STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/10/2025

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 Intake IN00464850. Intake IN00464850 - State deficiency related to the allegations is cited at R052. Survey date: October 10, 2025 Facility number: 014469 Residential Census: 114 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/16/25.	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 observation, record review and interview, the facility failed to ensure a resident was free from abuse, related to staff	R 0052	Two staff members, following existing protocol, immediately reported their concern to the Executive Director. Upon receiving the report of concern, the ED and DON immediately removed the CNAs from the facility and suspended both C.N.A. 1 and C.N.A 2. Resident B was assessed by nursing staff and was also interviewed by the Director of Social Services. Resident B does not recall the incident. Resident B did not experience any negative outcomes from this incident.	10/10/2025

physically and verbally mistreating a resident with dementia for 1 of 2 residents reviewed for abuse. (Resident B)

Finding includes:

The record for Resident B was reviewed on 10/10/25 at 9:20 a.m. Diagnoses included, but were not limited to, dementia, anxiety, and agitation.

A 9/5/25 Service Plan indicated the resident required cues for cognition.

A Resident Assessment, dated 9/15/25, indicated the resident had severe cognitive impairment and required daily interventions for unpredictable behavior.

On 9/16/25, a facility reported incident indicated Resident B, a Memory Care resident, had a bowel accident in the hallway and on himself. It was reported by QMA 1 and QMA 2 that while they assisted Resident B in getting cleaned up in his bathroom, he became agitated and aggressive. It was reported that CNA 1 became verbally and physically aggressive with Resident B while he was being cleaned. CNA 1 had allegedly put her hand over the resident's mouth to stop his screaming and had threatened to hit him. The report indicated CNA 1 and CNA 2 had held Resident B's arms down with force while he

The
Executive Director reported this incident to the state immediately per
protocol.

Resident
B’s POA and physician were notified of this incident. After the incident, all
residents that were under the care of CNAs 1 and 2 were assessed that same day with no injuries noted.

All
nursing staff have been retrained on resident rights, resident abuse, and abuse reporting. All new hires will continue to be trained on resident rights,
abuse, and reporting before providing direct care.

CNA 1 has
been with the company since 8/22/24 and was trained on resident rights and
abuse two times. There have been no prior incidents as it relates to
resident abuse for CNA 1.

CNA 2 has
been with the company since

	was cleaned up. The facility's investigation indicated many staff members were interviewed, staff were in-serviced on how to respond to combative behavior, dementia training and elder abuse. Disciplinary action occurred for CNA 1, and the employee was terminated for physical and verbal abuse of a resident. CNA 2 was terminated due to unreported abuse during an abuse investigation. QMA 1's written statement indicated she reported abuse of resident B at 1:50 p.m. on 9/15/25. QMA 1's witness statement indicated she and QMA 2 were asked to help give a shower to Resident B because he had known aggressive behaviors. While resident B was sitting on the toilet in his bathroom CNA 2 was standing behind the resident and CNA 1 was standing in front of the resident. The resident had started screaming in their faces and was making faces at QMA 2 which had made her and QMA 2 flinch. CNA 1 then grabbed Resident B by his face and mouth with her right hand and stated, "I'm going to bust your f***ing teeth in". They had tried to keep the resident calm, but he had continued swinging on them. CNA 1 and CNA 2 had eventually stepped away, and she and QMA 2 had taken over		9/23/22 and had been training on resident rights and abuse eight times. There have been no prior incidents as it relates to resident abuse for CNA 2. After a thorough investigation, CNA 1 and CNA 2 were terminated and the incident was reported immediately to the Indiana State Department of Health. All incidents will be reviewed by the ED or designee to ensure all appropriate matters are reported per ISDH and facility policies and procedures.	

to get the resident dressed. She had noticed a new skin tear on Resident B's left arm by where his watch had been. She had notified the nurse immediately. QMA 1 indicated CNA 1 had a very stern tone and aggressive tone with the resident. She held the resident's hands down with force, she had protected us from the resident's swings, but she had been agitated and her behavior escalated. CNA 1 was unable to calm herself down and acted out in anger towards the resident. CNA 2 had appeared unphased.

QMA 2's written interview dated 9/15/25, indicated CNA 1 and CNA 2 grabbed Resident B by the back of his arms, and CNA 1 stated "I'm going to bash your f***ing teeth in". CNA 1 had wrapped her hand around Resident B's mouth and CNA 2 held the resident back with his arms. She indicated CNA 1 and CNA 2 had not communicated to the resident in a calm manor. After wiping down the resident CNA 1 and CNA 2 had stepped back and she and QMA 1 continued care and dressed the resident. Once the two CNA's left the bathroom the resident was calm.

The Social Worker's interview with Resident B on 9/15/25 indicated he had felt safe and staff were kind to him. The resident remembered being

cleaned up but could not recall any details about the experience and he was not in any distress. The resident was observed to have had marks on both sides of his face that were red and purple in color. The resident indicated the marks were from him not shaving. The resident's son/POA was notified.

CNA 1's written interview, completed by the Executive Director (ED) and dated 9/15/25, indicated Resident B had come to the nurse's station and he had a bowel movement, and it was all over him. Her co-worker had instructed the resident to go to his room so he could be cleaned up. She had asked for assistance because the resident could get combative. There were 2 other aides that had come from another hall that were asked to assist them because he could become aggressive. While in the bathroom the resident had tried to hit her coworkers, she had grabbed his hands to stop them from being hit. They had notified the nurse and had him cleaned up the best they could and laid him down. She indicated she was positioned in front of him with her back facing the bathroom door and she had her arm to block the hit. She stated, "I did not hold him down at any time", I did not threaten a resident, nor would I ever tell my resident's that". During this time,

she had not heard her coworkers threaten the resident, the resident swung at them and tried to punch them. She acted in a manner that hospice would have told her to.

CNA 2's written interview, completed by the ED and dated 9/15/25, indicated Resident B had an accident and had become combative and they needed to wash him up. While she was washing the resident he began hitting them and QMA 1 had to hold his hands.

CNA 1's written statement on 9/16/25, indicated Resident B had come to the nurse's station and was covered in feces. QMA 1 and QMA 2 were walking down the hallway, and she had asked what had happened. She told them what had happened and asked them to help clean the resident up because he could become combative. QMA 1 and QMA 2 helped resident B to the toilet and got his robe off while she had gone to get gloves. Resident B was sitting on the toilet and QMA 1 and QMA 2 were holding his hands so he couldn't hit us. The resident was spitting, hitting, and cursed at us. They had to cut the resident's shirt off because he was combative. CNA 2 went to tell the nurse LPN 1. They stood the resident up and he started to swing again; she had put his hands in

front of him and asked the resident to stop hitting. She heard CNA 2 say "I will knock your teeth in". She had been washing him from the back and could not see if anyone put their hands on the resident.

LPN 1 written interview on 9/18/25, indicated the resident had behaviors and the aides went and had him cleaned up in his bathroom. She had prepared the resident's medicine and had given it to him in the bathroom. She then left the room.

During a phone interview on 10/10/25 at 11:23 a.m., QMA 1 indicated she was working with QMA 2 on another unit. They had come over to help CNA 1 and CNA 2. Resident B had a bowel movement that had gotten all over the floor. The other staff members had asked if they could assist since the resident was aggressive. "We were able to get him to the bathroom, sat him on the toilet, and were able to remove his pants. I had put my arms on top of the residents' arms; I had not squeezed him or had a tight grip. The resident was still able to move his arms and hands up. [CNA 2] pushed me out of the way and indicated she would do it. She had restrained the resident with her hands, the resident was screaming, and she took her right hand and covered the resident's mouth.

	[CNA 1] was holding the resident's shoulders from the back, non-aggressively. She and [QMA 2] were just watching at that point. [Resident B] had said something to [CNA 2] and she said, 'I am going to bust your f***ing teeth in'. [CNA 1 and 2] eventually stepped back and [QMA 2] and I had taken over care." On 10/10/25 at 1:42 p.m., Resident B was in bed lying awake, he was dressed appropriately. He had no complaints about his care. He indicated he felt safe and staff was nice to him. The resident had no recollection of any harm happening to him. There were no marks on the resident's face, and he was lying under a blanket and did not want to show his watch or wrist area. During an interview on 10/10/25 at 2:38 p.m., the Director of Nursing (DON) indicated she understood the concern about abuse and had informed the Executive Director of the concern, and they had no additional information to provide.			

During an interview on 10/10/25 at 3:45 p.m., the DON indicated they had inserviced the staff on abuse and dementia, and they had terminated CNA 1 and CNA 2. Resident B did not have a skin tear related to the incident.

This citation relates to Intake IN00464850.

Based on observation, record review and interview, the facility failed to ensure a resident was free from abuse, related to staff physically and verbally mistreating a resident with dementia for 1 of 2 residents reviewed for abuse. (Resident B)

Finding includes:

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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 SIGNATUREKaitlynn Redmon	TITLEExecutive Director	(X6) DATE10/30/2025