

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 07/29/2026	
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 471072. Intake 471072 - State deficiencies related to the allegations are cited at R0006, R0052, R0090, R0117, R0144, R0214, and R0215. Unrelated deficiencies are cited at R0273 and R0304. Survey date: July 28 and 29, 2026 Facility number: 014959 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 6, 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 0006	Scope of Residential Care - Deficiency	R 0006	1. Resident C received an immediate nursing	09/30/2026			

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410 IAC 16.2-5-0.5(f)(1-5) (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to ensure appropriate level of care of a resident, including failure to assess the resident upon and after admission, which resulted		assessment, physician evaluation, and level of care review. The resident's service plan was updated to reflect current cognitive status, wandering risk, and supervision needs. The resident was transitioned to the appropriate level of care following physician review and family involvement. 2. All current residents were reviewed by the Healthcare Director (HCD) or designee to identify residents exhibiting confusion, wandering, exit-seeking behaviors, cognitive decline, or changes in condition that may require reassessment or a different level of care. 3. The facility revised the admission, readmission, and change of condition processes. Licensed nurses will complete and document assessments at admission, following significant changes in condition, and whenever behaviors indicate a potential need for a different level of care. Service plans will be updated accordingly and physicians and responsible parties will be notified as appropriate. 4. The HCD or designee will	
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	in a resident eloping from the assisted living portion of the facility (Resident C) for 1 of 2 residents reviewed for elopement. Findings include: On 7/28/26 at 10:04 a.m., Resident C was sitting at the nurse's station with Qualified Medication Aide (QMA) 11. QMA 11 indicated Resident C was sitting with her while QMA 11 completed charting. Resident C indicated she was just visiting the facility and did not live there. When asked if she would like to live at the facility, Resident C stated, "No." On 7/28/26 at 4:13 p.m., Resident C came into the dining room asking how she was supposed to get food early because she had to eat before she got picked up. She indicated, "He told me to eat beforehand." Resident F told her to go wait at the kitchen door or go to the other dining room because they served dinner first in the other room. She kept asking the same questions and could not follow directions to wait at the kitchen door. Two unidentified residents and the Receptionist were overheard talking about how Resident C needed to be in the memory care unit. On 7/29/26, a local Facebook		audit all admissions, readmissions, and significant change assessments weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months to verify assessments are completed timely and residents are receiving the appropriate level of care. Findings will be reviewed during the Wellness meeting. 5. Completion Date: September 30, 2026	
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scanner page posted, at 6:50 a.m., an elderly person was found at a local intersection. The caller reported the person did not know where they came from. The post was updated and indicated the facility called to report a resident was missing, and the person found was returned to the facility by the police.

Apple Maps indicated the intersection where the resident was found was 1.5 miles from the facility and was approximately a 31 minute walk.

During an interview, on 7/29/26 at 9:00 a.m., QMA 11 indicated Resident C had gotten out of the facility last night. It happened on night shift. QMA 11 was told when she came in that night shift was checking on residents and discovered Resident C was not there. The staff called 911 and reported the resident missing. The police found the resident. QMA 11 indicated Resident C was very confused, and she was not sure why the resident was not on the Memory Care unit. The resident resided in the assisted living portion of the facility. The resident's family member was currently with her and planned to stay with her for now.

Resident C's record was reviewed on 7/28/26 at 3:01

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	p.m. The resident's only listed diagnosis was dementia (a decline in mental ability severe enough to interfere with daily life) in other diseases classified elsewhere. A pre-admission assessment, dated 6/26/26, indicated the resident was alert and oriented to person, place, time, and situation with mild impairment. Mild impairment included occasional disorientation to person, place, time, or situation that does not interfere with functioning in familiar surroundings and may require some direction or reminding from others. The resident had a mild short term memory impairment which included occasional difficulty remembering and using information, required some direction and reminding from others, and may have difficulty following written instructions. There was no long term memory impairment. The resident was independent with mobility, used a rollator, and had no impairment. The psychosocial evaluation indicated the resident did not exhibit wandering behaviors, had appropriate judgement, exhibited appropriate self-awareness, did not exhibit disruptive, aggressive, verbal, or socially inappropriate behaviors, had occasional anxiety, did not have			
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depression, hallucinations, or delusions. The resident did not require Memory Care.

A progress note, dated 7/24/26, indicated the resident was admitted to the facility and was disoriented, confused, trying to escape, and wandering. The resident was requesting information of a man that checked in with her and left. The resident wanted his name and number for a ride.

The resident's record lacked an assessment upon admission.

A progress note, dated 7/26/26 at 5:42 a.m., indicated the resident exhibited "continuous confusion" throughout the shift. The resident was observed wandering frequently, was redirected on multiple occasions, and assisted back to her room. The resident remained safe and was "monitored closely" for safety.

A progress note, dated 7/26/26 at 11:33 a.m., indicated the resident continued to wander throughout the unit and appeared confused and disoriented. The resident attempted to open exit doors and stated she wanted to go home. The staff redirected the resident from the exits and provided reassurance. The resident was escorted to a common area and engaged in

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conversation and calming activity. "Safety checks maintain." Resident "monitored closely" for wandering and exit seeking behavior. The provider and responsible party "will be" notified. The record lacked documentation anyone was notified of the resident's confusion.

A progress note, dated 7/27/26, indicated the resident was confused after dinner. Staff redirected the resident. "Safety checks" continued throughout the shift.

A progress note, dated 7/29/26 at 7:09 a.m., indicated the resident was reported missing around 5:00 a.m. The staff started looking for her around the building, but she was not found. The Administrator and the resident's family member were notified. The staff member called 911. "After a while" the resident was brought back to the facility by the police.

A progress note, dated 7/29/26 at 8:16 a.m., indicated the Director of Nursing (DON) received a call from the Administrator that the resident was unable to be located. Staff were instructed to continue to look for the resident, call 911, and call the resident's family member. The DON received an update from the Administrator,

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at 6:46 a.m., that the resident was found and was back in her apartment. The DON arrived at the facility and was informed the resident's family member was with her.

The record lacked documentation the resident's confusion, exit seeking, and wandering were addressed prior to the resident's elopement and lacked documentation the resident was assessed when she returned to the facility.

The resident's current service plan did not address the resident's confusion, wandering, or exit seeking behaviors.

During an interview, on 7/29/26 at 9:15 a.m., Resident C's family member indicated the facility called him this morning and told him they could not find the resident. He was unable to understand what they meant on the phone, so he got up and headed to the facility. On the way, he called the resident's cell phone, and she answered. She told him she was in a car and headed back home. The car she was in was the police car. This occurred between 5:00 and 6:00 a.m. The resident often asked to talk to her mom and asked to go home. She had not tried to leave the property before that he was aware of. The family member indicated he wanted to

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try assisted living before memory care, but now she would be going to memory care once he talked to the doctor and got a physician's order. He was taking the resident to the doctor today. The family member indicated the resident was confused at baseline, but this was worse than usual. The last time the resident was like this she had a urinary tract infection (UTI). The family member was going to have the doctor check the resident for a UTI at the visit today. At the same time, the resident indicated she did not remember leaving the facility this morning, then later indicated she "fell in a lake." During the interview, the resident was unable to correctly identify her family member's identity.

During an interview, on 7/29/26 at 9:54 a.m., the DON indicated Resident C had gotten out of the facility this morning, 911 was called, and the police brought her back to the facility. The DON indicated the resident possibly had a UTI, leading to increased confusion. They had noticed she was exit seeking and met with the resident's family member on Monday about the potential of moving to the Memory Care unit. They would have needed a physician's order to move her back to the unit. The DON was

unable to provide documentation of the meeting or attempts to get an order to move the resident to the memory care unit. The DON indicated residents were assessed at least 30 days prior to their move-in date and should have been re-assessed at the move-in and again in 30 days.

During an interview, on 7/29/26 at 10:10 a.m., the Executive Director (ED) indicated the facility staff called her around 6:10 a.m., and told her Resident C had been missing since 5:00 a.m. The staff had last seen Resident C around 3:00 a.m. They did rounds and were unable to locate her. The staff had looked around the building, and when they had not found the resident, they notified the ED. The ED instructed the staff to call 911, call the resident's family member, and continue to search for the resident. The police found the resident and brought her back to the facility. The resident's family member came in today and took the resident to the doctor. When the resident returned from the doctor, the plan was for her to go to the memory care unit. If they were unable to get the physician's order for the resident to go to memory care, then the resident would have to have someone with her at all times. The ED indicated the

process for the assessment of potential residents was being updated, and the DON was going to start doing the pre-admission assessments. Somewhere between the assessment, lease signing, and move-in something was missed with this resident.

On 7/29/26 at 11:41 a.m., the ED provided a document titled, "Resident Assessment Policy," dated April 2026, and indicated it was the policy currently being used by the facility. The policy 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. 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"

On 7/29/26 at 11:41 a.m., the

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	Administrator provided a document titled, "Move-in (Admission) policy," dated April 2026, and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: Before moving in a resident to an assisted living community, individuals must meet certain criteria in order to be accepted for admission to the ...community ...Procedure: Move In/Admission: The community may accept and retain residents who meet the following criteria: 1. Can exhibit signs of confusion and forgetfulness, and behaviors can be managed through programmatic services. 2. Can exhibit wandering behaviors, but if elopement is a risk, behavior must be able to be managed through programmatic services. If behaviors are beyond our ability to manage through programming, resident may be issued a discharge notice ...5. Is not experiencing a behavior that would be harmful to self or others ...10. Cannot be a danger to self or others" This citation relates to Intake 471072.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	1. Immediate corrective actions were implemented to ensure resident safety. Memory Care door locking	09/30/2026

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(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. 2. On 7/28/26 at 10:04 a.m., Resident C was sitting at the nurse's station with Qualified Medication Aide (QMA) 11. QMA 11 indicated Resident C was sitting with her while QMA 11 completed charting. Resident C indicated she was just visiting the facility and did not live there. When asked if she would like to live at the facility, Resident C stated, "No." On 7/28/26 at 4:13 p.m., Resident C came into the dining room asking how she was supposed to get food early because she had to eat before she got picked up. She indicated, "He told me to eat beforehand." Resident F told her to go wait at the kitchen door or go to the other dining room because they served dinner first in the other room. She kept asking the same questions and could not follow directions to wait at the kitchen door. Two unidentified residents and the Receptionist were		systems have been repaired and verified functional. Residents residing in Memory Care and residents identified as wandering or elopement risks were assessed for supervision needs. Elopement risk assessments and care plans were reviewed and revised as indicated. 2. This failed practice had the potential to affect all residents residing in Memory Care and residents identified with cognitive impairment, wandering behavior, confusion, or exit-seeking behaviors. A facility-wide audit was completed to identify residents at risk and implement individualized interventions. 3. All associates received education on Resident Rights, abuse and neglect prevention, elopement prevention, supervision requirements, emergency preparedness, resident assessments, change in condition reporting, and implementation of individualized interventions for residents at risk for elopement. The community also established an	
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overheard talking about how Resident C needed to be in the memory care unit.

On 7/29/26, a local Facebook scanner page posted, at 6:50 a.m., an elderly person was found at a local intersection. The caller reported the person did not know where they came from. The post was updated and indicated the facility called to report a resident was missing, and the person found was returned to the facility by the police.

Apple Maps indicated the intersection where the resident was found was 1.5 miles from the facility and was approximately a 31 minute walk.

According to Accuweather, found on 7/31/26 at 9:56 a.m. at <https://www.accuweather.com/en/us/avon/46123/july-weather/2109247>, the low temperature on 7/29/26 was 62 degrees Fahrenheit.

According to the Time and Date website, found on 7/31/26 at 10:00 a.m. at <https://www.timeanddate.com/sun/@4254021>, indicated sunrise on 7/29/26 was 6:41 a.m.

During an interview, on 7/29/26 at 9:00 a.m., QMA 11 indicated Resident C had gotten out of the facility last night. It happened on night shift. QMA

emergency contingency process requiring increased monitoring and staffing coverage whenever security systems, door alarms, or locking mechanisms become inoperable.

4. The Executive Director (ED) and HCD or designee will conduct weekly audits of elopement risk assessments, resident supervision plans, memory care safety systems, and emergency contingency documentation for eight weeks, bi-weekly for eight weeks, and monthly for three months. Results will be reviewed through Wellness meetings and corrective action taken as needed.
5. **Completion Date:**
September 30, 2026

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11 was told when she came in that night shift was checking on residents and discovered Resident C was not there. The staff called 911 and reported the resident missing. The police found the resident. QMA 11 indicated Resident C was very confused, and she was not sure why the resident was not on the Memory Care unit. The resident resided in the assisted living portion of the facility. The resident's family member was currently with her and planned to stay with her for now.

Resident C's record was reviewed on 7/28/26 at 3:01 p.m. The resident's only listed diagnosis was dementia (a decline in mental ability severe enough to interfere with daily life) in other diseases classified elsewhere.

A progress note, dated 7/24/26, indicated the resident was admitted to the facility and was disoriented, confused, trying to escape, and wandering. The resident was requesting information of a man that checked in with her and left. The resident wanted his name and number for a ride.

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wandering frequently, was redirected on multiple occasions, and assisted back to her room. The resident remained safe and was "monitored closely" for safety.

A progress note, dated 7/26/26 at 11:33 a.m., indicated the resident continued to wander throughout the unit and appeared confused and disoriented. The resident attempted to open exit doors and stated she wanted to go home. The staff redirected the resident from the exits and provided reassurance. The resident was escorted to a common area and engaged in conversation and calming activity. "Safety checks maintain." Resident "monitored closely" for wandering and exit seeking behavior. The provider and responsible party "will be" notified. The record lacked documentation anyone was notified of the resident's confusion.

A progress note, dated 7/27/26, indicated the resident was confused after dinner. Staff redirected the resident. "Safety checks" continued throughout the shift.

A progress note, dated 7/29/26 at 7:09 a.m., indicated the resident was reported missing around 5:00 a.m. The staff

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started looking for her around the building, but she was not found. The Administrator and the resident's family member were notified. The staff member called 911. "After a while" the resident was brought back to the facility by the police.

A progress note, dated 7/29/26 at 8:16 a.m., indicated the Director of Nursing (DON) received a call from the ED that the resident was unable to be located. Staff were instructed to continue to look for the resident, call 911, and call the resident's family member. The DON received an update from the ED, at 6:46 a.m., that the resident was found and was back in her apartment. The DON arrived at the facility and was informed the resident's family member was with her.

The record lacked documentation the resident's confusion, exit seeking, and wandering were addressed prior to the resident's elopement and lacked documentation the resident was assessed when she returned to the facility.

During an interview, on 7/29/26 at 9:15 a.m., Resident C's family member indicated the facility called him this morning and told him they could not find the resident. He was unable to understand what they meant on

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the phone, so he got up and headed to the facility. On the way, he called the resident's cell phone, and she answered. She told him she was in a car and headed back home. The car she was in was the police car. This occurred between 5:00 and 6:00 a.m. The resident often asked to talk to her mom and asked to go home. She had not tried to leave the property before that he was aware of. The family member indicated he wanted to try assisted living before memory care, but now she would be going to memory care once he talked to the doctor and got a physician's order. He was taking the resident to the doctor today. The family member indicated the resident was confused at baseline, but this was worse than usual. The last time the resident was like this she had a urinary tract infection (UTI). The family member was going to have the doctor check the resident for a UTI at the visit today. At the same time, the resident indicated she did not remember leaving the facility this morning, then later indicated she "fell in a lake." During the interview, the resident was unable to correctly identify her family member's identity.

During an interview, on 7/29/26 at 9:54 a.m., the DON indicated Resident C had gotten out of

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the facility this morning, 911 was called, and the police brought her back to the facility. The DON indicated the resident possibly had a UTI, leading to increased confusion. They had noticed she was exit seeking and met with the resident's family member on Monday about the potential of moving to the Memory Care unit. They would have needed a physician's order to move her back to the unit. The DON was unable to provide documentation of the meeting or attempts to get an order to move the resident to the memory care unit.

During an interview, on 7/29/26 at 10:10 a.m., the Executive Director indicated the facility staff called her around 6:10 a.m., and told her Resident C had been missing since 5:00 a.m. The staff had last seen Resident C around 3:00 a.m. They did rounds and were unable to locate her. The staff had looked around the building, and when they had not found the resident, they notified the ED. The ED instructed the staff to call 911, call the resident's family member, and continue to search for the resident. The police found the resident and brought her back to the facility. The resident's family member came in today and took the resident to the doctor. When the

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	resident returned from the doctor, the plan was for her to go to the memory care unit. If they were unable to get the physician's order for the resident to go to memory care, then the resident would have to have someone with her at all times. On 7/28/26 at 1:56 p.m., the ED provided a copy of current facility policy titled, "Elopement Policy," dated, 4/2026. The policy indicated, "The community is responsible for ensuring effective systems are in place to reduce the risk of residents wandering and becoming lost ... Definition of Elopement: An elopement is an incident in which a resident leaves the community without community associates' knowledge; unsupervised, unscheduled and unnoticed. This applies especially when the resident has impaired decision-making abilities and is unaware of his/her own safety and needs. This includes residents that leave a secured area without associate knowledge ... Should a resident be missing, or an elopement occurs, despite preventive steps, the community will provide a coordinated effort of available resources to ensure a prompt, thorough search for a missing resident. The goal is to locate and safely return a			
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missing resident to the community ... After Resident is Found ... Inform Law enforcement ... The licensed nurse completes and documents an assessment of the resident and reports any findings to the physician. The licensed nurse reviews and updates the resident's individualized service plan and ensures the resident is safe in the community ...

On 7/28/26 at 1:56 p.m., the ED provided a copy of current, but undated facility policy titled, "Emergency Procedure, Missing Resident," dated, 4/2026. The policy indicated, "The following procedure should be utilized when a resident is determined to be missing. All team members are trained to notify their supervisor immediately when a resident is believed to be missing from the community. A. "Code Pink" will be announced with the resident's apartment unit number, including neighborhood if applicable. B. Note the time that the resident was discovered to be missing. This is important as 911 will be contacted after 15 minutes of searching. The time will be recorded on the Resident Elopement Search Assignment Form. See Appendix J. C. Team members who are assigned to the floor/neighborhood of the resident missing will be

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	assigned to check the Daily Communication Log & Sign in/Sign out Log to confirm if resident has left the community with family member. The Concierge will also be contacted to see if the resident has left the community on an outing or to a scheduled appointment on the Transportation Log. o D. Executive Director, Health Care Coordinator/Harmony Square Coordinator, and Director of Maintenance will be notified if not on the premises. Activate Recall Roster if necessary. E. All other community staff should report to the Incident Command Post for a briefing and establishing a Missing Resident Search Team. F. A photograph of the resident should be obtained from the Resident Clinical or Administrative Record to show staff members and emergency personnel if warranted... H. If the resident has not been found after a period of fifteen minutes of the search, the Executive Director/Designated Person in Charge will call 911 to report the resident missing" This citation relates to Intake 471072. 1. Based on observations, interviews, and record review, the facility failed to protect residents' right to be free from neglect when the facility failed to			
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	immediately implement a staffing pattern, monitoring system, or emergency contingency plan to maintain resident safety facility following a lightning strike that destroyed the locking system securing the memory care unit resulting in a resident with dementia eloping from the facility, walking approximately 0.7 miles to a public gas station where she remained for nearly an hour without staff awareness for 1 of 2 residents reviewed for elopement (Resident B). This deficiency had the potential to affect 15 of 15 residents residing on the secured memory care unit. 2. Based on observations, interviews, and record review, the facility failed to protect residents' right to be free from neglect when the facility failed to assess, monitor, or implement safety interventions for a newly admitted resident who exhibited persistent exit seeking behaviors, confusion, and repeatedly stated she did not live at the facility and needed to leave resulting in the resident eloping from the facility and being found approximately 1.5 miles away for 1 of 2 residents reviewed for eloping (Resident C). Findings include:			
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	1. On 7/28/26 at 9:53 a.m., an initial observation of the secured memory care unit was conducted. A key-fob was provided, but not necessary, as the entrance doors to the memory care unit were unlocked. No staff were present in the front hall, dining room, or kitchenette. The dining room door leading to the fenced patio was unlocked and unsupervised. No staff were present at the nurses' station, secondary dining/activity area, or either lateral hallway. The only staff observed in the unit was an activity aide leading a Bible study with seven residents in the chapel. A door with a magnetic lock (maglock) that exited directly to the parking lot was unlocked, opened easily from both inside and outside, and had no staff assigned to monitor the door. This exit door was at the end of the lateral hallway not visible from the nurses' station, dining room, secondary dining/activity area, or entrance door. There were no signs posted anywhere in the building alerting staff, visitors, or families that the memory care doors were not locked. During an interview on 7/28/26 at 9:55 a.m. Certified Nursing Aide (CNA) 3 indicated staff normally used a key fob to access and exit the memory care unit, but the doors were not			
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locked at the time of the interview. She indicated management told staff the circuit panel had been damaged about eight days earlier and the doors had not been locked since. There were 14 residents in the unit at that time, with one resident currently hospitalized. A resident had exited the facility the previous Tuesday when the doors were unlocked. CNA 3 indicated staff were not given additional resources or a formal plan for increased monitoring or supervision. They were just told to watch the doors. CNA 3 indicated she performed head counts about every 20 minutes, although this was not required or documented. Staffing that day included two aides, one nurse, and an activity staff member, with similar staffing in the evenings and one aide and one nurse at night.

During an interview on 7/28/26 at 9:57 a.m., Qualified Medication Aide (QMA) 8 indicated the memory care doors had remained unlocked for "many days." She reported that staff were instructed only to "be extra vigilant" and that staffing had not been increased. She indicated they were unable to provide continuous observation of all 15 residents on top of routine responsibilities such as medication administration, meal

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	distributions, activities of daily living (ADLs), charting, etc., QMA 8 indicated, "it is impossible for one QMA and two CNAs to keep eyes on 15 people 24/7." During an interview on 7/28/26 at 10:03 a.m., QMA 11 was observed sitting outside the memory care entrance with Resident C, who stated she was visiting and did not live at the facility. QMA 11 indicated she was aware the memory care doors were unlocked and had been told only to "watch the doors closely." She stated that when she came on shift she was instructed to watch for any issues with the exit doors and that staff communicated informally with each other about monitoring the residents. Head counts were completed about hourly, but not documented, and if she needed to provide care another aide might assist with monitoring. On 7/28/26 at 10:30 a.m., during a second observation of the memory care unit, all exit doors were observed, tested, and found to be unlocked. Signage had not been posted. No audible alarms sounded when doors were tested, and the available nursing staff continued routine duties such as transporting residents to the main dining room, leaving halls			
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and exit doors unsupervised. The main long hall had the main entrance/exit at one end and stairwell exit between the dining room and nurses' station. The stairwell exit provided access to the stairwell and an exit door to the parking lot which was not locked.

During an interview on 7/28/26 at 10:34 a.m., a visiting family member indicated the door panel had malfunctioned after a storm, and the memory care doors were not locking. She reported she had not observed any increase in staffing in response to the issue, although staff appeared to be present in the common areas more frequently. She stated it would have been difficult for staff to monitor all residents' locations while also completing their regular daily duties.

During an interview on 7/28/26 at 11:03 a.m., Housekeeper 12 indicated that lightning had struck the building and caused the memory care doors to stop locking. She reported that staff informed her of the door malfunction when she began employment but did not explain what actions were being taken or whether a plan was in place. During the interview, the long hallway was observed with no supervising staff present, and HK 12 indicated it was not

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	possible for the CNAs to monitor every exit, 24/7 while also providing care. During an interview on 7/28/26 at 11:13 a.m., the Activity Director indicated she was present on the day lightning struck the building and that all doors, elevators, and phones stopped working. At that time, staff did not immediately realize the extent of the damage. She reported hearing a loud crack and impact sound at the time of the strike. She indicated no in-service or announcement was provided to staff regarding the door malfunction, and staff relied on informally spreading the word to each other to watch the doors more closely. The Activity Director indicated she independently decided to increase her rounding in the memory care unit because she thought it was unsafe and the management staff had not increased staffing patterns until the door locks could be repaired. The Activity Director indicated the internet in the memory care unit was down, which required the QMA to leave the unit to complete her charting.			
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On 7/28/26 at 11:15 a.m., QMA 8 was observed to leave the unit through the front door. She was not observed telling anyone she was leaving the unit.

The following was observed on the memory care unit on 7/28/26 at 11:20 a.m. The main entrance to the memory care unit entered a long hallway. The dining area was through an open entryway offset from the hallway limiting the ability to see the entrance door when in the dining area. Three staff members were observed in the dining area assisting with passing out lunch trays to residents. The hallway toward the lateral hallway and the exit to the stairwell were not visible from the dining room. The nurses' station was at the end of the hallway at the intersection of the long hallway and the lateral hallway, but it was offset and the exit doors were not visible from inside the nurses' station. The dining area/kitchenette/activity area near the nurses' station was offset from the hallway and the exit doors to the parking lot, stairwell, and entrance to the unit were not visible. The chapel area was a room off the lateral hallway near the parking lot exit door. The exit doors were not visible from the chapel.

On 7/28/26 at 11:58 a.m. the

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	parking lot and outside of the memory care unit exit door were observed. Across the parking lot and diagonal from the memory care unit exit was a pond with a 4 ft fence around the pond. The memory care unit was close to the main road. The sidewalk behind the memory care unit next to the main road was observed, looking north following the sidewalk there was a stoplight barely visible and on the lefthand side there was a faint neon green sign that belonged to a gas station. The sidewalk ended before the stoplight. The exit door to the memory care unit was not labeled as an entrance. There was a paper sign taped on the door blowing in the wind that provided a phone number to call for entrance. The door was easily pulled open and allowed entrance into the memory care unit. Upon survey entrance on 7/28/26 at 9:30 a.m., documentation of the investigation for Resident B's elopement was requested. Documentation was not provided until 7/28/26 at 2:00 p.m. and only one piece of paper titled, "Missing Resident Checklist," was provided. The Missing Resident Checklist indicated Resident B was noted missing at 5:00 p.m., on 7/20/26. The last time stamp on			
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the checklist was 5:05 p.m. A handwritten note on the back of the Checklist indicated, "When staff was doing round for dinner resident was not found. A search was conducted, police notified, family [notified]. Resident was found after. Guest let resident out."

On 7/26/28 at 12:40 p.m., the gas station north of the facility was observed and the employee indicated there had been a confused woman there on 7/20/26. The gas station employee indicated the resident walked to the gas station and came in. She didn't look like she had any issues and he thought she was just a regular person. She was dressed appropriately and was socially appropriately acting. He indicated she came in and as he talked to her, he realized she was confused. She was unable to say where she came from. She kept pointing down main road and saying she came from there. He asked where she was trying to go, and she told him that she wanted to go to her Mom and Dad's house. She thought her Mom and Dad lived in Clinton, Indiana. The resident told him that she walked there from Lafayette, Indiana. He asked her to write down the address of the place she wanted to go and her name. She wrote down something, but it was

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non-sensical. The longer she was there the more he felt like something wasn't right so he ended up calling the sheriff's department. He was really worried about her because it was so hot that day. She was crying some. He gave her some water and paper towels. They responded with an ambulance, and they took her. He did not know where she went or where she had come from. No facility staff ever showed up at the gas station. No facility staff had come afterward, and he had never talked to anyone from the facility. The gas station employee provided the gas station's video surveillance. On 7/20/26, around 4:00 p.m., the resident came into view walking on the sidewalk towards the gas station's parking lot. She was walking with a limp and looking around. She would have had to cross the street at some point as the facility was on the other side of the street, but the crossing was not seen in the video. The gas station is at the intersection where there was a stop light, and it was a fairly busy intersection, there were no sidewalks or cross walk signals at the intersection. There were some stopped cars at the traffic light visible in the video as the resident walked up. She entered the store and spent a considerable amount of time talking to the employee. The			
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police arrived at 5:01 p.m., and she ended up leaving with them. The resident was in the store for almost an hour. There was no facility staff ever noted on the video. The employee indicated the resident left in the ambulance as far as he knew.

During an interview on 7/28/26 at 12:50 p.m., a local police officer indicated, no calls were received and no services were dispatched to the facility address on 7/20/26 related to Resident B's elopement.

During an interview on 7/28/26 at 1:45 p.m., a local police officer indicated on 7/20/26 an officer and a ambulance had been dispatched to the gas station north of the facility for a welfare check for a confused female. The incident report was closed with a note indicating the female lived at the facility and the medics had returned her to the facility.

During an interview on 7/28/26 at 1:05 p.m., the Executive Director (ED) indicated that when she arrived at the facility, Resident B had already been returned and had not been out of the building for more than 10 minutes. The ED was told by staff that another resident's family member had let the resident out, but she did not verify how the resident exited

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the building and staff did not know who had let her out. The Executive Director indicated she assumed staff had contacted the police but did not confirm this. No head to toe assessment was completed when the resident returned because there was no Director of Nursing at the time, and she assumed the Emergency Medical Technicians (EMTs) had assessed the resident. She did not know what actions staff had taken following the elopement. She had not conducted an investigation that included interviews and visual assessment of the memory care unit.

During an interview with the Maintenance Director on 7/28/26 at 1:20 p.m., with the ED present, the Maintenance Director indicated the building was struck by lightning on 7/17/26. He did not know the memory care doors were affected at that time. He came in on 7/18/26 due to kitchen access issues and found multiple fire panel troubles. He contacted the vendor, who repaired fire related issues on 7/18/26 and 7/21/26. The lightning strike damaged numerous control boards, including those tied to the memory care maglock system. Once the fire related issues were fixed, he realized the maglocks were not fixed so he

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contacted two different companies to get them corrected. The ED confirmed that she did not learn the maglocks had failed until 7/23/26, six days after the event, and that staff had not reported the doors could be opened without a fob. The ED also stated she assumed the doors worked because her fob activated the panel by the entrance door and she did not check the doors to see if they were locked.

On 7/28/26 at 3:00 p.m., Resident B's record was reviewed. She admitted to the facility in February of 2026 and had a diagnosis which included, but was not limited to, dementia.

Her most recent service plan was dated 4/4/26, but lacked review since her elopement, and did not include revisions or interventions for increased monitoring/supervision.

A nursing progress note, dated 7/20/26 at 5:18 p.m., indicated, "Resident was reported by staff to be missing before dinner time. Staff reported to writer that doors have been unlocked from thunder strike since last week. [Resident] was brought back by EMS to the building a few minutes after staff started searching for [resident]. Writer notified the ED and

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Maintenance director who had both closed and left the community at the time. Writer notified daughter via phone call. [Resident] currently back in the community now eating dinner."

The last assessment completed was a Fall Risk Assessment dated April 2026, and there was no recent change of condition assessment, or Elopement assessment.

According to Accuweather, found on 7/31/26 at 9:56 a.m. at <https://www.accuweather.com/en/us/avon/46123/july-weather/2109247>, the high temperature on 7/20/26 was 87 degrees Fahrenheit.

On 7/28/26 at 3:30 p.m., the Facility's Elopement Binder was located in the memory care unit at the nurse's station. There was only one sheet of paper for a different resident. The Elopement Binder was not up to date and did not include any additional resident information.

On 7/28/26 at 3:00 p.m., the memory care unit was observed again. Upon entrance into the unit, no supervising staff were posted at any of the unlocked exit doors. Staff were busy with resident activities. CNA 13 was providing a shower for a resident in their room, and CNA 14 was providing a shower for a second resident in their room.

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	The Activity Director was talking with the Activity Assistant, giving guidance for activities and not monitoring residents at that time. At 3:15 p.m., QMA 8 was giving report to an incoming QMA inside the nurses station and therefore could not visualize all three halls. During an interview on 7/28/26 at 3:25 p.m., CNA 13 indicated she had worked the day Resident B eloped. Resident B had seemed fine and had been in her room most of the day. When CNA 13 went to tell Resident B it was dinner time, she was not in her room. That was when they noticed she was missing and began to look. Shortly after, EMTs returned her to the facility and she seemed fine. They brought her back in and she went to the dining room to eat dinner. QMA 13 indicated, the doors were still unlocked, and staff were supposed to watch the doors as close as they could but that was hard to do. QMA 13 indicated the evening was especially difficult, because many residents required showers, or had behaviors like sun-downing, and QMA 13 indicated they needed more staff.			
R 0090	Administration and Management - Deficiency	R 0090	1. The Executive Director reviewed all reportable incidents associated with	09/30/2026

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410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.	this survey and ensured appropriate reporting, follow-up documentation, investigation, and corrective actions were completed. 2. This failed practice has the potential to affect all residents. A facility-wide review was completed to ensure reportable incidents, investigations, resident assessments, and follow-up interventions were appropriately documented. 3. Regional Leadership provided education to the Executive Director, HCD, department leaders, nurses, QMAS, and direct care associates regarding Indiana reportable incident requirements, elopement investigations, change of condition assessments, documentation expectations, resident safety interventions, emergency response procedures, and notification requirements.
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(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on observation, record review, and interview, the Executive Director (ED) failed to oversee the facility effectively when an unusual occurrence was not reported to the State Agency within the required timeframe for 1 of 2 reportable incidents reviewed, and failed to ensure an elopement from the memory care unit was investigated and interventions were implemented to prevent additional elopements (Resident B), and failed to ensure a

4. The ED or designee will audit all incident reports, investigations, reportable event submissions, and follow-up documentation weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months.

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resident was assessed for the appropriate level of care which resulted in a resident eloping from the assisted living portion of the facility (Resident C) for 2 of 2 residents reviewed for elopement. This deficiency had the potential to affect 56 of 56 residents residing at the facility.

Findings include:

1. During an initial tour of the memory care unit, on 7/28/26 at 9:53 a.m., all exit doors were observed unlocked and unattended. There were two exits which provided parking lot access, one exit that provided courtyard access, and one exit that led to assisted living.

During an interview, on 7/28/26 at 9:55 a.m., Certified Nurse Aide (CNA) 3 indicated the staff normally used a key fob to enter and exit the Memory Care unit, but it was not needed at this time, because all of the doors were unlocked. The management told her it rained, and the panel had gotten wet, which damaged the circuit. This happened eight days ago, and the doors had been unlocked since. The management had not given the staff any instructions or plan for how to handle the doors being unlocked. They were supposed to watch the doors, but they were not given any additional staff to do so.

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They normally had one Qualified Medication Aide (QMA) and two CNAs on day and evening shifts, and one QMA and one CNA on night shift. CNA 3 indicated she did a head count of residents approximately every 20 minutes, but it was not documented or required. CNA 3 indicated she was in the bathroom when we entered the unit, and that was why there was no one monitoring the doors at that time.

During an interview with the Maintenance Director on 7/28/26 at 1:20 p.m., with the ED present, the Maintenance Director indicated the building was struck by lightning on 7/17/26. He did not know the memory care doors were affected at that time. He came in on 7/18/26 due to kitchen access issues and found multiple fire panel troubles. He contacted the vendor, who repaired fire related issues on 7/18/26 and 7/21/26. The lightning strike damaged numerous control boards, including those tied to the memory care maglock system. Once the fire related issues were fixed, he realized the maglocks were not fixed so he contacted two different companies to get them corrected. The ED confirmed that she did not learn the maglocks had failed until

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7/23/26, six days after the event, and that staff had not reported the doors could be opened without a fob. The ED also stated she assumed the doors worked because her fob activated the panel by the entrance door and she did not check the doors to see if they were locked.

On 7/28/26, the State Agency received a reportable incident which indicated, "Lightening hit the building shorting mag locks." Action taken indicated extra staff was posted to watch doors 24 hours a day and notified the company for a service call. The report lacked documentation the doors that were unlocked were on the Memory Care unit, or that they had been unlocked likely since 7/17/26. No other reportable incidents were received related to this issue.

During an interview, on 7/29/26 at 12:03 p.m., the ED indicated the issues with the door locks should have been accurately reported to the State Agency when it occurred. She thought she had reported it to the State Agency before, but she had not fully submitted the report. She first became aware of the issue with the doors on 7/23/26. Lightening hit the building around 7/18/26 and affected the elevators. It was possible the doors were impaired that day,

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but she was not notified until 7/23/26.

On 7/29/26 at 12:40 p.m., the ED provided a document titled, "...Incident Reporting," dated April 2026, and indicated it was the policy currently being used by the facility. The policy indicated, "...5. Reportable Incident: Reportable incidents are resident and community events and occurrences that require reporting to regulatory agencies. If reportable incidents occurs [sic], follow these guidelines: a. An associate notifies the Executive Director and Healthcare Director of the incident ...e. Notify state regulatory agencies as required"

An Indiana Department of Health (IDOH) policy titled, "Long-Term Care Abuse and Incident Reporting Policy," was dated 12/6/22. The policy indicated, "...Purpose To facilitate compliance with state ...law and regulation, as applicable, related to reporting of abuse and incidents in licensed long-term care facilities in Indiana ...LICENSED RESIDENTIAL CARE FACILITIES ...C. Types of Incidents reportable under state rules: Any occurrence that directly threatens the welfare, safety, or health of a resident, such as ...3. Elopement:

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Elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown or whose return involves law enforcement ...19. Utility interruption of more than four (4) hours in length in one or more major utilities to the facility"

Cross reference R052.

2. Upon survey entrance on 7/28/26 at 9:30 a.m., documentation of the investigation for Resident B's elopement was requested. Documentation was not provided until 7/28/26 at 2:00 p.m. and only one piece of paper titled, "Missing Resident Checklist," was provided. The Missing Resident Checklist indicated, Resident B was noted missing at 5:00 p.m., on 7/20/26. The last time stamp on the checklist was 5:05 p.m. A handwritten note on the back of the Checklist indicated, "When staff was doing round for dinner resident was not found. A search was conducted, police notified, family [notified]. Resident was found after. Guest let resident out."

On 7/28/28 at 12:40 p.m., Gas station video evidence confirmed Resident B's elopement: on 7/20/26 at approximately 4:00 p.m.,

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Resident B walked across a busy public intersection and entered the gas station at the intersection north of the facility. She appeared confused, cried intermittently, and wrote nonsensical information on paper. She remained in the store for nearly an hour. The gas station employee called law enforcement and an ambulance because of concern for her safety in extreme heat. No facility staff arrived at the gas station at any time. The resident left in an ambulance at 5:01 p.m.

During an interview on 7/28/26 at 12:50 p.m., a local police officer indicated, no calls were received and no services were dispatched to the facility address on 7/20/26 related to Resident B's elopement.

During an interview, on 7/28/26 at 1:05 p.m., the ED indicated when she arrived at the facility, Resident B had already returned and was not out of the building for more than 10 minutes. The ED was told by staff that another resident's family member had let the resident out, but she did not verify how the resident exited the building and staff did not know who had let her out. The ED indicated she assumed staff had contacted the police but did not confirm this. No head-to-toe assessment

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was completed when the resident returned because there was no Director of Nursing at the time, and she assumed the medics had assessed the resident. The ED further indicated she had not seen an incident report and did not know what actions staff had taken following the elopement.

During an interview on 7/28/26 at 1:45 p.m., a local police officer indicated on 7/20/26 an officer and an ambulance had been dispatched to the gas station north of the facility for a welfare check for a confused female. The incident report was closed with a note indicating the female lived at the facility and the medics had returned her to the facility.

On 7/28/26 at 3:00 p.m., Resident B's record was reviewed. She admitted to the facility in February of 2026 and had a diagnosis which included, but was not limited to, dementia.

Her most recent service plan was dated 4/4/26, but lacked review since her elopement, and did not include revisions or interventions for increased monitoring/supervision.

A nursing progress note, dated 7/20/26 at 5:18 p.m., indicated, "Resident was reported by staff to be missing before diner time. Staff reported to writer that

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	doors have been unlocked from thunder strike since last week. [Resident] was brought back by EMS to the building a few minutes after staff started searching for [resident]. Writer notified the ED and Maintenance director who had both closed and left the community at the time. Writer notified daughter via phone call. [Resident] currently back in the community now eating dinner." During an interview on 7/28/26 at 3:25 p.m., CNA 13 indicated she had worked the day Resident B eloped. Resident B had seemed fine and had been in her room most of the day. When CNA 13 went to tell Resident B it was dinner time, she was not in her room. That was when they noticed she was missing and began to look. Shortly after, EMTs returned her to the facility and she seemed fine. They brought her back in and she went to the dining room to eat dinner. QMA 13 indicated, the doors were still unlocked, and staff were supposed to watch the doors as close as they could but that was hard to do. QMA 13 indicated the evening was especially difficult, because many residents required showers, or had behaviors like sun-downing, and QMA 13 indicated they needed more staff.			
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	Cross reference R052 and R0117. 3. Resident C's record was reviewed on 7/28/26 at 3:01 p.m. The resident was admitted to the facility on 7/24/26. A pre-admission assessment, dated 6/26/26, indicated the resident was alert and oriented to person, place, time, and situation and did not wander. Progress notes, dated 7/24/26 to 7/29/26, indicated the resident was confused, wandering, and exit seeking. The record lacked documentation of a new level of care assessment was completed when the resident demonstrated confusion, wandering, and exit seeking upon her admission to the facility. During an interview, on 7/29/26 at 9:00 a.m., QMA 11 indicated Resident C had gotten out of the facility last night. It happened on night shift. QMA 11 was told when she came in that night shift was checking on residents and discovered Resident C was not there. The staff called 911 and reported the resident missing. The police found the resident. QMA 11 indicated Resident C was very confused, and she was not sure why the resident was not on the			
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	Memory Care unit. The resident resided in the assisted living portion of the facility. The resident's family member was currently with her and planned to stay with her for now. During an interview, on 7/29/26 at 9:15 a.m., Resident C's family member indicated the facility called him this morning and told him they could not find the resident. He was unable to understand what they meant on the phone, so he got up and headed to the facility. On the way, he called the resident's cell phone, and she answered. She told him she was in a car and headed back home. The car she was in was the police car. This occurred between 5:00 and 6:00 a.m. The resident often asked to talk to her mom and asked to go home. She had not tried to leave the property before that he was aware of. The family member indicated he wanted to try assisted living before memory care, but now she would be going to memory care once he talked to the doctor and got a physician's order. He was taking the resident to the doctor today. The family member indicated the resident was confused at baseline, but this was worse than usual. The last time the resident was like this she had a urinary tract infection (UTI). The family member was going to have the doctor check			
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the resident for a UTI at the visit today. At the same time, the resident indicated she did not remember leaving the facility this morning, then later indicated she "fell in a lake." During the interview, the resident was unable to correctly identify her family member's identity.

During an interview, on 7/29/26 at 9:54 a.m., the DON indicated Resident C had gotten out of the facility this morning, 911 was called, and the police brought her back to the facility. The DON indicated the resident possibly had a UTI, leading to increased confusion. They had noticed she was exit seeking and met with the resident's family member on Monday about the potential of moving to the Memory Care unit. They would have needed a physician's order to move her back to the unit. The DON was unable to provide documentation of the meeting or attempts to get an order to move the resident to the memory care unit.

During an interview, on 7/29/26 at 10:10 a.m., the Executive Director (ED) indicated the facility staff called her around 6:10 a.m., and told her Resident C had been missing since 5:00 a.m. The staff had last seen Resident C around 3:00 a.m.

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	They did rounds and were unable to locate her. The staff had looked around the building, and when they had not found the resident, they notified the ED. The ED instructed the staff to call 911, call the resident's family member, and continue to search for the resident. The police found the resident and brought her back to the facility. The resident's family member came in today and took the resident to the doctor. When the resident returned from the doctor, the plan was for her to go to the memory care unit. If they were unable to get the physician's order for the resident to go to memory care, then the resident would have to have someone with her at all times. Cross reference R0006 and R052. This citation relates to Intake 471072.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and	R 0117	1. Staffing schedules for Memory Care were reviewed and adjusted to ensure adequate supervision based upon resident acuity and safety needs. A contingency staffing plan was implemented to provide additional monitoring whenever safety systems	09/30/2026

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training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

are compromised or residents demonstrate increased risk behaviors.

2. All Memory Care residents had the potential to be affected. Staffing assignments and resident acuity were reviewed to ensure adequate supervision and coverage throughout all shifts.
3. The ED and HCD educated department leaders regarding staffing responsibilities, resident supervision expectations, acuity-based staffing decisions, and contingency staffing requirements for emergency situations.
4. The ED or designee will complete staffing and resident acuity audits weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months to ensure staffing levels remain adequate to meet resident needs. Findings will be discussed during Wellness meetings.
5. **Completion Date: September 30, 2026**

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	Based on observations, interviews, and record review, the facility failed to ensure adequate staffing levels to effectively monitor and supervise residents in the Memory Care unit who were identified as at risk for elopement, which resulted in Resident B eloping from the facility, and the facility failed to take immediate action to increase staffing after the elopement to provide supervision at exit points which had the potential to effect 15 of 15 residents who resided on the memory care unit. Findings include: On 7/28/26 at 9:53 a.m., an initial observation of the secured memory care unit was conducted. A key-fob was provided, but not necessary, as the entrance doors to the memory care unit were unlocked. No staff were present in the front hall, dining room, or kitchenette. The dining room door leading to the fenced patio was unlocked and unsupervised. No staff were present at the nurse's station, secondary dining/activity area, or either lateral hallway. The only staff observed in the unit was an activity aide leading a Bible study with seven residents in the chapel, from which all exit points could not be visualized.			
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	In addition to the unlocked main entrance into the unit, the memory care unit was also observed to have four direct exit doors to the outside as follows: -A double glass door in the main kitchen area that opened into a secured patio area. -A stairwell access door that led to an unlocked fire escape door which were both unlocked. -A double glass door that also opened into the secured patio area. -A double glass door that opened directly into the front parking lot, leading to the main road. During an interview on 7/28/26 at 9:55 a.m. Certified Nursing Aide (CNA) 3 indicated, the memory care doors had been unlocked since the previous week after lightening hit the building. Because the doors were unlocked, Resident B was able to exit and eloped from the facility. CNA 3 indicated the facility had not provided additional staff since the elopement to help monitor all exit doors, and staff had been told by word of mouth, to just watch the doors more closely. During an interview on 7/28/26 at 9:57 a.m., Qualified Medication Aide (QMA) 8			
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indicated, the memory care doors had remained unlocked for "many days." She reported that staff were instructed only to "be extra vigilant" and that staffing had not been increased. She indicated they were unable to provide continuous observation of all 15 residents on top of routine responsibilities such as medication administration, meal distributions, activities of daily living (ADLs), charting etc., QMA 8 indicated, "it is impossible for one QMA and two CNAs to keep eyes on 15 people 24/7."

During an interview on 7/28/26 at 10:03 a.m., QMA 11 indicated, she was aware the memory care doors were unlocked and had been told only to "watch the doors closely." She stated that when she came on shift she was instructed to watch for any issues with the exit doors and that staff communicated informally with each other about monitoring the residents. Head counts were completed about hourly, but not documented.

On 7/28/26 at 10:30 a.m., during a second observation of the memory care unit, all exit doors were observed, tested, and remained unlocked. Signage had not been posted. No audible alarms sounded

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	when doors were tested, and the available nursing staff continued routine duties such as transporting residents to the main dining room, leaving halls and exit doors unsupervised. During an interview on 7/28/26 at 10:34 a.m., a visiting family member indicated the door panel had malfunctioned after a storm and the memory care doors were not locking. She reported she had not observed any increase in staffing in response to the issue. Although staff appeared to be present in the common areas more frequently, it was difficult for staff to monitor all residents' locations while also completing their regular daily duties. During an interview on 7/28/26 at 11:03 a.m., Housekeeper 12 indicated that lightning had struck the building and caused the memory care doors to stop locking. She reported that staff informed her of the door malfunction when she began employment but did not explain what actions were being taken or whether a plan was in place. During the interview, the long hallway was observed with no supervising staff present, and HK 12 indicated it was not possible for the CNAs to monitor every exit, 24/7 while also providing care.			
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	During an interview on 7/28/26 at 11:13 a.m., the Activity Director indicated she had come back to the unit to check on Activity Aide 4 who was a new employee and had not worked in a memory care unit before and the Activity Director wanted to see how she was doing. The Activity Director indicated she independently decided to increase her rounding in the memory care unit because she thought it was unsafe and the management staff had not increased staffing patterns until the door locks could be repaired. The Activity Director indicated the internet in the memory care unit was down, which required the QMA to leave the unit to complete her charting. On 7/28/26 at 11:15 a.m., QMA 8 was observed to leave the unit through the front door. She did not tell anyone she was leaving the unit.			
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During an interview on 7/28/26 at 1:05 p.m., the Executive Director (ED) indicated staffing for the memory care unit during the day included, one QMA and two CNAs. At night, there was one QMA and one CNA. The ED indicated staffing remained the same at night, but they added more activity aide hours to help engage residents during the day.

During an interview with the Maintenance Director on 7/28/26 at 1:20 p.m., with the ED present, the Maintenance Director indicated the building was struck by lightning on 7/17/26. He did not know the memory care doors were affected at that time. He came in on 7/18/26 due to kitchen access issues and found multiple fire panel troubles. He contacted the vendor, who repaired fire related issues on 7/18/26 and 7/21/26. The lightning strike damaged numerous control boards, including those tied to the memory care maglock system. Once the fire related issues were fixed, he realized the maglocks were not fixed so he contacted two different companies to get them corrected. The ED confirmed that she did not learn the maglocks had failed until 7/23/26, six days after the event, and that staff had not

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reported the doors could be opened without a fob. The ED also stated she assumed the doors worked because her fob activated the panel by the entrance door and she did not check the doors to see if they were locked.

On 7/28/26 at 3:00 p.m., the memory care unit was observed again. Upon entrance into the unit, no supervising staff were posted at any of the unlocked exit doors. Staff were busy with residents' activities. CNA 13 was providing a shower for a resident in their room, and CNA 14 was providing a shower for a second resident in their room. The Activity Director was talking with the Activity Assistant, giving guidance for activities and not monitoring residents at that time. At 3:15 p.m., QMA 8 was giving report to an incoming QMA inside the nurse's station and therefore could not visualize all three halls.

During an interview on 7/28/26 at 3:25 p.m., CNA 13 indicated that the doors were still unlocked, and staff were supposed to watch the doors as close as they could but that was hard to do. QMA 13 indicated that the evenings were especially difficult, because many residents required showers, or have behaviors like sun-downing, and QMA 13

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indicated they needed more staff.

On 7/28/26 at 1:56 p.m., the ED provided a copy of current facility policy titled, "Elopement Policy," dated, 4/2026. The policy indicated, "The community is responsible for ensuring effective systems are in place to reduce the risk of residents wandering and becoming lost"

On 7/30/26 at 4:20 p.m., the ED provided a copy of current facility policy titled, "Staffing," dated 4/2026. The policy indicated, "Harmony Senior Services will provide a sufficient number of team members with adequate knowledge and skills to attain and maintain the physical, mental and psychosocial well-being of each resident as outlined in their individualized service plan ... Changes in the over-all number of associates being staffed will vary with the needs and service requirements (acuity) of the resident. This will be discussed at morning stand-up utilizing the daily communication log. The Executive Director / Healthcare Director or Designee will make the final decision as to the needs of the over-all community and in what department the staffing changes need to be made. The appropriate department leader will then

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	make the required adjustments to their schedules" Cross reference R52. This Residential Tag relates to Intake 471072.			
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. Based on observations, interviews, and record reviews, the facility failed to maintain a clean homelike environment in the memory care unit. This deficient practice had the potential to effect 15 of 15 residents who resided in the unit. Findings include: An anonymous complaint alleged that the building was filthy with bugs everywhere. On 7/28/26 at 3:00 p.m., the memory care unit was observed and the following was noted: A ceiling tile above the memory care entrance door was observed to have a large brown	R 0144	1. The Memory Care unit received a comprehensive deep cleaning. Dead insects, debris, cobwebs, and accumulated dust were removed. Damaged ceiling tiles were replaced or scheduled for replacement, and environmental concerns identified during survey were addressed. Pest control services were completed and scheduled for ongoing treatment. 2. This failed practice had the potential to affect all Memory Care residents. Environmental rounds were conducted throughout the building to identify and correct sanitation and maintenance concerns. 3. Housekeeping, maintenance, and department leaders were educated regarding environmental cleanliness standards, routine environmental inspections, pest	09/30/2026

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	ring stain, that appeared to be from water damage. Numerous dead bugs were observed on the floor inside the unlocked stairwell exit egress. Several dead bugs were observed on the floor outside of both double glass doors, one leading to the parking lot, the second leading to a patio area. The handrails throughout the unit were observed to have copious amounts of various and random debris built up on the dust ledge of the railings. Debris observed included, but were not limited to: clumps of hair, dead beetles/bugs, crumpled up straw papers, cobwebs in railing corners and food crumbs. There was a malodorous lingering mildew smell at the nurse's station and the carpet throughout the unit was observed to be thread bare in some area as well as darkened and stained in the highest traffic areas especially the front hallway, with various smaller spot-stains throughout. During an interview on 7/28/26 at 11:21 a.m., Certified Nursing Aide (CNA) 3 indicated the carpet around the nurses' station had gotten wet at some point and the smell was likely still being caused by that.		prevention measures, and timely maintenance repairs. 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. 5. Completion Date: September 30, 2026	
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	On 7/30/26 at 4:20 p.m., the Executive Director provided an e-mail statement, that the facility did not have a policy or procedure for maintaining a clean homeliness environment, but they followed the Indiana Residential Regulations. This citation relates to Intake 471072.			
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 record review and interview, the facility failed to evaluate a resident's individual needs after the resident eloped for 1 of 4 residents reviewed for service plans (Resident B). Findings include: Upon survey entrance on 7/28/26 at 9:30 a.m., documentation of the investigation for Resident B's elopement was requested. Documentation was not	R 0214	1. An assessment process was implemented to ensure residents experiencing elopement, significant changes in condition, or safety incidents receive timely nursing evaluations and service plan revisions. 2. All residents experiencing significant changes in condition, falls, elopements, wandering behaviors, or other safety concerns had the potential to be affected. A review was completed to verify evaluations and service plans accurately reflected current needs. 3. Licensed nurses received education regarding evaluation requirements, documentation standards, post-incident assessments, and care plan updates for changes in resident condition. 4. The HCD or designee will	09/30/2026

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provided until 7/28/26 at 2:00 p.m. and only one piece of paper titled, "Missing Resident Checklist," was provided. The Missing Resident Checklist indicated Resident B was noted missing at 5:00 p.m., on 7/20/26. The last time stamp on the checklist was 5:05 p.m. A handwritten note on the back of the Checklist indicated, "When staff was doing round for dinner resident was not found. A search was conducted, police notified, family [notified]. Resident was found after. Guest let resident out."

During an interview on 7/28/26 at 1:05 p.m., the ED indicated that when she arrived at the facility, Resident B had already been returned and had not been out of the building for more than 10 minutes. The ED was told by staff that another resident's family member had let the resident out, but she did not verify how the resident exited the building and staff did not know who had let her out. No head to toe assessment was completed when the resident returned because there was no Director of Nursing at the time, and she assumed the Emergency Medical Technicians (EMTs) had assessed the resident. She did not know what actions staff had taken following the elopement. She had not conducted an investigation that

audit resident evaluations completed following significant changes in condition weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months. Findings will be reviewed during Wellness meetings.

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	included interviews and visual assessment of the memory care unit. On 7/28/26 at 3:00 p.m., Resident B's record was reviewed. She admitted to the facility in February of 2026 and had a diagnosis which included, but was not limited to, dementia. Her most recent service plan was dated 4/4/26, but lacked review since her elopement, and did not include revisions or interventions for increased monitoring/supervision. A nursing progress note, dated 7/20/26 at 5:18 p.m., indicated, "Resident was reported by staff to be missing before diner time. Staff reported to writer that doors have been unlocked from thunder strike since last week. [Resident] was brought back by EMS to the building a few minutes after staff started searching for [resident]. Writer notified the ED and Maintenance Director who had both closed and left the community at the time. Writer notified daughter via phone call. [Resident] currently back in the community now eating diner."			
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	The last assessment completed was a Fall Risk Assessment dated April 2026, and there was no recent change of condition assessment, or Elopement assessment. During an interview on 7/28/26 at 3:25 p.m., CNA 13 indicated she had worked the day Resident B eloped. Resident B had seemed fine and had been in her room most of the day. When CNA 13 went to tell Resident B it was dinner time, she was not in her room. That was when they noticed she was missing and began to look. Shortly after, EMTs returned her to the facility and she seemed fine. They brought her back in and she went to the dining room to eat dinner. On 7/29/26 at 11:41 a.m., the ED provided a document titled, "Resident Assessment Policy," dated April 2026, and indicated it was the policy currently being used by the facility. The policy 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			
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	...associate ...upon admission, no more than 14 days prior to the resident's move into the community ...2. 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 R052. This citation relates to Intake 471072.			
R 0215	Evaluation - Deficiency 410 IAC 16.2-5-2(b) (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on observation, interview, and record review, the facility failed to conduct subsequent evaluations on a newly admitted resident to compare the resident's current status to her preadmission	R 0215	1. Resident C's assessment, service plan, cognitive status, and supervision needs were reviewed and updated to reflect current functioning and behaviors. 2. A review was conducted on newly admitted residents to ensure post-admission evaluations accurately reflected their current status compared to pre-admission assessments. 3. Licensed nurses and department leaders were educated regarding pre-admission assessments, admission assessments, ongoing	09/30/2026

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	baseline and assure the resident received appropriate care for 1 of 4 residents reviewed for service plans (Resident C). Findings include: On 7/28/26 at 10:04 a.m., Resident C was sitting at the nurse's station with Qualified Medication Aide (QMA) 11. QMA 11 indicated Resident C was sitting with her while QMA 11 completed charting. Resident C indicated she was just visiting the facility and did not live there. When asked if she would like to live at the facility, Resident C stated, "No." On 7/28/26 at 4:13 p.m., Resident C came into the dining room asking how she was supposed to get food early because she had to eat before she got picked up. She indicated, "He told me to eat beforehand." Resident F told her to go wait at the kitchen door or go to the other dining room because they served dinner first in the other room. She kept asking the same questions and could not follow directions to wait at the kitchen door. Two unidentified residents and the Receptionist were overheard talking about how Resident C needed to be in the memory care unit. Resident C's record was		evaluations, change in condition requirements, and documentation expectations. 4. The HCD or designee will audit all admissions and readmissions weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months to ensure assessments are completed timely, compared to baseline information, and care plans updated appropriately. Completion Date: September 30, 2026	
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reviewed on 7/28/26 at 3:01 p.m. The resident's only listed diagnosis was dementia (a decline in mental ability severe enough to interfere with daily life) in other diseases classified elsewhere.

A progress note, dated 7/24/26, indicated the resident was admitted to the facility and was disoriented, confused, trying to escape, and wandering. The resident was requesting information of a man that checked in with her and left. The resident wanted his name and number for a ride.

A progress note, dated 7/26/26 at 5:42 a.m., indicated the resident exhibited "continuous confusion" throughout the shift. The resident was observed wandering frequently, was redirected on multiple occasions, and assisted back to her room. The resident remained safe and was "monitored closely" for safety.

A progress note, dated 7/26/26 at 11:33 a.m., indicated the resident continued to wander throughout the unit and appeared confused and disoriented. The resident attempted to open exit doors and stated she wanted to go home. The staff redirected the resident from the exits and provided reassurance. The

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resident was escorted to a common area and engaged in conversation and calming activity. "Safety checks maintain." Resident "monitored closely" for wandering and exit seeking behavior. The provider and responsible party "will be" notified. The record lacked documentation anyone was notified of the resident's confusion.

A progress note, dated 7/27/26, indicated the resident was confused after dinner. Staff redirected the resident. "Safety checks" continued throughout the shift.

A progress note, dated 7/29/26 at 7:09 a.m., indicated the resident was reported missing around 5:00 a.m. The staff started looking for her around the building, but she was not found. The Administrator and the resident's family member were notified. The staff member called 911. "After a while" the resident was brought back to the facility by the police.

A progress note, dated 7/29/26 at 8:16 a.m., a progress note indicated the Director of Nursing (DON) received a call from the ED that the resident was unable to be located. Staff were instructed to continue to look for the resident, call 911, and call the resident's family member.

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The DON received an update from the ED, at 6:46 a.m., that the resident was found and was back in her apartment. The DON arrived at the facility and was informed the resident's family member was with her.

The record lacked documentation the resident's confusion, exit seeking, and wandering were addressed prior to the resident's elopement and lacked documentation the resident was assessed when she returned to the facility.

During an interview, on 7/29/26 at 9:00 a.m., QMA 11 indicated Resident C was very confused, and she was not sure why the resident was not on the Memory Care unit. The resident resided in the assisted living portion of the facility. The resident's family member was currently with her and planned to stay with her for now.

During an interview, on 7/29/26 at 9:15 a.m., Resident C's family member indicated the facility called him this morning and told him they could not find the resident. He was unable to understand what they meant on the phone, so he got up and headed to the facility. On the way, he called the resident's cell phone, and she answered. She told him she was in a car and headed back home. The car she

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was in was the police car. This occurred between 5:00 and 6:00 a.m. The resident often asked to talk to her mom and asked to go home. She had not tried to leave the property before that he was aware of. The family member indicated he wanted to try assisted living before memory care, but now she would be going to memory care once he talked to the doctor and got a physician's order. He was taking the resident to the doctor today. The family member indicated the resident was confused at baseline, but this was worse than usual. The last time the resident was like this she had a urinary tract infection (UTI). The family member was going to have the doctor check the resident for a UTI at the visit today. At the same time, the resident indicated she did not remember leaving the facility this morning, then later indicated she "fell in a lake." During the interview, the resident was unable to correctly identify her family member's identity.

During an interview, on 7/29/26 at 9:54 a.m., the DON indicated the resident possibly had a UTI, leading to increased confusion. They had noticed she was exit seeking and met with the resident's family member on Monday about the potential of moving to the Memory Care

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unit. They would have needed a physician's order to move her back to the unit. The DON was unable to provide documentation of the meeting or attempts to get an order to move the resident to the memory care unit. The DON indicated residents were assessed at least 30 days prior to their move-in date and should have been re-assessed at the move-in and again in 30 days.

During an interview, on 7/29/26 at 10:10 a.m., the Executive Director (ED) indicated the resident's family member came in today and took the resident to the doctor. When the resident returned from the doctor, the plan was for her to go to the memory care unit. If they were unable to get the physician's order for the resident to go to memory care, then the resident would have to have someone with her at all times. The ED indicated the process for the assessment of potential residents was being updated, and the DON was going to start doing the pre-admission assessments. Somewhere between the assessment, lease signing, and move-in something was missed with this resident.

On 7/29/26 at 11:41 a.m., the ED provided a document titled, "Resident Assessment Policy," dated April 2026, and indicated

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	it was the policy currently being used by the facility. The policy 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. 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" On 7/29/26 at 11:41 a.m., the Administrator provided a document titled, "Move-in (Admission) policy," dated April 2026, and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: Before moving in a resident to an assisted living community, individuals must meet certain criteria in order to be accepted for admission to the ...community ...Procedure: Move In/Admission: The community may accept and			
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	retain residents who meet the following criteria: 1. Can exhibit signs of confusion and forgetfulness, and behaviors can be managed through programmatic services. 2. Can exhibit wandering behaviors, but if elopement is a risk, behavior must be able to be managed through programmatic services. If behaviors are beyond our ability to manage through programming, resident may be issued a discharge notice ...5. Is not experiencing a behavior that would be harmful to self or others ...10. Cannot be a danger to self or others" Cross reference R0006 and R052. This citation relates to Intake 471072.			
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, interviews, and record review, the facility failed to ensure appropriate sanitation requirements were met by staff	R 0273	1. The kitchen and dining areas received an immediate deep cleaning. Dead insects, food debris, cobwebs, stained linens, and environmental concerns identified during survey were removed or replaced. Staff observed not following sanitation requirements received immediate corrective education. 2. This failed practice had the potential to affect all residents receiving food	09/30/2026

	in the kitchen and failed to ensure dining areas were thoroughly cleaned of spot stains and dead insects. This deficient practice had the potential to effect 56 of 56 residents who were served out of the kitchen. Findings include: On 7/28/26 at 4:14 p.m., the kitchen was observed related to resident complaints about food temperatures and infection control measures. Upon entrance into the kitchen, three staff were present. Hairnets were not observed in place, or appropriately placed to cover all hair: The Lead Cook, who wore a baseball cap that did not cover all his hair, as he leaned over the steam table of prepared food to test temperatures. Server 15 wore a hair net on top of her head, that did not cover all her hair. Server 18 was not observed with a hair net as he walked through the kitchen, around food service and preparation areas as he went about his routine activities. The kitchen floors throughout were observed to be littered with		service. Dining rooms, kitchen areas, storage areas, and food service practices were reviewed and corrected as necessary. 3. Dietary associates were educated regarding hand hygiene, proper handling of clean dishes and utensils, hair restraint requirements, sanitation expectations, meal service procedures, and infection control practices. 4. The Culinary Director or designee will conduct sanitation audits of food service and dining areas weekly for eight weeks, bi-weekly for eight weeks, and monthly for three months. Findings will be reviewed through Wellness meetings and corrective action taken as needed. 5. Completion Date: September 30, 2026	
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	various random debris such as food crumbs, paper wrappers, pieces of discarded plastic wrap etc. Server 15 failed to wash her hands before handling clean dishes and was observed as she picked up clean soup bowls by pinching the rims so that her thumb was inside the bowl. She held the stack of clean bowls with one arm against her person, so that the bowls came into direct contact with her potentially contaminated outer clothing. As the Lead Cook temped the food items on the steam table, several flying insects were observed. The Lead Cook indicated they flew from the dining room or from the back doors when they were opened for the food truck deliveries. On 7/28/26 at 4:05 p.m., Resident F showed the placements on the dining room tables and indicated they did not get cleaned after each meal, but the new clean silverware were placed directly onto the mats. He showed there was food under the table from after his lunch service and indicated they had not cleaned it despite dinner service getting ready to start. A dead beetle was observed on the floor next to a table in the main aisle of the			
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dining room.

On 7/29/26 at 10:29 a.m., Dietary Aide 20 indicated the placemats were cleaned in the kitchen at the end of the day. The dead beetle was observed still in the main aisle of the dining room next to a table.

On 7/29/26 at 2:05 p.m., Dining Room 1 was observed. There was a dead brown beetle on the floor directly beside a dining table and was not been swept up before survey exit.

There were a copious number of dead bugs observed when the patio door curtains were moved to the side, and every window sill was observed with dead bugs around the corners.

There were several cobwebs along the baseboards of the 90-degree angles.

There were several obvious stains throughout which would require spot cleaning which was not performed during the survey period.

On 7/29/26 at 2:10 p.m., Dining Room 2 was observed. A soup station table was observed to be covered with a fitted burgundy cloth. The cloths was badly stained, and previous spills were still visible across the table.

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	The 90-degree angle baseboard next to the soup table, an active cobweb was observed with a large spindly house spider. The egress of the double doors was observed to have a build up of dirt and debris including several dead insects. Every window sill had copious numbers of small dead bugs in the corners. While the table tops were observed to be neatly wiped and place setting prepared, under the tables and carpets throughout, various and random debris were noted which included, but were not limited to: a small broken off piece of a hamburger bun, a leaf of lettuce, pieces of shredded cheese, spill and stains on chair legs, a napkin stuck under a table leg. During an interview on 7/29/26 at 2:15 p.m., the Culinary Director indicated he started working a few months ago and inherited a lot of problems. He was working to fix as many problems as he could, but the kitchen was short-staffed, so it had been a slow process. The Culinary Director indicated that the staff he had needed to be re-trained to meet his standards, which included thorough deep cleanings of all dining areas.			
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During an interview on 7/29/26 at 2:26 p.m., the Regional Culinary Support indicated he had been in the building for several days and also noted several concerns which included but were not limited to: the kitchen being out of several frequently requested items, cleanliness of the kitchen and staffing needs. The Regional Culinary Director took action to order supplies and directed the staff to clean the kitchen. He indicated that hair nets should be worn at all times while in the kitchen to cover all hair and/or beards, and staff should not hold clean dishes against their soiled outer clothes.

On 7/30/26 at 4:20 p.m., the ED provided a copy of current facility policy titled, "Hair Restraints," dated 2020. The policy indicated, "Hair restraints shall be worn by all Dining Services staff when in food production areas, dishwashing areas, or when serving food.

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	On 7/30/26 at 4:20 p.m., the ED provided a copy of current facility policy titled, "Sanitation of Dining and Food Service Areas," dated 2020. The policy indicated, "The Dining Services staff will uphold sanitation of the dining areas according to a thorough, written schedule ... Staff will be held responsible for all cleaning tasks" On 7/30/26 at 4:20 p.m., the ED provided a copy of current facility policy titled, "Storing Utensils, Tableware, and Equipment," dated 2020. The policy indicated, "Employees will store utensils, tableware, and equipment according to the following guidelines ... Cleaned and sanitized equipment and utensils should be handled in a way that protects them from contamination. Spoons, knives and forks should be touched only by their handles. Cups, glasses, bowls, plates and similar items should be handled so as not to touch any surface that may come into contact with food or a resident's mouth" On 7/30/26 at 4:20 p.m., the ED provided a copy of current facility policy titled, "Cleaning Instructions: Floors," dated 2020. The policy indicated, "Floors will be kept clean and sanitary, washed daily or as needed ... Kitchen floors will be swept and cleaned after each			
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	meal"			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, record review, and interview, the facility failed to ensure unattended medications were securely stored in a locked area during 1 of 1 random observations (Resident E). Findings include: During an observation, on 7/28/26 at 11:35 a.m., the nurse's station outside of the unlocked Memory Care unit was unattended. During an observation, on 7/28/26 at 11:48 a.m., the nurses' station outside of the unlocked Memory Care unit remained unattended. A stack of medication cards was sitting in plain sight at the desk, with a rubber band and drug	R 0304	1. The medications identified during survey were immediately secured in the locked medication room. Medication storage practices were reviewed with all licensed staff and QMAs. 2. This failed practice had the potential to affect all residents receiving medication services. Medication storage areas and medication carts were audited to ensure compliance with storage requirements. 3. Nurses and QMAs received education on medication security, handling of discontinued medications, medication return procedures, and requirements for maintaining medications in locked storage when unattended. 4. The HCD or designee will conduct weekly audits of medication storage and security practices for eight weeks, bi-weekly for eight weeks, and monthly for three months. Results will be reviewed during Wellness meetings. 5. Completion Date:	09/30/2026

disposition sheet around it. The medications were for Resident E. The medication cards included the following medications.

-Celecoxib (anti-inflammatory medication) 100 milligrams (mg), 60 capsules

-Famotidine (antacid) 40 mg, 60 tablets

-Potassium (electrolyte supplement) 10 milliequivalents (mEq), 30 tablets

-Escitalopram (antidepressant) 10 mg, 30 tablets

-Atenolol (blood pressure medication) 50 mg, 30 tablets

-Atorvastatin (cholesterol medication) 10 mg, 30 tablets

-Magnesium gluconate (supplement) 250 mg, 30 tablets

-Vitamin D (supplement) 50 micrograms (mcg), 30 tablets

-Memantine (helps cognitive function) 10 mg, 60 tablets

-Tolterodine (treats overactive bladder) extended release (ER) 4 mg, 30 capsules

-Furosemide (diuretic) 20 mg, 30 tablets

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-Vitamin B-12 (supplement) 250 mcg, 60 tablets

-Aspirin enteric coated (EC) 81 mg, 30 tablets.

-Amlodipine (blood pressure medication) 5 mg, 30 tablets

On 7/28/26 at 11:55 a.m., Qualified Medication Aide (QMA) 11 returned to the nurses' station. At the same time, QMA 11 indicated she had been on break. The medications for Resident E were going to be sent back to the pharmacy because the resident had been discharged from the facility. The pharmacy usually picked up medication returns around 8:00 p.m., and the medications should have been stored in the locked medication room until then.

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FORM APPROVED

OMB NO. 0938-0391

On 7/29/26 at 11:41 a.m., the Administrator provided a document titled, "Medication Storage," dated December 2024, and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy Statement: It is the policy of the community to ensure that residents' medications are stored in a safe and secure manner ...Procedure ...c. All medications ...are secured in a locked medication cart, cabinet, or other area that is locked and only accessible to authorized team members"

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