

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER HARMONY AT AVON		STREET ADDRESS, CITY, STATE, ZIP CODE 2141 NORTH DAN JONES ROAD, AVON, , 46123			
(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 471202. Intake 471202 - State deficiencies related to the allegations are cited at R0036, R0052, R0144, and R0214. Survey date: August 5, and 6, 2026 Facility number: 014959 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 13, 2026.	R 0000	The following is a summary of the Plan of Correction (POC) for Harmony at Avon. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.		
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	R 0036	1. Resident B was hospitalized, evaluated, and treated for his change in condition. Upon return to the community, nursing staff	09/30/2026	

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representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to consult the resident's physician and legal representative when a resident had a decline in physical health for 1 of 3 residents reviewed for neglect and quality of care (Resident B). Findings include: During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated that on the morning of Monday 7/27/26, she had gone to the facility to take Resident B out for an appointment. The resident told her that he was weak and could not stand and the appointment was canceled. The resident's representative informed two nursing personnel that Resident B was having difficulty and requested they check on him. She checked on the resident again around noon and he was sleeping, so she again requested staff check on him.		will complete a comprehensive assessment, reviewed physician recommendations, and updated the resident's service plan as appropriate. 2. This failed practice has the potential to affect all residents. The HCD or designee conducted a review of current residents with recent changes in condition to ensure physician and responsible party notifications were completed and documented appropriately. 3. All licensed nurses, QMAs, and direct care associates received education regarding identification of significant changes in condition, physician notification requirements, responsible party notification requirements, documentation standards, and escalation procedures. 4. The HCD or designee will audit resident records weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months to verify significant changes in condition are documented and physician and	
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On Tuesday there seemed to be no change in the resident's condition. On Wednesday 7/29/26 around 6:00 p.m., Resident B called the resident representative, and he sounded confused, scared, and told her something was wrong and he needed help. The resident's representative arrived at the facility to find Resident B in bed dressed only in a depends, the sheets were off the bed, soiled with bowel movement (BM), and lying on the floor, and he was covered only with a small throw that normally lay on the bottom of the bed. The bathroom was observed with soiled towels on the floor, feces on the toilet, and the toilet paper dispenser that was partially pulled off the wall indicating to her he had struggled. The resident indicated he had pulled the emergency pull cord and nobody came, and when the nurse came to give his medications, she told him it looked like his light had been turned off. The resident indicated since her last visit, the nurses had only come to see him to bring his meds, which he got twice daily in the morning and evening. Resident B indicated he'd only eaten what was in his bedside drawer to snack on as staff had not brought him meals in the past 3 days.

responsible party notifications are completed timely. Findings will be reviewed during Wellness meetings.

5. **Completion Date:**
September 30, 2026

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During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated during her visit on the evening of 7/29/26, QMA 7 had entered the room to administer the resident's medications. She had asked what was going on as she had not worked since the evening of 7/26/26, and there was no documentation in the resident's chart to indicate the resident had a change in condition. After the situation was explained, QMA 7 left the apartment and returned with HCD. The HCD indicated she had not been aware of Resident B being ill. QMA 7 explained that there was no documentation in the resident's chart about his condition or a request to have dietary deliver meals. The HCD had suggested the resident be sent to the hospital via EMS and had gone to call an ambulance for transport. The resident remained in the hospital from 7/29/26 until 8/4/26 with diagnoses to include dehydration that required treatment of intravenous (IV) fluids.			
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Resident B's clinical record was reviewed on 8/5/26 at 1:30 p.m. Diagnoses on Resident B's profile included unspecified dementia, hypertension (high blood pressure), hearing loss, and a history of falls.

A current service plan, completed on 5/8/26, assessed Resident B as being independent with transfers, ambulation, bathing, dressing, eating, toileting, personal grooming, medication administration, and shopping. The resident had mild short term memory loss and was at a moderate risk for falls. The resident required trash to be taken out twice daily or as needed, and he would be provided with standard housekeeping services.

A progress note by Qualified Medication Aide (QMA) 6, dated 7/27/26 at 12:20 p.m., indicated the writer noticed the resident didn't come for breakfast and decided to check on the resident. Resident B reported weakness in both legs, with no visible injury or swelling. Writer advised resident to rest and avoid walking for the day. Follow-up monitoring would continue, and the family and Health Care Director (HCD) were notified.

A progress note by QMA 7,

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dated 7/29/26 at 8:47 p.m., indicated the writer found the resident resting in bed. The resident reported feeling unsteady and stated that he has been experiencing a loss of balance since Monday July 27 due to ongoing diarrhea. He stated that because of the imbalance he has been unable to get out of bed. The writer assessed the resident, and his vital signs were blood pressure 117/67, pulse was 62, temperature was 98.3 F, and oxygen saturation was 94% on room air. There were no visible injuries or signs of trauma observed during the assessment. The resident's family was notified of his condition. The HCD was notified and after reviewing the information, instructed that the resident be transferred to the hospital for further evaluation. The family granted permission for the resident to be sent to the hospital. Arrangements were made for transfer in accordance with the HCD's instruction and Emergency Medical Services (EMS) was activated.

Resident B's clinical record lacked documentation of on-going assessment and monitoring of the resident's condition, that the physician or resident representative were notified of his condition, assistance was provided with

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his care, or that he was offered food and fluids.

During an interview on 8/5/26 at 10:31 a.m., Licensed Practical Nurse (LPN) 7 indicated if a resident was not well, a text was sent to an electronic system for the physician and Nurse Practitioner (NP), that generated a list for the NP to see during her Tuesday visits. Laboratory testing and x-rays could be done in the facility as needed. If a resident needed to be seen on days other than when the NP visited, the family was notified to take them out, or the resident was sent out by ambulance. Meals could be delivered to a resident's room by either the resident, resident representative, or a staff member contacting the front concierge desk.

There was no facility policy provided during the survey process regarding documentation of a resident's change in condition. The ED indicated the facility followed state and local regulations.

Cross reference R0052.

This citation relates to Intake 471202.

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	1. Resident B was immediately assessed,	09/30/2026
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(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 observations, interviews, and record review, the facility failed to protect a residents' right to be free from neglect when the facility failed to ensure a resident with new onset complaints of weakness and being unable to get out of bed was monitored, was assisted with activities of daily living, provided meals in his room, and treated timely resulting in the resident having a delay in treatment, having no meals for 3 days, and subsequently being admitted to the hospital with a diagnosis of dehydration for 1 of 3 residents reviewed for neglect (Resident B). Findings include: A concern during the survey indicated, on 7/27/26, staff were notified that Resident B was unable to walk due to weakness and were asked to look in on		transferred to the hospital for evaluation and treatment, and received follow-up review upon return to the community. The resident's care needs, monitoring requirements, meal assistance needs, and service plan were reviewed and updated. 2. This failed practice has the potential to affect all residents. A facility-wide audit was conducted to identify residents requiring increased monitoring, assistance with meals, medication administration, illness management, or changes in condition. Appropriate interventions were implemented where indicated. 3. Nursing staff, QMAs, CNAs, and department leaders received education regarding resident neglect prevention, change in condition reporting, resident monitoring expectations, meal delivery procedures, resident wellness checks, documentation standards, physician notification requirements, and resident rights. 4. The HCD or designee will complete weekly audits of resident monitoring,	
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	him and notify the family if he worsened. On the evening of Wednesday 7/29/26, the family received a call from the resident, and he sounded confused and scared and told them he needed help. Family arrived at the facility to find Resident B in bed dressed only in adult depends, and he told them he had not eaten in three days. Soiled bed linens had been stripped from the bed and were on the floor and the bathroom was soiled with bowel movement. The resident was subsequently transported to the hospital via ambulance where he was admitted for diagnoses that included dehydration. Resident B's clinical record was reviewed on 8/5/26 at 1:30 p.m. Diagnoses on Resident B's profile included unspecified dementia, hypertension (high blood pressure), hearing loss, and a history of falls. A current service plan completed on 5/8/26, assessed Resident B as being independent with transfers, ambulation, bathing, dressing, eating, toileting, personal grooming, medication administration, and shopping. The resident had mild short term memory loss and was at a moderate risk for falls. The resident required trash to be taken out twice daily or as		physician notifications, meal delivery requests, wellness checks, and documentation compliance for eight weeks, bi-weekly for eight weeks, and monthly for three months. Results will be reviewed at the Wellness meeting and corrective action initiated as necessary. Completion Date: September 30, 2026	
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needed, and he would be provided with standard housekeeping services.

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A progress note by QMA 7, dated 7/29/26 at 8:47 p.m., indicated the writer found the resident resting in bed. The resident reported feeling unsteady and stated that he has been experiencing a loss of balance since Monday July 27 due to ongoing diarrhea. He stated that because of the imbalance he had been unable to get out of bed. The writer assessed the resident, and his vital signs were blood pressure 117/67, pulse was 62, temperature was 98.3 F, and oxygen saturation was 94% on room air. There were no visible injuries or signs of trauma observed during the assessment. The resident's family was notified of his

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	condition. The HCD was notified and after reviewing the information, instructed that the resident be transferred to the hospital for further evaluation. The family granted permission for the resident to be sent to the hospital. Arrangements were made for transfer in accordance with the HCD's instruction and Emergency Medical Services (EMS) was activated. A medication administration record for Resident B, dated July 2026, documented routine medications had been administered as ordered by 5 different nursing personnel from 7/27 through 7/29/26. Medications included oral meds, a pain patch, and multiple eye drops daily. During an interview on 8/5/26 at 10:31 a.m., Licensed Practical Nurse (LPN) 7 indicated if a resident was not well, a text was sent to an electronic system for the physician and Nurse Practitioner (NP), that generated a list for the NP to see during her Tuesday visits. Laboratory testing and x-rays could be done in the facility as needed. If a resident needed to be seen on days other than when the NP visited, the family was notified to take them out, or the resident was sent out by ambulance. Meals could be delivered to a resident's room by either the			
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resident, resident representative, or a staff member contacting the front concierge desk.

A welcome notice was posted in the elevators with a picture of the NP along with her credentials and introduced the new electronic messaging system for the NP.

During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated that on the morning of Monday 7/27/26, she had gone to the facility to take Resident B out for an appointment. The resident told her that he was weak and could not stand and the appointment was canceled. The resident's representative informed two nursing personnel that Resident B was having difficulty and requested they check on him. She checked on the resident again around noon and he was sleeping, so she again requested staff check on him. On Tuesday there seemed to be no change in the resident's condition. On Wednesday 7/29/26 around 6:00 p.m., Resident B called the resident representative, and he sounded confused, scared, and told her something was wrong and he needed help. The resident's representative arrived at the facility to find Resident B in bed dressed only in a depends, the

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	sheets were off the bed, soiled with BM, and lying on the floor, and he was covered only with a small throw that normally lay on the bottom of the bed. The bathroom was observed with soiled towels on the floor, feces on the toilet, and the toilet paper dispenser that was partially pulled off the wall indicating to her he had struggled. The resident indicated he had pulled the emergency pull cord and nobody came, and when the nurse came to give his medications, she told him it looked like his light had been turned off. The resident indicated since her last visit, the nurses had only come to see him to bring his meds, which he got twice daily in the morning and evening. Resident B indicated he'd only eaten what was in his bedside drawer to snack on as staff had not brought him meals in the past 3 days. During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated during her visit on the evening of 7/29/26, QMA 7 had entered the room to administer the resident's medications. She had asked what was going on as she had not worked since the evening of 7/26/26, and there was no documentation in the resident's chart to indicate the resident had a change in			
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condition. After the situation was explained, QMA 7 left the apartment and returned with HCD. The HCD indicated she had not been aware of Resident B being ill. QMA 7 explained that there was no documentation in the resident's chart about his condition or a request to have dietary deliver meals. The HCD had suggested the resident be sent to the hospital via EMS and had gone to call an ambulance for transport. The resident remained in the hospital from 7/29/26 until 8/4/26 with diagnoses to include dehydration that required treatment of intravenous (IV) fluids.

A hospital History and Physical report, dated 7/29/26, indicated Resident B had trouble walking over last 2-3 days, and the resident felt he was unable to walk safely. At his usual baseline the resident walked independently with a walker. Diagnoses for his admission to the hospital were generalized weakness, ambulatory dysfunction/debility, generalized deconditioning, bilateral lower leg pain, and urine concentrated possibly related to worsening oral intake. Laboratory test results indicated elevated ketones (chemicals your liver makes when it breaks down fat for energy which happens when

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	your body does not have enough insulin or carbohydrates to use sugar for fuel, such as during fasting) and blood urea nitrogen (BUN- lab test which measures the amount of urea nitrogen in your blood to check how well your kidneys and liver are working). The plan was to repeat labs, hydrate the resident, and push oral hydration. A hospital Discharge Summary indicated the resident had non-specific muscle pain and generalized decline, and the resident did not feel safe to ambulate. Primary discharge diagnoses included mild dehydration with elevated BUN and ketonuria (presence of excess ketone bodies in the urine with common causes being fasting, starvation or extended periods without food). During an interview on 8/5/26 at 11:42 a.m., QMA 7 indicated that Resident B was routinely independent with his care. He would come downstairs twice daily to get his medications, and he ate his meals in the main dining room. The QMA indicated she had last seen the resident when she worked on Sunday 7/26/26. She was unaware of him feeling ill at that time. She returned to work for the evening shift on Wednesday 7/29/26, and when the resident did not come down for his medications, she had gone to his apartment			
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to check on him. That was when she learned he had been ill since Monday morning and was told staff had not had meals delivered to his apartment during that time. QMA 7 indicated room meal requests were to be made at the front desk.

During an interview on 8/6/26 at 9:10 a.m., QMA 10 indicated she only worked part time and could not answer most resident specific questions but did know staff were supposed to contact the NP to have residents added to a list to be seen. The NP worked out of an office on the 3rd floor, and she was in the facility most days. QMA 10 indicated housekeeping staff were responsible for cleaning resident rooms, and the nursing staff were responsible for picking up resident trash daily during care.

During an interview on 8/6/26 at 9:43 a.m., the Regional Culinary Director indicated all meals served to residents were logged into eMenuChoice. The electronic documentation system tracked the resident's name, room number, date, location of service (table number or room service), food ordered, and if there was a monetary charge associated with the meal. Review of Resident B's meal service

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indicated the last meal he had been served was breakfast in the main dining room on 7/26/26.

During an interview on 8/6/26 at 10:35 a.m., a representative for the new electronic messaging system for the NP indicated Resident B was in their system, but he was not an active patient as they had not received a consent to treat. There was no documentation in their system to indicate a message had been received for the NP to see Resident B.

During an interview on 8/6/26 at 11:00 a.m., a representative for Resident B's primary physician's office indicated there was no documentation in the resident's clinical record to indicate the office or physician had been notified of the resident's decline in condition before his admission to the hospital on 7/29/26.

During an interview on 8/6/26 at 11:45 a.m., a hospital representative indicated there was no documentation in the clinical record to indicate a physician had been contacted about the resident's condition prior to his admission to the hospital. Hospital records indicated Resident B was admitted to the hospital on 7/29/26 due to worsening

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	ambulatory ability/debility, and bilateral lower leg pain. The resident had been alert and oriented times 2 (person, place, and/or time) and had a history of dementia. A peripheral IV had been started on the right wrist on 7/29/26 and was discontinued on 8/4/26 upon discharge. Documentation indicated, "some symptomatic improvement after IV fluids, and statin cessation." During an interview on 8/6/26 at 12:23 p.m., the Executive Director (ED) indicated that most of the nursing staff were QMAs. They were supposed to report resident illness or incidents to the HCD, and that had not happened last week with Resident B. The ED had also not been notified that he was ill, and she found out after the resident had been transferred to the hospital. The ED indicated she had presented multiple staff in-services in the past month to include documentation and resident rights, but that education had not been applied to this situation as it should have. Additional staff interviews were conducted with staff that had been documented as having provided care to Resident B on 7/27/26 - 7/29/26, including LPN 8, QMA 10, QMA 12, QMA 13, QMA 14, CNA 15, and CNA16.			
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	All denied they had provided care to the resident or knew that he had been ill. During an interview on 8/6/26 at 1:46 p.m., the HCD indicated nursing staff were supposed to call or text her with the information of a resident being sick, and then the staff member was supposed to document the resident was ill and that family and the physician had been notified. She did not remember staff telling her that Resident B was sick and had not found out until 7/29/26 when the QMA had come to get her and asked that she go to the resident's apartment. The QMA told the HCD that no one had checked on Resident B for 3 days before they got to the room and she spoke with the family. Resident B was observed lying in bed, he was pale, he was verbally responding, and he acted as if he did not feel well. There had been a urinal next to him on the floor that contained dark urine, and blankets were on the floor. The HCD did not know if the resident had confusion as he was new to her and she did not know his baseline. The HCD and resident representative discussed the situation and Resident B's condition, and it was decided that he should be sent out 911 to be evaluated. The HCD indicated, at the time she was new to the facility and			
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	thought the resident's room was in independent living (IL), so she instructed the QMA to call 911. The HCD indicated staff were to call and request a meal be sent to any resident's room when the resident was ill as there was a concierge were on duty 7 days a week through mealtimes. The HCD indicated that she could not answer as to why nursing staff had not noticed the resident not following his normal routine of going downstairs to get his medications from the staff or not going to the dining room for meals. But she did know that the staff had not notified her that he was ill, and staff had been responsible for assisting Resident B with care, providing fluids and meals, and calling the physician, even if the resident had been serviced planned to be independent. On 8/6/26 at 2:26 p.m., the ED provided a Change of Condition Policy, dated 4/2026, and indicated the policy was the one currently being used by the facility. The policy indicated, "A change in condition will be evaluated and documented for residents who exhibit significant deviation, from their baseline, in physical or mental status ...Non-emergent: 1. The physician and legal responsible party will be notified of resident's change in condition, within 24 hours of change. 2. All			
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	necessary medical care and treatment measures will be initiated and provided at the direction of the physician. 3. Document the occurrence in Notes ... 4. Resident evaluation and Service Plan shall be updated within 24 hours of change." On 8/6/26 at 2:26 p.m., the ED provided a Meal Delivery protocol from the Resident Handbook, dated 6/2026, and indicated the facility had no specific policy related to providing meals to residents. The protocol indicated, "We understand that there may be times when residents are not feeling well. In such cases, please contact the Executive Director to discuss available accommodations ..." The ED indicated that there was no facility policy specific to documentation. This citation relates to Intake 471202.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.	R 0144	1. Resident B's apartment received a thorough cleaning and sanitation review. All environmental concerns identified during the survey were addressed, including removal of soiled materials, cleaning and	09/30/2026

	Based on observation, interview, and record review, the facility failed to maintain a sanitary and clean environment for 1 of 3 residents observed for cleanliness (Resident B). Findings include: A concern during the survey indicated, on 7/27/26, staff were notified that Resident B was unable to walk due to weakness and asked to look in on him and notify the family if he worsened. On the evening of Wednesday 7/29/26, the family received a call from the resident, and he sounded confused and scared and told them he needed help. Family arrived at the facility to find Resident B in bed dressed only in adult depends, and he told them he had not eaten in three days. Soiled bed linens had been stripped from the bed and were on the floor and the bathroom was soiled with bowel movement (BM). The resident was subsequently transported to the hospital via ambulance where he was admitted for diagnoses that included dehydration. Pictures of Resident B and his apartment, dated and time stamped 7/29/26 at 7:24 p.m., showed the resident was lying towards the left side of a bed that was bare of sheets,		sanitizing bathroom surfaces, disposal of contaminated items, and restoration of the apartment to a clean and orderly condition. 2. This failed practice has the potential to affect all residents. Housekeeping and nursing staff completed environmental rounds throughout the community to identify and correct sanitation or housekeeping concerns. 3. Housekeeping personnel, nursing staff, and department leaders received education regarding maintaining a clean resident environment, environmental rounds, reporting concerns, infection prevention, and responsibilities for room sanitation and resident comfort. 4. The Environmental Services Director or designee will conduct weekly environmental audits for eight weeks, bi-weekly for eight weeks, and monthly for three months to verify resident apartments remain clean, orderly, and sanitary. 5. Completion Date: September 30, 2026	
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	covered with a turquoise and white blanket that was partially on the floor, and 2 pillows in the middle of the right side of the bed. There was wadded up gray, brown and green bedding on the floor at the foot of the bed. There was also white bedding in a pile outside the bathroom door. The bathroom pictured a soiled white towel and clothing on the floor in front of the toilet, and the toilet was smeared with BM. A partial roll of toilet paper was laying on clothing on the floor near the wall on the far side of the toilet, and a metal toilet paper holder was broken and part of it was hanging from the wall. Resident B's apartment was observed with Housekeeper 9, on 8/5/26 at 10:35 a.m. There were multiple newspapers stuffed into the handle on the outside of the locked apartment door and the housekeeper indicated the resident must be out of the building. Housekeeper 9 indicated that she was the only housekeeper on staff who cleaned the Assisted Living (AL) part of the facility, and that she routinely cleaned the resident's apartment every Wednesday. Resident B's bathroom was observed to have BM smeared on the toilet and floor, and there was a metal toilet paper roll holder observed in pieces on			
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the floor in front of the toilet. The resident's bedroom was observed to include the bed stripped of the sheets and mattress bare, a wadded-up bedspread in the middle of the bed, soiled socks on the floor, and crushed crackers on the carpeted floor on the back side of the bed. There were 2 partially filled clear cups of unidentified liquid and an opened plastic drink bottle of clear liquid with mold floating on top sitting on a bedside table, and a urinal with 3 inches of dark colored urine sitting on the floor. There was a basket of folded linens at the end of the bed.

During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated during her visit on the evening of 7/29/26, the HCD had suggested the resident be sent to the hospital via EMS and had gone to call an ambulance for transport. The resident remained in the hospital from 7/29/26 until 8/4/26 with diagnoses to include dehydration that required treatment of intravenous (IV) fluids. Housekeeping personnel had come into the apartment and taken the soiled linens to take to the laundry, but Resident B had not been cleaned up before he was transported to the hospital

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around 7:30 p.m. 8:00 p.m. The resident representative indicated she had returned to the facility on Sunday 8/2/26 to get Resident B some clothing for him to wear upon discharge from the hospital. The resident's room had not been cleaned up, the bed had not been made, and there was just a basket of clean laundry sitting inside the door to the apartment. Resident B's son had called the facility and asked to speak to the Executive Director (ED) and had not received a return call.

A second observation of Resident B's apartment with Housekeeper 9, on 8/6/26 at 11:22 a.m. The housekeeper indicated she was still not sure where the resident was, but she had cleaned his apartment the prior afternoon. Resident B's carpet in the bedroom had been swept, the bathroom floor mopped, the toilet cleaned, and pieces of the broken metal toilet paper holder were lying on the bathroom counter. The 2 clear plastic cups of liquid and bottle of liquid with mold floating in the bottle remained on the bedside table. The bed was still not made, and the basket of folded bed linens remained at the end of the bed. Housekeeper 9 indicated standard housekeeping services meant the apartment was cleaned weekly by housekeeping. The

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	unmade bed was the responsibility of the Certified Nursing Aides (CNAs), who were also responsible for taking trash from resident rooms twice a day. Housekeeper 9 indicated that she had cleaned Resident B's apartment on the afternoon of 7/29/26, and at the time the resident been sitting in his chair and there was nothing wrong with him. When told the resident had gone to the hospital on the evening of 7/29/26, the housekeeper indicated, well maybe he had been in his bed when I cleaned last week. This citation relates to Intake 471202.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to update a service plan for a resident who started receiving medication assistance for 1 of 3 residents reviewed for neglect	R 0214	1. Resident B's assessment and service plan will be reviewed and updated to accurately reflect medication administration assistance and current care needs. 2. This failed practice has the potential to affect all residents receiving changes in services. The HCD or designee reviewed resident records to verify service plans accurately reflect current needs, medication administration assistance, and nursing services provided. 3. Licensed nurses, QMAs,	09/30/2026

and quality of care (Resident B).

Findings include:

During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated that on Wednesday 7/29/26 around 6:00 p.m., Resident B indicated since her last visit, the nurses had only come to see him to bring his medications, which he got twice daily in the morning and evening.

During an interview on 8/5/26 at 10:59 a.m., Resident B's representative indicated during her visit on the evening of 7/29/26, QMA 7 had entered the room to administer the resident's medications. She had asked what was going on as she had not worked since the evening of 7/26/26, and there was no documentation in the resident's chart to indicate the resident had a change in condition.

Resident B's clinical record was reviewed on 8/5/26 at 1:30 p.m. Diagnoses on Resident B's profile included unspecified dementia, hypertension (high blood pressure), hearing loss, and a history of falls.

A current service plan, completed on 5/8/26, assessed Resident B as being independent with medication administration. The resident had

and department leaders received education regarding resident evaluations, service plan updates, change in condition requirements, medication assistance documentation, and ongoing assessment responsibilities.

4. The HCD or designee will audit resident assessments and service plans weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months to ensure they accurately reflect resident care needs and services provided. Findings will be reviewed through Wellness meeting.

5. **Completion Date:**
September 30, 2026

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mild short term memory loss and was at a moderate risk for falls.

During an interview on 8/5/26 at 11:42 a.m., QMA 7 indicated that Resident B was routinely independent with his care. He would come downstairs twice daily to get his medications. The QMA indicated she had last seen the resident when she worked on Sunday 7/26/26. She was unaware of him feeling ill at that time. She returned to work for the evening shift on Wednesday 7/29/26, and when the resident did not come down for his medications, she had gone to his apartment to check on him. That was when she learned he had been ill since Monday morning.

A document titled, "Resident Assessment Policy," dated April 2026, indicated, " ...Policy: Residents should be assessed to determine the level of care and services needed or requested utilizing various systems and processes ...The assessment will be used to determine the appropriate level of care and individual needs of the resident ...Procedure: 1. An initial service plan should be developed by an appropriately trained ...associate ...upon admission, no more than 14 days prior to the resident's move into the community ...2.

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The final resident assessment should be completed by a licensed nurse or registered nurse if required by state regulation(s): a. At move-in ...d. As soon as possible after a change in condition that results in altered care needs" Cross reference R0052. This citation relates to Intake 471202.			
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 SIGNATUREAndrea Lake	TITLEExecutive Director	(X6) DATE08/24/2026	