STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/23/2026

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 a State Residential Licensure Survey. This visit included the Investigation of Intake 468088. Intake 468088 - State deficiency related to the allegations are cited at R0349. Survey dates: April 22 and 23, 2026 Facility number: 014469 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 5/4/26.	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 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 record review and interview, the facility failed to ensure the resident's physician was notified of accucheck (checking of the blood sugar) refusals, x-ray results, and Registered Dietitian (RD)	R 0036	Residents E and C did not experience any negative outcomes associated with this finding. Resident C’s physician has been notified of all the Accu-Chek refusals by the resident. Resident E’s family has been notified of the recommended supplements for weight loss. The POAs from all residents with recommendations from March 2026 have been notified of the recommendations. Resident E’s x-ray report was received before the time of the survey. An in-service will be completed for all nurses on notifying a resident’s physician of Accu-check refusals by a resident, notifying the resident’s POA of any new Registered Dietician recommendations, and	05/23/2026

	recommendations for 2 of 7 records reviewed. (Residents E and C) Findings include: 1. The record for Resident E was reviewed on 4/22/26 at 1:23 p.m. Diagnoses included, but were not limited to, type 2 diabetes and psychosis. A Physician's Order, dated 1/21/26, indicated the resident's blood sugar was to be checked three times a day. The physician was to be notified if the resident's blood sugar was less than 70 or greater than 400. The March 2026 Medication Administration Record (MAR) indicated the resident refused her accucheck on the following dates and times: AM: 3/4, 3/14, 3/15, 3/16, 3/19, 3/23, 3/27, 3/29, 3/30, and 3/31/26 Midday: 3/2, 3/4, 3/5, 3/6, 3/7, 3/9, 3/12, 3/13, 3/14, 3/16, 3/19, 3/23, 3/24, 3/25, 3/26, 3/28, and 3/29/26 PM: 3/7, 3/12, 3/13, 3/14, 3/19, 3/20, 3/24, 3/26, and 3/29/26 The April 2026 MAR indicated the resident refused her accucheck on the following dates and times:		obtaining x-ray results in a timely manner. An audit will be completed by the Director of Resident Services or designee of all residents that currently receive blood glucose monitoring for 60 days or until 100% compliance is achieved to ensure the physicians are notified of any Accu-check refusals. The Director of Resident Services or designee will audit to ensure all dietary recommendations are communicated to the resident's physician and POA within 48 hours after receiving the report. The Director of Resident Services, or designee will read nursing notes daily to ensure x-ray results are received in a timely manner. These audits will be reviewed by the quality assurance committee. These systematic changes will be put into place by May 23, 2026.	

	AM: 4/6, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/18, 4/20, 4/21, and 4/22/26 Midday: 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, 4/13, 4/14, 4/15, 4/16, 4/20, 4/21, and 4/22/26 PM: 4/1, 4/5, 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, and 4/12/26 There was no documentation of the Physician or Nurse Practitioner (NP) being notified of the refusals. During an interview on 4/23/26 at 11:25 a.m., the Director of Nursing indicated the Physician or NP should have been notified of the resident refusing her accucheck. 2. The record for Resident C was reviewed on 4/22/26 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, falls, depression, stroke and right hip replacement. The Service Plan, dated 12/4/25, indicated the resident was not cognitively intact for daily decision making. a. A Nurse's Note, dated 4/16/26 at 1:28 p.m., indicated the resident was guarding her right hand and her finger was purple in color. The Nurse Practitioner (NP) was notified and ordered for the resident to			

	have an X-ray of the right hand. The mobile X-ray company was notified. A Physician's Order, dated 4/16/26, indicated stat (immediate) X-ray of the right hand and wrist. A Nurse's Note, dated 4/17/26 at 8:39 a.m., indicated the mobile X-ray was called in regards to the results of the right hand and wrist. The main fax number was given to them at that time. A Nurse's Note, dated 4/17/26 at 2:58 p.m., indicated the X-ray results had still not been received by fax. The mobile X-ray company was contacted and they read the results over the phone. The NP was notified and suggested the family take the resident to the urgent care or at least get an appointment to be seen as soon as possible. The resident's brother was at the bedside and was given all of that information. The X-ray was reported on 4/16/26 at 4:28 p.m. and indicated the resident had an impacted non-displaced distal radius fracture. The results were not obtained until 4/17/26 at 2:58 p.m., (22.5 hours) later after the report was available. There were no nursing progress notes reaching			

	out to the mobile X-ray company until the next day 4/17/26. During an interview on 4/23/26 at 10:10 a.m., the Director of Nursing (DON) indicated the X-ray results were given to the nursing staff the next day. b. The resident's weights were as follows: - 11/1/25: 116 pounds - 12/16/25: 110 pounds - 1/6/26: 109 pounds - 2/8/26: 107 pounds - 3/2/26: 107 pounds - 4/10/26: 103 pounds The resident had a weight loss in the last six months. A Registered Dietitian (RD) Note, dated 3/9/26 at 2:48 p.m., indicated the resident had a weight loss of 12.6 pounds in 6 months. Her Body Mass Index was 17.9 which indicated an underweight status. The resident may benefit from Ensure, Boost or a generic equivalent supplement twice a day if approved and supplied by the family. An RD Note, dated 4/15/26 at 3:11 p.m., indicated the resident's weight was 103			

	pounds and was down 4.3% in the past month. With her current weight, it was her lowest. Documentation indicated the resident may benefit from supplementation with Ensure, Boost, or a generic equivalent twice a day to help meet nutritional needs and stabilize weight. There was no documentation to indicate the family was notified to bring in any supplements for the weight loss. During an interview on 4/23/26 at 10:10 a.m., the DON indicated she missed the RD note on 3/9/26 and the weight loss, but was working on the weight loss now and just got an order for the Ensure supplement.			
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:	R 0045	Resident F did not experience negative outcomes associated with this finding. EMS personnel were provided with a discharge packet including the transfer/discharge form when Resident F went to the hospital. A copy of the transfer/discharge form was not made and scanned into the resident’s chart at the time of this survey. All Resident Services staff will be in-serviced on providing a copy of the transfer/discharge form to the resident and/or	05/23/2026

	(i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or		representative at the time of discharge and making a copy for the resident’s file. The Resident Services staff will make a copy of the transfer/discharge form for the resident’s chart. The Resident Services Director will audit this for compliance for 60 days or until 100% compliance is achieved and report audit results to the quality assurance committee. These systematic changes will be put into place by May 23, 2026.	

	discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and			

	you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure discharge/transfer papers were completed and provided to the resident or resident's authorized representative when transferred to the hospital for 1 of 2 closed records reviewed. (Resident F) Finding includes:			

	The closed record for Resident F was reviewed on 4/22/26 at 1:10 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and arthritis. A Progress Note, dated 4/14/26, indicated the resident had been found on the floor in his bathroom lying on his right side. He was alert and oriented and vital signs were within normal limits. An IDOH (Indiana Department of Health) Facility Reportable Incident (FRI), dated 4/14/26, indicated the resident had fallen in his bathroom and been sent to the hospital for evaluation. On 4/16/26, the family indicated the resident had fractured his femur and had surgery. There was no documentation in the progress notes or copies available to review that indicated discharge/transfer papers had been provided to the resident or his authorized representative.			

	During an interview on 4/22/26 at 3:10 p.m., the Director of Nursing indicated they normally sent the face sheet, medication list and bed hold policy with the resident when they were sent out to the hospital. She indicated there were no discharge/transfer papers provided.			
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. 2. The closed record for Resident 8 was reviewed on 4/23/26 at 2:00 p.m. Diagnoses included, but were not limited to, vascular dementia with anxiety, restlessness and agitation, and adjustment disorder.	R 0052	Resident 3 has lived at the facility since 12/3/23 and has never had any sexual interactions in the past. Camera footage revealed that Resident 3 was checking several resident apartment doors to see if they were unlocked carrying a pillow and blanket appearing like she was looking for a bed to sleep in before the first incident occurred. Before the survey took place, increased staffing was put in place due to a census increase in the memory care units which helped with monitoring of all residents in memory care including Resident 3. Also, before the survey, and after the first incident, protocol was put into place to escort Resident 3 throughout the unit to limit wandering into other resident apartments as well as routine monitoring. Resident 3's son was informed about the incident through a telephonic conference and was notified about the need for increased supervision, but due to his	05/23/2026

	A Service Plan, dated 2/3/26, indicated the resident had moderate to severe cognitive impairment with a history of agitated behaviors. A Nursing Progress Note, dated 12/26/25 at 8:25 p.m., indicated at 5:45 p.m. the resident had been pacing back and forth between units and was redirected out of several rooms, then stayed pacing back and forth from unit to unit in the hallway. The nurse from MC2 (Memory Care 2) reported to the nurse that the resident had gotten into an altercation with another resident. The nurse heard yelling from the room and upon entering the room, she saw Resident 8 holding her nose and the other resident stated Resident 8 came into her room and hit her, so she hit her back in the nose. She also ripped Resident 8's necklace off and stated that it was hers. Resident 8, who resided in the dementia unit and stated the other resident hit her in the face, could not explain anything else. Staff actions at the time of the incident: MC2 nursing staff separated the residents and walked Resident 8 back onto MC1. The nurse assessed Resident 8 for injury and the resident had a bloody nose and upon assessing, the resident flinched when her nose was touched and yelled at the nurse		schedule, he could not provide that at the time. Resident 3's physician was notified of the incident and suggested a UA, but no further recommendations or orders were given. Resident 3 has been on Great Lakes Behavioral Services since December 2023. Great Lakes was notified of the incidents with no further recommendations or suggestions. The CNAs were instructed to closely supervise Resident 3. After this survey and upon conferring with the son, Resident 3 was moved to another area of memory care where there are predominantly women residing and the building layout presents itself like a smaller neighborhood area. There have not been any further incidents with Resident 3. Resident 8 was not living at the facility at the time of this survey and had moved out after the facility suggested increased supervision to be provided by the family. Upon admission, Resident 8 was on Great Lakes Behavioral Services. During her stay at the facility, Resident 8 completed two in-patient psychiatric stays ordered by the Physician and Great Lakes Services, Also, Resident 8 was on a medication regime to assist in reducing agitation. She wandered through the memory care units often entering other resident apartments due to her	

	not to touch her. Vitals refused from the resident. Ice was offered to the resident and she refused that as well, 15 minute checks were started and the CNA stayed with the resident and walked along side of her as the nurse called the physician to notify of the incident and requested an order for a urinalysis with a culture and sensitivity and an x-ray for the nose as the nose started swelling and turning purple in color. As needed (PRN) Ativan (an anti-anxiety medication) was administered. Orders were received and the Director of Nursing (DON) and the resident's son were notified as well as behavioral health. As the CNA was walking along side of Resident 8, the resident got agitated again and punched the CNA in the face. The resident was redirected back to the living room area on Memory Care and she continued to yell and attempted to go into more rooms. After unsuccessful redirecting, the resident was sent out 911 for evaluation. The resident returned to the facility on 12/27/25 at 1:45 p.m. with the diagnoses of a nasal fracture and urinary tract infection. Upon returning from the hospital, the resident's 15 minute checks were resumed. A Physician's Order, dated 12/29/25, indicated the resident		confusion on her whereabouts. After any incident, Resident 8 was monitored and her POA and Physician were notified often increasing or changing medications to help ease the agitation. After the second in-patient psych visit and altercations continued, the family was required by the facility to increase supervision daily. The family chose to move this resident out of the facility into a smaller environment instead of increasing supervision as an alternative, less stimulating environment. All Resident Services staff will be in-serviced on proper protocol and procedure if there are any altercations between residents including, but not limited to, timely charting and documentation, assessment, and follow-up. Also, timely notifying the POA and physician at the time of the altercation. An interdisciplinary meeting will take place to discuss potential interventions based on the circumstances including but not limited to alternative apartment locations, in-patient hospital stays, behavioral health interventions, or alternative placement for the resident. The Director of Resident Services or designee will audit all resident charts after any incident to ensure that proper	

	was to receive Haldol (an antipsychotic medication) 0.5 milligrams (mg) twice a day. A Nursing Progress Note, dated 12/30/25 at 8:55 p.m., indicated the resident refused resident care, was pacing the halls and attempting to move furniture. A Nursing Progress Note, dated 1/6/26 at 10:45 p.m., indicated earlier in the shift the resident hit both CNAs in the mouth and was going into other resident rooms and would not come out. At 5:00 p.m. the Nurse Practitioner (NP) was notified of the increased agitation and refusing medications. The NP indicated he would see the resident tomorrow morning, 1/7/26. A Nursing Progress Note, dated 1/7/26 at 12:51 p.m., indicated the resident went into another resident's room, the CNA went to redirect the resident to her own room and the resident became combative with the CNA. The DON and Social Worker went to assist the CNA. Staff were able to redirect the resident out of the room and offered to call the resident's son for distraction. The resident declined. Her physician was rounding and notified of the behaviors. New orders were received to increase Zyprexa (an antipsychotic) from 2.5 mg		documentation, assessment, and follow-up was complete as well as POA and physician notification. The DRS will notify POA for an interdisciplinary meeting recommendations or physician orders, if necessary. The Resident Services Director will audit this for compliance for 60 days or until 100% compliance is achieved and report audit results to the quality assurance committee. These systematic changes will be put into place by May 23, 2026	

	to 5 mg every evening and increase the Haldol to 0.5 mg three times a day. The resident's son was notified. A Nursing Progress Note, dated 1/17/26 at 1:31 p.m., indicated the resident entered another resident's room. The nurse attempted to redirect the resident and the resident proceeded to slap the nurse in the face. A Nursing Progress Note, dated 2/2/26 at 6:00 p.m., indicated Resident 8 was walking down the hall holding the wrists of another resident, the resident couldn't explain what happened. The nurse separated the residents and upon separating the residents from one another, Resident 8 punched the other resident in the face with a closed fist. An unexplained cut to the right side of the chin was observed on the resident who got punched in the face. PRN Ativan was administered to Resident 8 and the Administrator and DON would review the cameras on 2/3/26 to see how the other resident received the unexplained cut to the chin. Fifteen minute checks were initiated. The next entry in the nursing progress notes was on 2/4/26, which indicated the resident punched a staff member in the			

	stomach the evening before on 2/3/26 while redirecting the resident. The next entry in the nursing progress notes was on 3/4/26, which indicated the resident returned to the facility at 3:15 p.m. and arrived to the facility via stretcher. No new interventions were implemented or added to the service plan to address Resident 8's ongoing aggressive behaviors. During an interview on 4/23/26 at 3:00 p.m., the DON indicated Resident 8 had an inpatient psychiatric stay from 2/6/26-3/4/26. An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 3/6/26, indicated on 3/5/26 at 1:01 p.m., Resident 8 entered another resident's room and was going through her things. The resident indicated Resident 8 then proceeded to slap her in the face. The resident's were observed in the hallway striking at each other before they were separated. The resident's physician, psych services and her son were notified. An IDOH Facility Reported Incident (FRI), dated 3/6/26 at 12:30 a.m., indicated Resident 8 had scratched another resident			

	on the cheek. Orders from the Psychiatric NP, dated 3/6/26, indicated the resident was to receive Lorazapam (an anti-anxiety medication) 0.5 mg twice a day PRN, discontinue the Haldol 0.5 mg three times a day PRN, start Risperidone 0.5 mg every evening for seven days to see if effective and Buspirone 5 mg twice a day for anxiety. A Nursing Progress Note, dated 3/6/26, indicated the resident slapped a CNA in the right eye while she was trying to perform care. A Nursing Progress Note, dated 3/13/26 at 7:47 p.m., indicated the resident punched a CNA in the face while she was trying to redirect the resident. The next documented entry in the nursing progress notes was on 3/15/26 at 6:32 a.m. An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 3/24/26 at 5:01 p.m., indicated Resident 8 had attempted to enter another resident's room. When the other resident tried to stop Resident 8, she punched the resident on the side of the neck and the other resident proceeded to push Resident 8 to the floor. An IDOH (Indiana Department of Health) Facility Reported			

	Incident (FRI), dated 3/26/26 at 1:01 p.m., indicated Resident 8 had an altercation with two other female residents in the hallway. Resident 8 pushed one of the residents and punched the other other in the back. After consulting with Resident 8's family on 3/27/26, one-to-one supervision was suggested by the facility. The resident's family decided to move the resident to another facility which had a smaller environment on 3/28/26. During an interview on 4/23/26 at 4:00 p.m., the DON indicated even though the resident did have ongoing behaviors, she felt the facility was able to care for her since psych services were involved, medications were changed and the resident had an inpatient psych hospital stay. 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 cognitively impaired residents who engaged in sexual and physical altercations for 8 of 8 residents reviewed for abuse and supervision. (Residents 3, 11, 10, 8, 9, 12, 13 & C) This			

	deficient practice also resulted in the potential for further sexual interactions for Resident 3 without the cognitive ability to consent. Findings include: 1. The record for Resident 3 was reviewed on 4/23/26 at 11:05 a.m. Diagnoses included, but were not limited to, high blood pressure, major depressive disorder, anxiety disorder, and dementia. The resident resided on the memory care unit. The Service Plan, dated 4/7/26, indicated the resident had severe cognitive impairment and was independent with mobility and transfers. The resident had two instances of wandering into male resident rooms creating resident-to-resident incidents of a sexual nature. She required supervision or interventions to manage mood or behavior one to two times a week. A Nurse's Note, dated 3/20/26 at 3:33 p.m., indicated on 3/19/26 at 9:45 p.m., a resident abuse/neglect incident occurred. Resident 3 was noted to be in bed with a male resident (Resident 11) and she was partially unclothed on her upper torso only. She was lying on top of the blanket and Resident 11, who was fully dressed, was lying under the covers. There			

	was a space between both residents, and his hand was resting on her lower abdomen. Resident 11 removed his hand when the CNA entered the room. Neither resident was able to describe the incident due to the diagnoses of dementia. After reviewing the video, Resident 3 was noted to be in the hall wandering and trying room doors to get in. She happened to open Resident 11's door and entered. Both residents were immediately separated, and a head-to-toe assessment was completed for both with no injury. Fifteen-minute monitoring was initiated and the physician, the behavioral health center and the family were notified. A Physician's Order, received on 3/20/26 at 3:33 p.m., indicated to collect for a urinalysis with a culture and sensitivity. There was no documentation completed on 3/19/26 when the incident initially happened, and there was no documentation of what was immediately done for the resident besides the 15-minute checks. There was no follow-up physical or emotional assessment completed for either resident The 15-minute checks for Resident 3 were completed from			

	3/19/26 at 9:30 p.m. through 3/20/26 at 6:00 a.m. The checks were blank and there was no documentation from 3/20/26 at 6:15 a.m. to 7:45 a.m. They resumed on 3/20/26 at 8:00 a.m. and were completed through 3/21/26 at 7:00 a.m. There were no further 15-minute checks completed for the resident. There was no further behavior documentation or monitoring for wandering into other resident rooms. An Incident Tracking Form was completed, signed and dated by the Director of Nursing (DON) on 3/20/26 at 3:30 p.m. The incident investigation, provided by the Administrator, indicated there were two staff witness statements who were able to recall the events that took place on 3/19/26. A handwritten witness statement from CNA 1 indicated an incident took place on 3/19/26. Resident 3 was lying in bed with Resident 11 in his room. Resident 3 did not have her shirt on. Resident 11 had his right hand down her pants. The CNA helped Resident 3 out of the bed and helped her put her shirt back on. She then escorted her back to her room. The nurse was notified. A handwritten witness statement			

	by LPN 1 indicated she was notified of the occurrence between Resident 3 and Resident 11 on 3/19/26. An interview with Resident 11 at that time was as follows: "Writer asked resident an open-ended question, what happened with the young lady that entered your room, the resident did not answer. Writer proceeded to ask the resident was there a lady in your bed? The resident said yes. Writer proceeded to ask the resident, was the lady's shirt off, resident did not answer, then asked did the lady touch you? The resident stated no. Then asked the resident, did you touch the lady? The resident shook his head yes and then proceeded to smile." She then initiated 15-minute checks for both residents. During an interview on 4/23/26 at 2:10 p.m., the Director of Nursing (DON) indicated she completed the incident report on 3/20/26 (the next day). The information documented on the incident report then created a nursing progress note, so that was the entry on 3/20/26. The DON waited until the next day to complete the incident report so they could look at the video. She was unaware the nurse had not charted anything in the resident's chart regarding the incident or made no documentation of her			

	assessment after the sexual encounter. The DON indicated 15-minute checks usually were completed for a day, however, it depended on the resident. She had called the Resident 3's son and he was concerned about the incident, however, there was no conversation with him regarding needing increased supervision for the resident. She did instruct staff after the incident to make sure they escorted the resident to her room, rather than having her wander around. A Nurse's Note, dated 4/7/26 at 11:32 a.m., indicated there was a resident abuse/neglect incident on 4/6/26 at 5:40 p.m. The CNA went into the room to let Resident 10 know it was time for dinner. Resident 3 was in the room sitting on the couch next to Resident 10. There was a blanket over them and Resident 3's hand was under the blanket. As Resident 3 got up from the couch, she grabbed the blanket and the male resident was exposed. Both residents were unable to describe the incident due to dementia. The two residents were immediately separated and assessed with no injury. Fifteen-minute checks were initiated; the physician and family were notified. A Nurse's Note, dated 4/7/26 at 11:37 a.m., indicated the			

	behavioral health center was notified of the resident-to-resident incident from the previous evening. There was no immediate nursing documentation regarding the incident on 4/6/26 when it occurred, and there was no documentation of what was immediately done for the resident besides the 15-minute checks. There was no further documentation related to additional supervision or follow up physical and emotional assessments. . A Nurse's Note, dated 4/13/26 at 3:27 p.m., indicated Resident 3 did not recall anything that happened in Resident 10's room and she had no signs and symptoms of injury or complaints of pain. The 15-minute checks for Resident 3 were documented as starting at 5:00 p.m. and continued to 11:45 p.m. but was not dated. Another 15-minute check sheet for Resident 3 began at 7:00 a.m. and continued until 11:45 p.m. but was also undated.			

	There were no additional 15-minute checks completed or available for review. The Incident Tracking Form was completed, signed and dated by the DON on 4/7/26 at 11:29 a.m. The incident investigation, provided by the Administrator, indicated there were two staff witness statements who were able to recall the events that took place on 4/6/26. A handwritten witness statement from CNA 1 indicated on 4/6/26, she entered Resident 10's room. Resident 3 was observed sitting on the couch to Resident 10's right. Resident 3 had her hand under a blanket that was covering Resident 10's lap. The CNA informed the residents it was time for dinner and they had to go. Resident 3 was escorted away from the couch, and at that time, she grabbed the blanket and Resident 10's genitals were exposed. A handwritten witness statement from RN 1 indicated on 4/6/26, the CNA on shift told her that she had gone into Resident 10's room and saw him sitting on the couch next to Resident 3 with a blanket over them. The CNA told the residents it was time for dinner and Resident 3 removed the blanket and she saw the male resident was exposed.			

	She got him dressed and escorted him to the dining room. Each resident was assessed after dinner, and both families were called and made aware of the situation. The physicians for both parties and the DON were also made aware. Fifteen-minute checks were initiated. There were no new interventions initiated or added to the service plan to prevent unsupervised wandering or encounters in male residents' rooms, even after the first incident. During an interview on 4/23/26 at 2:10 p.m., the DON indicated she completed the incident report on 4/7/26 (the day after the event), which triggered the nursing note. She was unaware the nurse had not charted anything in Resident 3's chart regarding the incident or documentation of her assessment. There were no dates on Resident 3's 15-minute checks and she was unable to determine when they started or stopped. After the incident, they hired more staff and added an extra CNA for increased supervision on the unit. There were no further conversations with the resident's son regarding increased supervision for the resident. The resident was severely cognitively impaired,			

	but she did not think the resident needed to leave the memory care unit or go to a skilled facility. During an interview on 4/23/26 at 3:00 p.m., the Administrator did not believe the resident needed to leave the facility for a higher level of care. She did not think the resident was seeking a sexual relationship as she was very confused.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.	R 0092	No residents experienced negative outcomes associated with this finding. A fire drill was completed on 4/30/26 for all shifts. The Director of Plant Operations or designee will ensure a fire drill is conducted on each shift at least quarterly. The fire drill will be scheduled in advance and documented accordingly. The fire drill documentation will be routinely reviewed at the quality assurance committee. These systematic changes will be put into place by May 23, 2026.	05/23/2026

	(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift. This had the potential to affect all 107 residents who lived in the facility. Finding includes: The fire drills were reviewed on 4/23/26 at 9:30 a.m. Fire drills were completed on the following dates and shifts: 3/5/25 - second shift 4/8/25 - third shift 5/13/25- first shift 6/5/25 - first and second shifts 7/23/25 - third and first shifts 8/3/25 - first and second shifts There were no fire drills conducted in September, October, November or December 2025. During an interview on 4/23/26 at 10:10 a.m., the Maintenance Director indicated he did not			

	know why, but no fire drills had been completed during the above months.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure kitchen areas were clean and in a state of good repair related to food spillage on garbage cans, dirty floors and dirty dish machines for 1 of 1 kitchen area. (The Main Kitchen) Findings include: 1. During the Kitchen Sanitation Tour on 4/22/26 at 9:45 a.m. with the Dietary Food Manager (DFM), the following was observed: a. Three garbage cans were dirty on the outside with dried food spillage on top of them and on the sides. b. The floor underneath the three compartment sink was	R 0154	No residents experienced negative outcomes associated with this finding. The three garbage cans will be thoroughly cleaned and sanitized. The floor underneath the three-compartment sink will be power washed, and the floor behind the stove, convection oven, and steamer will be cleaned. The food spillage will be cleaned up under the dish machine. The top of the dish machine and the gauges were cleaned. The Executive Chef will in-service all kitchen staff on proper kitchen sanitation and safety standards. Regular cleaning tasks will be assigned to kitchen staff and a routine audit will be done by the Executive Chef or designee to ensure the kitchen is sanitized. These audits will be routinely reviewed by the quality assurance committee. These systematic changes will be put into place by May 23, 2026.	05/23/2026

	dirty against the base board. c. There was a large accumulation of grease and dirt on the floor behind the stove, convection oven, and steamer. d. The floor under the dish machine was dirty and stained with a large accumulation of food spillage. e. The dish machine was very dirty with a large amount of food, grease and grime on top of it and the gauges were sticky and greasy. During an interview on 4/22/26 at 10:10 a.m., the DFM indicated all of the above was in need of cleaning.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure food was prepared and stored under sanitary conditions related to staff touching food with their bare hands, dirty food prep	R 0273	No residents experienced negative outcomes associated with this finding. All affected areas of the kitchen that were noted during the survey will be cleaned.	05/23/2026

	equipment, accumulation of food debris on containers and on the floor and food temperatures not holding at 135 degrees Fahrenheit on the steam table for 1 of 1 kitchen area and for 1 of 1 meal observed. (The Main Kitchen and the Lunch Meal) Findings include: 1. During the Kitchen Sanitation Tour on 4/22/26 at 9:45 a.m. with the Dietary Food Manager (DFM), the following was observed: a. Dietary Cook 1 was observed picking up raw onions with his bare hands and putting them on top of the raw pork chops. He then left the area and got some oil and donned a glove to his right hand and poured oil into his glove and spread it all over the pork chops and onions. During an interview at that time, the DFM indicated the Cook should not have picked up the raw onions with his bare hands and put them on top of the raw pork chops. b. Both microwaves were dirty on the inside with dried food spillage noted on the bottom and on the inside door.		All kitchen staff will be in-serviced by the Executive Chef on proper glove wearing. All new dining service employees are trained on how to properly wear gloves as a part of their orientation. The kitchen staff will be in-serviced on properly storing food containers. An in-service will be completed on how to properly take food temperatures before food is delivered to the residents. Also, an in-service will be completed on how to transport clean dishes throughout the kitchen and overall-all kitchen cleanliness. The Executive Chef or designee will randomly audit and observe the dining services staff to ensure they are properly wearing gloves until 100% compliance is achieved. Also, the Executive Chef will have a cleaning schedule for the kitchen staff and will audit on a routine basis to ensure the kitchen is sanitary and items are stored properly. Temperature logs for food will be reviewed on a daily basis to ensure food is to proper temperature before going out to the residents. These audits will be routinely reviewed by the quality assurance committee. These systematic changes will be put into place by May 23,	

	c. The outside of the peanut butter container had a moderate amount of peanut butter noted. d. The top of the plate warmer was dirty with food crumbs and dried food spillage. e. The inside of the steamer doors had a heavy accumulation of dried food spillage noted, there were food crumbs observed on the bottom shelf of the steamer. f. The inside of the convection ovens were dirty as well as both oven doors. g. The back splash of the stove was dirty with food spillage. h. The grill had dried black and old food noted on the grates i. The sides of the convection oven had a large amount of grease from the deep fryer j. The deep fryer had a large amount of grease splatter around it. k. There was a large accumulation of food crumbs on the clean pans below the food prep table. l. The wall by the stand mixer had a large amount of food splatter. During an interview on 4/22/26		2026.	

	at 10:10 a.m., the DFM indicated all of the above was in need of cleaning. 2. On 4/22/26 at 11:50 a.m., Dietary Aide 1 was observed carrying eight clean coffee cups against her shirt out of the kitchen. At 12:10 p.m., the same Dietary Aide was observed carrying clean plates against her body to the plate warmer on the steam table. 3. On 4/22/26 at 12:00 p.m., the DFM was asked to check the temperature of the food on the steam table. The DFM indicated the temperatures were already checked, documentation on the temperature log indicated only the temperature of the pork chops was recorded. Staff were observed plating the turkey, green beans and noodles without them being temped. The green beans were 107 degrees Fahrenheit a that time. There was plated food with the green beans on the chef's counter ready for staff to serve the residents. Both plates went out to the residents. During an interview at 12:08 p.m., the DFM indicated they only temp one or two items before each meal, they did not temp all of the food prepared.			

R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and	R 0274	The one resident that received the pureed food did not have any negative outcomes associated with this finding. Cook 1 could not be individually in-serviced on properly pureeing food as he resigned shortly after this survey. An in-service will be completed by the Executive Chef for the remaining Dining services staff on how to properly puree meals, the spoon tilt test standard, and the fork drip test. Recipes from our menu program are provided for pureed meals and given to the trained dining services staff when the weekly menu is made. At the time of the observation, Cook 1 had the recipe in front of him, but did not follow it. Also, the Executive Chef had just completed training on how to properly puree food before this survey. All new dining service employees will be trained on how to properly puree food. This training will be added to their skills/orientation checklist. The Executive Chef or designee will randomly audit and observe the dining services staff when making purees. These audits will be reviewed routinely at the quality assurance committee. These systematic changes will	05/23/2026

	experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, record review and interview, the facility failed to ensure the recipe was followed related to puree food preparation. This had the potential to affect the one resident who received a pureed diet. Finding includes: On 4/22/26 at 11:45 a.m., Dietary Cook 1 was observed preparing the pureed lunch meal. The Cook added one serving of turkey breast into the blender, he then added three teaspoons of dried oats, one cup of chicken stock, and one teaspoon of thickener. He turned on the machine and blended it together. He then stopped the machine and added another cup of chicken stock and blended again. When he stopped the blender, the consistency was smooth with no lumps or bumps. He proceeded		be put into place by May 23, 2026.	

	to pour the mixture into a divided plate. The Cook then proceeded to puree green beans with mushrooms. He added the green beans and mushrooms to the blender, then added a half cup of chicken stock, and two teaspoons of thickener, blended, and added another half cup of chicken stock, blended again, stopped the blender, stirred and added another half cup of chicken stock. When removed from the blender, the mixture was very runny. The Cook added one teaspoon of thickener, blended again, stirred the mixture and it was still runny. He put it in the divided plate and covered it with saran wrap, he said he was going to place it in the hot box. When asked if he was going to temp it first he said "oh yeah" and removed the saran wrap and temped it, both were 101 degrees so he rewrapped it with saran and placed it in the hot box which was not heated, it was just an insulated food carrier that was going to the memory care unit. He did not heat up the food before it was served to the resident. During an interview at 12:08 p.m., the Dietary Food Manager (DFM) indicated the pureed food should have been heated before it left the kitchen. The			

	Registered Dietitian (RD) provided recipes and staff should use them for the pureed food, but had not been. She had no idea why the Cook added oats to the pureed turkey. The pureed recipe for the turkey indicated to puree to a smooth texture that held shape with no lumps, wasn't sticky and fell off the spoon when tilted. Liquid must not separate from solids. The pureed recipe for the green beans indicated to process each serving, adding two to four tablespoons of chicken stock until smooth and the mixture meets the spoon tilt test standard. Food should be smooth with no lumps and cohesive enough to hold it's shape on the spoon but fall off easily in a solid lump with very little left on the spoon. It may also be necessary to try the fork drip test. If either mixture became too thin, begin with one teaspoon of thickener, allow to rest for 30 seconds to take full effect. During an interview on 4/23/26 at 1:45 p.m., the Administrator was informed of the observation and had no additional information to provide.			
R 0349	Clinical Records - Noncompliance	R 0349	Resident E, B, D, C, and F did not experience any negative	05/23/2026

	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. 3. The record for Resident D was reviewed on 4/22/26 at 3:30 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia and depression. The resident was admitted to the facility on 4/8/26. A Service Plan, dated 4/8/26, indicated the resident had some memory impairment. A Physician's Order, dated 4/20/26, indicated Xanax (an anti-anxiety medication) 0.25 milligrams (mg) by mouth every 12 hours as needed (PRN) for increased anxiety/agitation.		outcomes associated with this finding. Nurses will be in-serviced on maintaining clinical records that are complete and accurate. Specifically, the training was in relation to properly documenting in the MAR and follow-up charting on medication and treatment administration, wound assessment, follow-up documentation after a fall and indication for the use of anti-anxiety medication. The Director of Resident Services or designee will audit all resident nursing notes daily to ensure that the resident clinical records are complete and accurate and follow-up charting is being done. Audits will be completed for 60 days by the Resident Services Director or designee or until 100% compliance is achieved. These audits will be reviewed routinely at the quality assurance committee. These systematic changes will be put into place by May 23, 2026.	

	The 4/2026 Medication Administration Record (MAR) indicated the Xanax was administered on 4/19/26 at 6:34 p.m., 4/20/26 at 7:16 p.m., and on 4/21/26 at 8:00 a.m. There was no documentation in the nursing progress notes that the resident requested the medication or had anxiety or agitation prior to the administration of the PRN Xanax. During an interview on 4/23/26 at 2:10 p.m., the Director of Nursing had no additional information to provide. 4. The record for Resident C was reviewed on 4/22/26 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, falls, depression, stroke and right hip replacement. The 12/4/25 Service Plan indicated the resident was not cognitively intact for daily decision making. A Nurse's Note, dated 4/16/26 at 1:28 p.m., indicated the resident was guarding her right hand and her finger was purple in color. The Nurse Practitioner (NP) was notified and ordered for the resident to have an X-ray of the right hand. The mobile X-ray company was notified.			

	A Physician's Order, dated 4/16/26, indicated STAT (immediate) X-ray of the right hand and wrist. The X-ray was reported on 4/16/26 at 4:28 p.m. and indicated the resident had an impacted non-displaced distal radius fracture. A Nurse's Note, dated 4/17/26 at 8:39 a.m., indicated the mobile X-ray company was called in regards to the results of the right hand and wrist X-ray. The main fax number was given to them at that time. A Nurse's Note, dated 4/17/26 at 2:58 p.m., indicated the X-ray results still had not been received by fax yet. The mobile X-ray company was contacted and they read the results over the phone. The NP was notified and suggested the family take the resident to the urgent care or at least get an appointment to be seen as soon as possible. The resident's brother was at the bedside and was given all of that information. A Nurse's Note, dated 4/17/26 at 3:18 p.m., indicated the resident's brother took the resident to the bone and joint urgent care. There was no further documentation until 4/20/26.			

	A Nurse's Note, dated 4/20/26 at 8:51 a.m., indicated the nurse called the resident's daughter regarding any orders from the orthopedic urgent care. The daughter indicated they got to the urgent care close to closing time, but the X-rays were read and a velcro hard cast was in place. They were to schedule a follow up appointment for this week. There was no documentation indicating when the resident came back from urgent care on 4/18 or 4/19/26. There was no documentation of what the resident's hand looked like or an assessment of the resident. During an interview on 4/23/26 at 10:10 a.m., the Director of Nursing indicated there were no nursing progress notes when the resident came back to the facility or an assessment of the wrist over the weekend of 4/18 and 4/19/26. 5. The closed record for Resident F was reviewed on 4/22/26 at 1:10 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and arthritis. A Progress Note, dated 4/14/26, indicated the resident had been found on the floor in his bathroom lying on his right side. He was alert and oriented and vital signs were within normal			

limits. He indicated his hand had slipped off the rail.

There were no additional progress notes after the 4/14/26 entry. The record did not indicate the resident was injured or transferred to the hospital.

An IDOH (Indiana Department of Health) Facility Reportable Incident (FRI), dated 4/14/26, indicated Resident F had fallen in his bathroom and been sent to the hospital for evaluation. On 4/16/26, the family indicated the resident fractured his femur, had surgery and had been admitted to the hospital.

During an interview on 4/22/26 at 3:10 p.m., the Director of Nursing indicated there should have been additional charting related to the fall with injury.

This citation relates to Intake 468088.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication and treatment administration, wound assessment, follow-up documentation after a fall and indication for the use of an anti-anxiety medication for 5 of 7 records reviewed. (Residents E, B, D, C, and F)

Findings include:

1. The record for Resident E was reviewed on 4/22/26 at 1:23 p.m. Diagnoses included, but were not limited to, type 2 diabetes and psychosis.

Physician's Orders, dated 1/21/26, indicated the resident's blood sugar was to be checked three times a day. The physician was to be notified if the resident's blood sugar was less than 70 or greater than 400. The resident was to receive Lispro (fast acting) insulin per sliding scale three times a day 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, 400 or above give 6 units and call the physician.

A Physician's Order, dated 1/21/26, indicated the resident was to receive Amlodipine (a blood pressure medication) 5 milligrams (mg) every morning. Hold for systolic blood pressure (top number) less than 110 or heart rate less than 60.

The March 2026 Medication Administration Record (MAR) indicated there was no documentation the resident's blood sugar was checked on the following dates and times:

AM: 3/11, 3/15, 3/18, 3/20, 3/21 and 3/22/26

	Midday: 3/8, 3/11, 3/15, 3/17, 3/18, 3/20, 3/21, 3/27 and 3/31/26 PM: 3/10 and 3/21/26 The resident should have received insulin coverage for the PM accucheck on 3/8 for blood sugar 231, 3/25 for blood sugar 182 and 3/27/26 for blood sugar 165. There was no documentation of insulin administration for those dates. The March 2026 MAR also indicated the resident's Amlodipine was not signed out as being administered on 3/11, 3/15, 3/18, 3/20, 3/21, 3/22 and 3/27/26. The April 2026 MAR indicated there was no documentation the resident's blood sugar was checked on the following dates and times: AM: 4/3, 4/5, 4/7, and 4/17/26 Midday: 4/1, 4/3 and 4/17/26 PM: 4/11 and 4/13/26 A Nursing Progress Note, dated 3/31/26 at 2:42 p.m., indicated during therapy, the resident complained of her right heel hurting. A scabbed area was observed to the right heel. The Nurse Practitioner (NP) was made aware and he indicated he would visit the resident on			

	4/1/26. The next documented entry in the nursing progress notes was not until 4/7/26 at 1:01 p.m. A Nursing Progress Note, dated 4/7/26 at 1:01 p.m., indicated upon giving morning care, the CNA observed a dried skin tear about 2.5 centimeters (cm). The skin was pushed back and dried and steri-strips were not able to be applied. The area was cleansed and covered. The Director of Nursing (DON), NP and the resident's daughter were notified. The next documented entry was not until 4/9/26 at 10:30 a.m. and there was no further documentation related to the right heel or skin tear. A Nursing Progress Note, dated 4/15/26 at 2:51 p.m., indicated the resident had a scabbed skin tear to the right lower leg with the scab being black and reddened in color. An approximate half dime-sized sore was observed to the heel of the right foot. Orders were received for home health for wound care of the heel and skin tear to the right/left foot. Orders were faxed to the home health agency. The next documented entry was not until 4/19/26 at 9:10 p.m., there was no documentation			

	related to the right heel sore and skin tear. During an interview on 4/23/26 at 11:25 a.m., the Director of Nursing indicated the accucheck results and medication administration should have been documented on the MAR. She also indicated follow up documentation should have been completed for the heel sore and skin tear. 2. The closed record for Resident B was reviewed on 4/23/26 at 8:42 a.m. Diagnoses included, but were not limited to, anxiety, history of breast cancer and chronic pain. A Nursing Progress Note, dated 2/1/26 at 8:40 a.m., indicated the resident had a fall and was screaming for help. She was assisted into her wheelchair. The resident had a small bruise on top of her right hand and no complaints of pain. Documentation at 1:33 p.m. indicated hospice visited and was notified of the resident's fall. The next documented entry in the progress notes was not until 2/10/26 at 6:27 a.m., which indicated the resident was found on the floor next to her bed at 6:00 a.m. The resident had no injury. There were no other progress			

	notes until 2/12/26 at 10:48 a.m. A Nursing Progress Note, dated 2/17/26 at 5:30 p.m., indicated the resident was found on the floor next to her bed. The resident had no injury. There were no other progress notes until 2/19/26 at 6:49 p.m. A Nursing Progress Note, dated 2/22/26 at 6:45 p.m., indicated the resident was found on the floor near her recliner. The bedside table was found broken and the resident was assisted back to her chair. Skin tears were observed to both forearms. Both areas were cleaned and covered. There were no other progress notes until 3/2/26 at 12:58 p.m. During an interview on 4/23/26 at 11:30 a.m., the Director of Nursing indicated fall follow-up documentation should be completed for at least 24 hours with no injury and for 72 hours following an injury.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:	R 0356	Residents 3, 6, C, D, and E did not experience any negative outcomes associated with this finding. The concierge team was in the process of working on updating the emergency binder prior to and during the survey.	05/23/2026

	(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 5 of 5 residents reviewed. (Residents 3, 6, C, D and E) Finding includes:		The records for residents 3, 6, C, D, and E have been updated in the emergency binder. All resident records in the emergency binder will be updated with accurate and complete information for all residents currently residing in the facility. The administration staff will be in-serviced on ensuring the emergency binder is complete and accurate. All new resident records will be added to the emergency binder within 24 hours of admission or the following Monday after a weekend. The Executive Director or designee will audit all new resident records for 60 days or until 100% compliance is achieved. These systematic changes will be put into place by May 23, 2026.	

	The resident Emergency Binder was reviewed on 4/23/26 at 11:45 a.m.. The following information was missing: Resident 3 - missing hospital preference, advance directives and emergency contacts. Resident 6 - missing hospital preference and advance directives. Resident C - missing hospital preference, advance directives, allergies and emergency contacts. Resident D - missing hospital preference and advance directives. Resident E - missing hospital preference, advance directives, allergies and physician contact. During an interview on 4/23/26 at 1:14 p.m., the Director of Nursing indicated the items were missing and she would get the records for those residents updated.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded	R 0410	Residents D and F did not experience any negative outcomes associated with this finding.	05/23/2026

	in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure tuberculin skin testing was completed for new admissions for 2 of 7 records reviewed. (Residents D and F) Findings include: 1. The record for Resident D was reviewed on 4/22/26 at 3:30 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia and depression. The resident was admitted to the facility on 4/8/26. A Service Plan, dated 4/8/26, indicated the resident had some		Resident D and F have received their TB tests. All other residents in the facility have received their TB tests. All nursing staff will be in-serviced on completing a TB test, or chest x-ray if necessary, for all new residents upon admission. The Director of Resident Services, or designee, will review all new residents charts after being admitted to ensure a TB test or x-ray was completed. Any findings will be brought to the quality assurance meeting. These systematic changes will be put into place by May 23, 2026.	

memory impairment.

There was no documentation related to the resident receiving a first or second step Tuberculin (TB) skin test prior to or upon admission.

During an interview on 4/23/26 at 10:10 a.m., the Director of Nursing indicated the TB test was not completed at the time of admission.

2. The closed record for Resident F was reviewed on 4/22/26 at 1:10 p.m. The resident was admitted on 2/20/26. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and arthritis.

A Physician's Order, dated 2/20/26, indicated to administer a tuberculin (TB) test upon admission and read the results in 72 hours.

There was no documentation in the record a TB test had been completed upon admission.

During an interview on 4/22/26 at 3:10 p.m., the Director of Nursing indicated the resident had not received the TB test on admission. He had been on her list, but it had not been completed.

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) DATE05/15/2026