA [Resident Care Associate] to ensure the body is appropriate presented for when family comes in. 3. The doctor must be notified, and an order must be obtained to release the body to the funeral home...9. Ensure that you have charted everything..."

This citation is related to 466191.

Based on interview and record review, the facility failed to include in the resident's medical chart the required documentation that included: residents' vitals and condition prior to death, and the disposition of the resident's body and possessions for residents' that are transitioning to death or has deceased for 3 of 3 residents reviewed for death. (Residents' D, G, and H)

Findings include:

1. The clinical record for Resident D was reviewed on

1/14/25 at 2:45 p.m. The resident's diagnosis included, but weas not limited to, lung cancer.

A nursing progress note, dated 9/11/25 at 11:00 a.m., indicated, "Hospice visited resident. Resident is at the beginning stages of actively transitioning [end of life]..."

A nursing progress note, dated 9/14/25 at 5:45 a.m., indicated, "...Hospice Nurse assisted with coordinating with Funeral Home to pick up residents body.

A discharge progress note, dated 10/6/25, indicated the resident was discharged, because deceased.

Resident D's clinical record did not include resident's assessment, resident's condition prior to death, and disposition of the resident's body or possessions.

2. The clinical record for Resident G was reviewed on 1/14/25 at 1:30 p.m. The resident's diagnosis included, but was not limited to, respiratory failure.

A nursing progress note for Resident G, dated 10/30/25 at 8:45 a.m., indicated the resident appeared to be sleeping and comfortable. The resident's vitals were "...100/72 [blood pressure], 106 [heart rate], temp

[temperature] 99.5 Res [respirations] 14 and spo2 [oxygen saturations] 92."

A nursing progress note, dated 10/30/25 at 6:30 p.m., indicated Resident G had deceased. The resident's representative and hospice were notified.

A discharge progress note, dated 11/11/25, indicated Resident G had been discharged due to death.

Resident G's medical record did not include the resident's condition prior to death and disposition of the resident's body or possessions.

3. The clinical record for Resident H was reviewed on 1/14/25 at 3:15 p.m. The resident's diagnosis included, but was not limited to, heart failure.

A nursing progress note, dated 12/19/25 at 8:45 p.m., indicated the resident was resting in bed with eyes closed. The resident's vitals were "...v/s [vitals] B/P [blood pressure] 73/47, T [Temperature] 97.3, P [pulse] 80, R [respirations] 16. Writer not able to an O2 stat [oxygen saturation]."

A nursing progress note, dated 12/20/25 at 6:15 a.m., indicated the resident's respirations have ceased in the early hours of the shift. The Coroner had still not

arrived but the paperwork was ready.

Resident H's medical record did not include the resident's condition prior to death and disposition of the resident's body or possessions.

An interview was conducted with the DON on 1/16/26 at 9:50 a.m. She was unable to provide additional documentation that was charted in the medical chart that indicated residents' vitals, condition prior to death and disposition of the residents' body and possessions for Residents' D, G, and H.

A death of a resident policy was provided by the Executive Director on 1/14/26 at 1:00 p.m. It indicated, "How to death of a resident...2. Instruct the RCA [Resident Care Associate] to ensure the body is appropriate presented for when family comes in. 3. The doctor must be notified, and an order must be obtained to release the body to the funeral home...9. Ensure that you have charted everything..."

This citation is related to 466191.

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	TITLEExecutive Director	(X6) DATE02/10/2026

SIGNATUREDametria Marshall		