STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT, CHESTERTON, , 46304

(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 465695 and 465990. Intake 465695 - State deficiencies related to the allegations are cited at R052 and R217. Intake 465990 - State deficiencies related to the allegations are cited at R052 and R217. Survey date: November 17 and 18, 2025 Facility number: 14469 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/19/25.	R 0000	Residences at Coffee Creek (the “Provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider herby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana	

			or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. We are requesting paper compliance for the deficiencies cited.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from neglect and had adequate	R 0052	Residents B and C have developed a fondness for one another, which was acknowledged and accepted by the families of both residents. No other residents experienced negative outcomes associated with this finding. At the time of this survey, Resident B had just transferred to the other side of the Memory Support unit. It was explained to the surveyor that after the first incident, the memory support was fully occupied and Resident B could not move at that time. A census sheet was provided to the surveyor as confirmation no apartments	12/19/2025

	supervision provided to cognitively impaired residents living in the memory support unit, related to two cognitively impaired residents who engaged in sexual behavior during two separate incidents for 2 of 4 residents reviewed for resident-to-resident abuse. (Residents B and C) Finding includes: On 10/24/25, an Indiana Department of Health (IDOH) facility reported incident indicated two memory support residents were sitting in the living room area together in front of the care station. After a few minutes, staff realized both residents were not in the living area. Residents B and C were noted to be in resident C's apartment together. Resident C was unclothed at the end of the bed and Resident B was partially clothed on the bed. The residents were immediately separated, and a nurse completed a head-to-toe assessment on each resident with no injuries noted. There had not appeared to be any sexual activity. The residents were separately interviewed but due to dementia diagnoses for both residents, neither was able to recall the incident. Families and Physicians were notified. An Incident Tracking Note, dated 10/24/25 at 4:00 p.m.,		were available that the time of the first incident. Resident B was moved as soon as an apartment on the other side of memory care became available. Resident B and C were closely monitored during this in-between time. Both Resident B and C are ambulatory and able to move about the community freely. After reviewing all memory care residents, no other memory care residents are experiencing sexual behaviors or are in relationships with one another and do not need to move apartments. Currently, resident B and C have not had any interaction with one another. Resident B is currently completing a stay at a psych facility. This facility is consistently keeping in contact with the psych facility on Resident B’s progress. Resident B will be assessed before returning to the facility. Staff in-servicing with nursing staff is currently being completed to include education on what to do when ambulatory residents are exhibiting sexual behaviors. This includes closely monitoring the residents and updating their service plans to reflect the new behaviors as well as notifying the POA and	

	indicated Resident B was noted to be in Room 90 lying on the bed partially clothed. Resident C was also present sitting at the end of the bed and was unclothed. When staff asked residents about incident neither was unable to recall any of the incident. Both residents were asked to put clothes back on and resident B was escorted from Resident C's room. Upon assessment there was no injury noted and there were no observed signs of sexual activity. Physicians were made aware and son was notified twice, and 15-minute checks were initiated. An Interdisciplinary Note, dated 10/27/25 at 3:41 p.m., indicated Resident B had new orders for a urinalysis with culture/sensitivity. The family was notified. On 11/10/25, an IDOH facility reported incident indicated when staff went to check on residents, it was noted that Resident C was in Resident B's apartment. Resident C was fully clothed, and Resident B was partially clothed. Resident C was noted to have been touching Resident B in a sexual manner. Both residents were separated immediately and the nurse assessed Resident C. Resident B refused an assessment. Family and Physicians were notified of the incident.		physician of any new behaviors. These systematic changes will be in place January 14, 2026.	

	During an interview on 11/17/25 at 11:21 a.m., CNA 1 indicated on 11/10/25, she had noticed Residents B and C were not on the couch where they usually would sit together. It had been known that they tried to go into each other's rooms, and staff had monitored them constantly. She went to check on other residents, and it was just her and QMA1 on the unit. QMA 1 was passing medications or checking on residents as well. When she came back 5-10 minutes later, she had noticed Residents B and C were gone. She listened at the door of Resident B's apartment to see if they were in there and she heard grunting noises coming from Resident B. When she entered resident B's room, she had seen Resident C's head coming up and she was grabbing Resident B's penis and was pulling up and down with her fingers. She became startled and covered Resident B with two hands when she noticed CNA 1 enter the room. CNA 1 indicated she said, "get out of [Resident B]'s room you know you are not allowed in here". Resident C reported she understood and would get out. However, resident C would not leave. Resident B had his pants on and lowered near his knees, and he had a shirt on. Resident C was fully dressed. Resident B had become angry and asked CNA 1 to leave. CNA 1 called			

	CNA 2 and QMA 1 for assistance in removing Resident C from Resident B's apartment. CNA 2 walked in and she had asked resident C to grab her things because she needed to leave. Resident B had become hostile and QMA 1 took over from there. Resident C was escorted back to her room and was assessed by LPN 1. They had started 15 minutes checks on them until Resident B was moved to a different unit. During an interview on 11/17/25 at 12:08 p.m., the Director of Nursing (DON) indicated the facility had been staffing-challenged recently, they had offered bonuses to cover shifts, she had come in to cover shifts, and they started to split the unit in 3 so they could share staff with the other memory care unit. She indicated the 15-minute checks on Resident B and Resident C occurred more frequently than 15 minutes, and they were heavily monitored. After the first incident, both residents had a urine sample obtained and both had urinary infections that were treated with antibiotics and they both had psych services ordered. During an interview on 11/17/25 at 12:55 p.m., CNA 3 indicated on 10/24/25, she had found Resident B in Resident C's room. He was lying on his side			

	closest to the window and only had a shirt on. Sitting near the foot of the bed and completely unclothed was Resident C and she was folding her clothes. CNA 3 had been supervising both residents until they left the living room area. She immediately went to search for them. They were not in Resident C's room for more than ten minutes and she believed staff were able to catch them "before they were able to do anything." During an interview on 11/17/25 at 3:34 p.m., QMA 1 indicated she was assisting another resident and when she had gotten to Resident B's apartment, Resident C was fully dressed and a little confused. Resident B was upset with her and called her names. She had grabbed Resident C's hand and helped escort her out of the apartment while the other staff remained with Resident B. LPN 1 then completed separate assessments on the residents. During an interview on 11/18/25 at 9:11 a.m., the DON indicated both residents' service plans had been updated on 11/18/25 to reflect changes and Resident C's Power of Attorney (POA) verbally stated all boxes checked were accurate. Resident B's family was left a voicemail to go over the updated service plan.			

	During an interview on 11/18/25 at 12:05 p.m., Social Services indicated she had reached out to Resident B's son and she had explained the incident and they had discussed an increase of supervision or moving him. She had talked to Resident C's family as well and they did not want her to be moved because she was settled. Once a room was available, Resident B was moved. During an interview on 11/18/25 at 12:16 p.m., LPN 2 indicated she had contacted Resident C's family the day before the first incident occurred and told her son they were like little teenagers. They would sit in front of the nurse's station and had planned and plotted to get away together. Resident C had been overheard saying, "I am going to say I have to go to the bathroom so they will unlock my door." She relayed to Resident C's son that it was "pretty serious", and they were trying hard to love each other and they had constant staff eyes on them. a. The record for Resident B was reviewed on 11/17/25 at 10:35 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's, high blood pressure, Asperger's, testicular hypofunction and erectile dysfunction.			

	On 11/17/25 at 2:06 p.m., Resident B was observed in his apartment standing by the bathroom holding a pair of pants. He was calm and dressed appropriately. During an interview at the time, Resident B indicated he did not move, and he did not know Resident C. He also reported he needed to put on pants, but he was already wearing pants. When he was told he had pants on he indicated, "Who did that?" The resident could not remember moving to a new apartment or being in an apartment together with Resident C. A 9/23/25 Service Plan for Resident B indicated the resident required reality orientation as needed related to dementia. The resident was independent with mobility and transfers. A 9/23/25 Resident Assessment for Resident B indicated the cognition and mental status required guidance 1-3 times per day and had no reported behaviors. Urinalysis results for Resident B were received on 11/3/25 and indicated klebsiella pneumonia. An Incident Tracking Note, dated 11/9/25 at 11:00 a.m., indicated upon entering Room 103 as stated by CNA 1, a			

	female resident (Resident C) was in a male resident's (Resident B) room. This resident was lying on his bed partially clothed. A female resident was lying next to him further down the bed. She was fully clothed. The female resident was noted to be touching the male resident in a sexual manner. The CNA immediately attempted to separate the two residents. This male resident became agitated with the CNA. The CNA continued to stay in the room until the female resident was escorted out of the room. The nurse asked this resident what they were doing and he stated, "Its none of your business what we were doing, and you think you know everything". Resident B then refused a skin check. Both residents were separated, and 15-minute checks were initiated. Female resident assessed, male resident refused assessment.			

	An Interdisciplinary Note, dated 11/10/25 at 3:13 p.m., indicated there was a new order to increase in Aricept and Seroquel. Resident B had an incident of becoming very angry with staff who attempted to separate him from a female resident and remained very angry after the incident was over. The nurse practitioner was notified and had ordered Lorazepam 0.5 milligrams twice a day. An Interdisciplinary Note, dated 11/11/25 at 9:16 a.m., indicated there was a new order for geriatric psychiatry services. B An Interdisciplinary Note, dated 11/11/25 at 1:18 p.m., indicated Resident B was moved from room 103 to room 88 and had increased confusion and agitation with initial move. b. Resident C's record was reviewed on 11/17/25 at 10:40 p.m. Diagnoses included, but were not limited to, memory loss and high blood pressure. Resident C was observed on 11/17/25 at 2:12 p.m. The resident was seen in the main foyer room and watched a live musical performance. Many peers and staff members were present. During an interview on 11/17/25 at 2:39 p.m., Resident C indicated she lived in Illinois and			

she was a loner and a pilot. She had recalled a friend named [Resident B] but indicated "no way, she did not go to his room, that is not allowed". She had no recollection of going to Resident B's room or of him coming to her room. She was not sure where she was and when the social worker told her where she was, she indicated, "that's right, coffee is my favorite drink". Resident C knew her birthday, but did not know the month, the president, or her son's name initially.

A Service Plan, dated 9/15/25, indicated the residents were independent with dressing, toileting, mobility, dressing and hygiene and was alert and oriented. No behaviors were noted.

Resident Assessment, dated 9/15/25, indicated the resident was alert and oriented and independent with dressing, mobility, hygiene and toileting.

Both investigations consisted of medication administration records, and written statements from staff.

An Interdisciplinary Note, dated 11/6/25 at 9:16 a.m., indicated urine was positive with E. coli and results were faxed results to the physician.

An Interdisciplinary Note, dated 11/8/25 at 3:22 p.m., indicated

nitrofurantoin was ordered for 7 days.

During an interview on 11/17/25 at 1:55 p.m., the DON indicated Resident C had dementia and memory loss and did not know why the service plan or resident assessment had not reflected that information.

Abuse policy was provided but was not applicable.

This citation relates to Intakes 465695 and 465990.

Based on record review and interview, the facility failed to ensure residents were free from neglect and had adequate supervision provided to cognitively impaired residents living in the memory support unit, related to two cognitively impaired residents who engaged in sexual behavior during two separate incidents for 2 of 4 residents reviewed for resident-to-resident abuse. (Residents B and C)

Finding includes:

On 10/24/25, an Indiana Department of Health (IDOH) facility reported incident indicated two memory support residents were sitting in the living room area together in front of the care station. After a few minutes, staff realized both residents were not in the living area. Residents B and C were

	noted to be in resident C's apartment together. Resident C was unclothed at the end of the bed and Resident B was partially clothed on the bed. The residents were immediately separated, and a nurse completed a head-to-toe assessment on each resident with no injuries noted. There had not appeared to be any sexual activity. The residents were separately interviewed but due to dementia diagnoses for both residents, neither was able to recall the incident. Families and Physicians were notified. An Incident Tracking Note, dated 10/24/25 at 4:00 p.m., indicated Resident B was noted to be in Room 90 lying on the bed partially clothed. Resident C was also present sitting at the end of the bed and was unclothed. When staff asked residents about incident neither was unable to recall any of the incident. Both residents were asked to put clothes back on and resident B was escorted from Resident C's room. Upon assessment there was no injury noted and there were no observed signs of sexual activity. Physicians were made aware and son was notified twice, and 15-minute checks were initiated. An Interdisciplinary Note, dated 10/27/25 at 3:41 p.m., indicated Resident B had new orders for a			

urinalysis with culture/sensitivity. The family was notified.

On 11/10/25, an IDOH facility reported incident indicated when staff went to check on residents, it was noted that Resident C was in Resident B's apartment. Resident C was fully clothed, and Resident B was partially clothed. Resident C was noted to have been touching Resident B in a sexual manner. Both residents were separated immediately and the nurse assessed Resident C. Resident B refused an assessment. Family and Physicians were notified of the incident.

During an interview on 11/17/25 at 11:21 a.m., CNA 1 indicated on 11/10/25, she had noticed Residents B and C were not on the couch where they usually would sit together. It had been known that they tried to go into each other's rooms, and staff had monitored them constantly. She went to check on other residents, and it was just her and QMA1 on the unit. QMA 1 was passing medications or checking on residents as well. When she came back 5-10 minutes later, she had noticed Residents B and C were gone. She listened at the door of Resident B's apartment to see if they were in there and she heard grunting noises coming from Resident B. When she entered resident B's room, she

	had seen Resident C's head coming up and she was grabbing Resident B's penis and was pulling up and down with her fingers. She became startled and covered Resident B with two hands when she noticed CNA 1 enter the room. CNA 1 indicated she said, "get out of [Resident B]'s room you know you are not allowed in here". Resident C reported she understood and would get out. However, resident C would not leave. Resident B had his pants on and lowered near his knees, and he had a shirt on. Resident C was fully dressed. Resident B had become angry and asked CNA 1 to leave. CNA 1 called CNA 2 and QMA 1 for assistance in removing Resident C from Resident B's apartment. CNA 2 walked in and she had asked resident C to grab her things because she needed to leave. Resident B had become hostile and QMA 1 took over from there. Resident C was escorted back to her room and was assessed by LPN 1. They had started 15 minutes checks on them until Resident B was moved to a different unit. During an interview on 11/17/25 at 12:08 p.m., the Director of Nursing (DON) indicated the facility had been staffing-challenged recently, they had offered bonuses to cover shifts, she had come in to cover shifts, and they started to			

split the unit in 3 so they could share staff with the other memory care unit. She indicated the 15-minute checks on Resident B and Resident C occurred more frequently than 15 minutes, and they were heavily monitored. After the first incident, both residents had a urine sample obtained and both had urinary infections that were treated with antibiotics and they both had psych services ordered.

During an interview on 11/17/25 at 12:55 p.m., CNA 3 indicated on 10/24/25, she had found Resident B in Resident C's room. He was lying on his side closest to the window and only had a shirt on. Sitting near the foot of the bed and completely unclothed was Resident C and she was folding her clothes. CNA 3 had been supervising both residents until they left the living room area. She immediately went to search for them. They were not in Resident C's room for more than ten minutes and she believed staff were able to catch them "before they were able to do anything."

During an interview on 11/17/25 at 3:34 p.m., QMA 1 indicated she was assisting another resident and when she had gotten to Resident B's apartment, Resident C was fully dressed and a little confused. Resident B was upset with her

	and called her names. She had grabbed Resident C's hand and helped escort her out of the apartment while the other staff remained with Resident B. LPN 1 then completed separate assessments on the residents. During an interview on 11/18/25 at 9:11 a.m., the DON indicated both residents' service plans had been updated on 11/18/25 to reflect changes and Resident C's Power of Attorney (POA) verbally stated all boxes checked were accurate. Resident B's family was left a voicemail to go over the updated service plan. During an interview on 11/18/25 at 12:05 p.m., Social Services indicated she had reached out to Resident B's son and she had explained the incident and they had discussed an increase of supervision or moving him. She had talked to Resident C's family as well and they did not want her to be moved because she was settled. Once a room was available, Resident B was moved. During an interview on 11/18/25 at 12:16 p.m., LPN 2 indicated she had contacted Resident C's family the day before the first incident occurred and told her son they were like little teenagers. They would sit in front of the nurse's station and had planned and plotted to get			

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resident required reality orientation as needed related to dementia. The resident was independent with mobility and transfers.

A 9/23/25 Resident Assessment for Resident B indicated the cognition and mental status required guidance 1-3 times per day and had no reported behaviors.

Urinalysis results for Resident B were received on 11/3/25 and indicated klebsiella pneumonia.

An Incident Tracking Note, dated 11/9/25 at 11:00 a.m., indicated upon entering Room 103 as stated by CNA 1, a female resident (Resident C) was in a male resident's (Resident B) room. This resident was lying on his bed partially clothed. A female resident was lying next to him further down the bed. She was fully clothed. The female resident was noted to be touching the male resident in a sexual manner. The CNA immediately attempted to separate the two residents. This male resident became agitated with the CNA. The CNA continued to stay in the room until the female resident was escorted out of the room. The nurse asked this resident what they were doing and he stated, "Its none of your business what we were doing, and you think you know everything". Resident

B then refused a skin check. Both residents were separated, and 15-minute checks were initiated. Female resident assessed, male resident refused assessment.

An Interdisciplinary Note, dated 11/10/25 at 3:13 p.m., indicated there was a new order to increase in Aricept and Seroquel. Resident B had an incident of becoming very angry with staff who attempted to separate him from a female resident and remained very angry after the incident was over. The nurse practitioner was notified and had ordered Lorazepam 0.5 milligrams twice a day.

An Interdisciplinary Note, dated 11/11/25 at 9:16 a.m., indicated there was a new order for geriatric psychiatry services. B

An Interdisciplinary Note, dated 11/11/25 at 1:18 p.m., indicated Resident B was moved from room 103 to room 88 and had increased confusion and agitation with initial move.

b. Resident C's record was reviewed on 11/17/25 at 10:40 p.m. Diagnoses included, but were not limited to, memory loss and high blood pressure.

Resident C was observed on 11/17/25 at 2:12 p.m. The resident was seen in the main foyer room and watched a live

musical performance. Many peers and staff members were present.

During an interview on 11/17/25 at 2:39 p.m., Resident C indicated she lived in Illinois and she was a loner and a pilot. She had recalled a friend named [Resident B] but indicated "no way, she did not go to his room, that is not allowed". She had no recollection of going to Resident B's room or of him coming to her room. She was not sure where she was and when the social worker told her where she was, she indicated, "that's right, coffee is my favorite drink". Resident C knew her birthday, but did not know the month, the president, or her son's name initially.

A Service Plan, dated 9/15/25, indicated the residents were independent with dressing, toileting, mobility, dressing and hygiene and was alert and oriented. No behaviors were noted.

Resident Assessment, dated 9/15/25, indicated the resident was alert and oriented and independent with dressing, mobility, hygiene and toileting.

Both investigations consisted of medication administration records, and written statements from staff.

An Interdisciplinary Note, dated

	11/6/25 at 9:16 a.m., indicated urine was positive with E. coli and results were faxed results to the physician. An Interdisciplinary Note, dated 11/8/25 at 3:22 p.m., indicated nitrofurantoin was ordered for 7 days. During an interview on 11/17/25 at 1:55 p.m., the DON indicated Resident C had dementia and memory loss and did not know why the service plan or resident assessment had not reflected that information. Abuse policy was provided but was not applicable. This citation relates to Intakes 465695 and 465990.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and	R 0217	No other residents experienced negative outcomes associated with this finding.Resident B and C did not experience any negative outcomes associated with this finding.Before the exiting of this survey, The Service plans for residents B and C were reviewed, updated, and signed by the POA. Director of resident Services or designee will reviewall memory care resident charts to ensure that service plans are updated,	01/12/2026

	(D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 2 of 4 resident records reviewed. (Residents B and C) Findings include: 1. The record for Resident B was reviewed on 11/17/25 at		reviewed, and signed. The Director of Resident Services, or designee will in-service nursing staff on updating resident service plans when there is a new behavior. Director of Resident Services or designee will review nursing notes 5 days per week to ensure any new behaviors are updated in the service plans. These audits will continue until 100% compliance is achieved to ensure ongoing compliance with this requirement. These audits will be reviewed routinely by the quality assurance committee. These systematic changes will be in place January 12, 2026.	

10:35 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's, high blood pressure, Asperger's, testicular hypofunction and erectile dysfunction.

A 9/23/25 Service Plan for Resident B indicated the resident required reality orientation as needed related to dementia. The resident was independent with mobility and transfers.

A 9/23/25 Resident Assessment for Resident B indicated the cognition and mental status required guidance 1-3 times per day and had no reported behaviors.

The Service Plan was not updated to include the resident's recent behaviors.

During an interview on 11/18/25 at 9:11 a.m., the Director of Nursing indicated the resident's service plans had been reviewed and updated on 11/18/25 to reflect changes in behavior and cognition.

2. Resident C's record was reviewed on 11/17/25 at 10:40 p.m. Diagnosis included, but were not limited to, memory loss and high blood pressure.

A Service Plan, dated 9/15/25, indicated the residents were independent with dressing, toileting, mobility, dressing and

hygiene and was alert and oriented. No behaviors were noted.

A Resident Assessment, dated 9/15/25, indicated the resident was alert and oriented and independent with dressing, mobility, hygiene and toileting.

The Service Plan was not updated to include the resident's updated cognition and current behaviors.

During an interview on 11/17/25 at 1:55 p.m., the DON indicated Resident C had dementia and memory loss and she did not know why the service plan or resident assessment had not reflected that information.

During an interview on 11/18/25 at 9:11 a.m., the Director of Nursing indicated the resident's service plan had been reviewed and updated on 11/18/25 to reflect changes in behavior and cognition.

This citation relates to Intake 465695 and 465990.

Based on record review and interview, the facility failed to ensure service plans were reviewed and revised as appropriate for 2 of 4 resident records reviewed. (Residents B and C)

Findings include:

1. The record for Resident B was reviewed on 11/17/25 at 10:35 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's, high blood pressure, Asperger's, testicular hypofunction and erectile dysfunction.

A 9/23/25 Service Plan for Resident B indicated the resident required reality orientation as needed related to dementia. The resident was independent with mobility and transfers.

A 9/23/25 Resident Assessment for Resident B indicated the cognition and mental status required guidance 1-3 times per day and had no reported behaviors.

The Service Plan was not updated to include the resident's recent behaviors.

During an interview on 11/18/25 at 9:11 a.m., the Director of Nursing indicated the resident's service plans had been reviewed and updated on 11/18/25 to reflect changes in behavior and cognition.

2. Resident C's record was reviewed on 11/17/25 at 10:40 p.m. Diagnosis included, but were not limited to, memory loss and high blood pressure.

A Service Plan, dated 9/15/25, indicated the residents were

	independent with dressing, toileting, mobility, dressing and hygiene and was alert and oriented. No behaviors were noted. A Resident Assessment, dated 9/15/25, indicated the resident was alert and oriented and independent with dressing, mobility, hygiene and toileting. The Service Plan was not updated to include the resident's updated cognition and current behaviors. During an interview on 11/17/25 at 1:55 p.m., the DON indicated Resident C had dementia and memory loss and she did not know why the service plan or resident assessment had not reflected that information. During an interview on 11/18/25 at 9:11 a.m., the Director of Nursing indicated the resident's service plan had been reviewed and updated on 11/18/25 to reflect changes in behavior and cognition. This citation relates to Intake 465695 and 465990.			

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 SIGNATUREKaitlynn Redmon	TITLEExecutive Director	(X6) DATE12/30/2025