STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE, MERRILLVILLE, , 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes IN00459600, IN00463775, and IN00464219. Intake IN00459600 - State deficiency related to the allegations is cited at R0090. Intake IN00463775 - State deficiency related to the allegations is cited at R0090. Intake IN00464219 - State deficiency related to the allegations is cited at R0090. Survey date: August 28, 2025 Facility number: 0014178 Residential Census: 120 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/2/25.	R 0000		

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.	R 0090	**R – 090 Administration and Management -Deficiency** **Corrective Action:** **1.No Residents were harmed by the alleged deficient practice.** **Administrator and DON were re-educated on 09/10/2025 on conducting an abuse investigation with timely reporting of allegations of abuse to the Indiana Department of Health by Regional Director of Clinical Services.** **2.All residents have the potential to be affected by alleged deficiency.** **No other residents were affected by alleged deficient practice.**	09/19/2025

	(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: During an interview on 8/28/25 at 9:26 a.m., Resident B indicated while she was waiting		**3.All** **Staff will be in-serviced on 09/12/25 by Executive Director on Abuse and** **Neglect to include allegation of abuse, the proper reporting criteria and** **timely reporting of any allegation of abuse to IDOH.** **Executive Director and/or Director of Nursing** **will review/report any notifications from staff or residents on signs of changes in behaviors/unusual occurrence and report Indiana Department of Health.** **4.A** **QA audit will be conducted by ED/designee to ensure compliance of reporting allegations of abuse/neglect to IDOH weekly x 4 weeks and then monthly for 6** **months. At the end of 6 months a re-evaluation will be conducted to** **determine if ongoing monitoring is required.**	

for friends to arrive for the Mother's Day meal on 5/9/25, a ping pong ball forcefully hit her on her back and she thought the employee standing behind her had thrown the ball at her. She indicated she reported this allegation to the Administrator per grievance on 5/12/25.

An email from Resident B addressed to the Administrator, dated 5/12/25 and received from the Administrator on 8/28/25, indicated the resident had felt something hit her back and she turned around and saw the staff member standing behind her.

During an interview on 8/28/25 at 10:44 a.m., the Administrator indicated the allegation had not been reported to the IDOH because after a video of the event was reviewed and other residents were interviewed, they were unable to prove the incident occurred.

A facility abuse policy, dated 7/2025, indicated within 24 hours, the IDOH was to be notified of an allegation of abuse.

This citation relates to Intakes IN00459600, IN00463775, and IN00464219.

Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Indiana

Department of Health (IDOH) for 1 of 3 residents reviewed for abuse. (Resident B)

Finding includes:

During an interview on 8/28/25 at 9:26 a.m., Resident B indicated while she was waiting for friends to arrive for the Mother's Day meal on 5/9/25, a ping pong ball forcefully hit her on her back and she thought the employee standing behind her had thrown the ball at her. She indicated she reported this allegation to the Administrator per grievance on 5/12/25.

An email from Resident B addressed to the Administrator, dated 5/12/25 and received from the Administrator on 8/28/25, indicated the resident had felt something hit her back and she turned around and saw the staff member standing behind her.

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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 SIGNATURE	TITLE	(X6) DATE