STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT AVON	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 Intakes 470438, and 470642. Intake 470438 - State deficiencies related to the allegations are cited at R0041, R0052, R0090, and R357. Intake 470642 - State deficiencies related to the allegations are cited at R0041, R0052, R0090, and R357. Survey date: July 7, and 8, 2026 Facility number: 014959 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 22, 2026.	R 0000		
R 0041	Residents' Rights - Deficiency	R 0041		07/28/2026

	410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 7 of 7 months reviewed for grievance resolutions for the facility's grievance log (Resident B). This deficiency has the potential to affect 54 of 54 of residents who resided in the facility. Findings include, During an interview with Resident B's representative on 7/7/26 at 12:12 p.m., she indicated the resident had moved into an assisted living apartment in April 2026. On 5/23/26, the resident had a fall with hip fracture that required surgical repair and a short stay in a skilled nursing facility for rehabilitation. On 6/11/26, Resident B was moved back to			

	the facility and placed in a room on the secured memory care unit. The resident's representative informed staff upon arrival, the resident had severe diarrhea, and the Nurse Practitioner (NP) gave an order for Imodium (anti-diarrhea medication) and family were told the resident had received it. Resident B was observed by family via video surveillance repeatedly going to the bathroom, and the next day the Memory Care Coordinator/QMA 6 informed the resident's representative that Resident B had not received the Imodium. Staff were supposed to have checked on Resident B often as she was weak and had just returned from therapy, but the resident's family members were told that staff would only see the resident when administering her medications. On 6/12/26 at 1:17 a.m., Resident B was observed on video going to the bathroom and she was not seen again on the video until 7:34 a.m. when staff members were observed dragging her on the floor back to her bed. Resident B's representative indicated she had voiced concerns to staff members regarding her mother's care after she'd returned to the facility and needed more assistance with her care, and again on 6/12/26 after video footage showed her mother had fallen while going to			

	the bathroom and staff had not checked on her for hours, and management had denied her mother had fallen. Her concerns had not been answered. Resident B's clinical record was reviewed on 7/7/26 at 12:45 p.m. Diagnoses on Resident B's profile included Alzheimer's disease, generalized anxiety disorder, and status-post surgical repair of a femoral neck fracture (upper part of the femur - thigh bone). A progress note, dated 6/12/26 at 10:50 a.m., indicated Resident B had experienced rectal bleeding and loose stools. Hospice personnel were notified and had completed an assessment of the resident. Following the assessment, a new order was received for a change in the resident's morphine dosage. QMA 6 faxed the updated order to the preferred facility pharmacy for processing. Resident B's family expressed concerns regarding the resident's care. QMA 6 listened to and acknowledged the family's concerns, then notified Executive Director (ED) 7 and Director of Health Services (DHS) 8 of the family's concerns for awareness and follow-up as appropriate. During an interview on 7/8/26 at 9:03 a.m., ED 2 indicated she			

	had been unable to locate a grievance log or grievance intake/follow-up documentation for 2026. An attempt to reach out to ED 7, who had separated from employment with the facility on 6/26/26, had been unsuccessful. A binder in the ED's office labeled for grievance documentation, had last been updated in 2025. A facility Resident Rights and Complaint Procedures policy, dated 3/2022, indicated, "Prior to and upon admission, each resident and, if applicable, the resident's designated person, shall be informed of the resident's rights to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter ... 1. The community shall permit and respond to oral and written complaints from any source ...3. The community shall conduct an investigation and resolution of complaints ...4. Within two [2] business days after the submission of a written complaint, a status report shall be provided by the community to the complainant ...5. Within seven [7] days after the submission of a written complaint, the community shall give the complainant, the resident [and the resident's authorized representative if applicable] a written decision			

	explaining the investigation findings and the action the community shall take to resolve the complaint ...." Cross reference tag R52. This citation relates to Intakes 470438 and 470642.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from physical abuse when two Certified Nursing Aides (CNAs) dragged a resident across the floor then forcefully jerked her body multiple times while attempting to lift her off of the floor and position her on a bed for 1 of 1 residents reviewed for abuse (Resident B). The facility failed to protect the resident's	R 0052		07/28/2026

	right to be free from neglect when staff failed to check on a dementia resident throughout the night, assess a resident after a fall, and failed to provide medication as ordered after reports of diarrhea and a rectal bleed for 1 of 3 residents reviewed for neglect (Resident B). Findings include: An allegation during the survey process indicated, on 6/12/26, Resident B's representative witnessed a recorded video incident involving two facility employees (CNAs 10 and 11) responding after Resident B had fallen and was found on the bathroom floor. Staff had been observed using what appeared to be a sling device and were dragging Resident B across the floor to her bed. Resident B's representative indicated, she observed what she believed to be "rough and improper handling" and felt the resident "was moved in an inhumane, abrupt, and forceful manner, and the transfer onto the bed appeared uncontrolled and aggressive." After the incident, Resident B did not return to her prior level of responsiveness, she no longer engaged in meaningful conversation and only responded with sounds versus words, did not open her eyes in response to the			

	presence of others, and her condition declined rapidly. During an interview on 7/7/26 at 12:12 p.m., Resident B's representative indicated the resident had moved into an assisted living apartment in April 2026. On 5/23/26 she had a fall with hip fracture that required surgical repair and a short stay in a skilled facility for rehabilitation. On 6/11/26, Resident B was moved back to the facility and placed in a room on the secured memory care unit. The resident's representative informed staff upon arrival, the resident had severe diarrhea, and the Nurse Practitioner (NP) gave an order for Imodium (anti-diarrheal medication) and family was told the resident had received it. Resident B was observed by family via video surveillance repeatedly going to the bathroom, and the next day the Memory Care Coordinator/QMA 6 informed the resident's representative that Resident B had not received the Imodium. Family had requested the resident receive more assistance and staff were supposed to check on Resident B more often as she was weak and had just returned from therapy, but the resident's family members were told that staff would only see the resident when administering her			

	medications. Resident B's representative indicated video surveillance in the resident's room showed the resident repeatedly getting up by herself the day of and day after she had returned to the facility from a skilled nursing rehabilitation center. She assumed the resident fell at least twice on 6/12/26 since Resident B was seen crawling back to bed once and then being dragged back to bed by two CNAs. The representative was upset that she could see her mother crying and when she heard the 2 staff members laughing on the video as they were jerking the resident into bed and she hit her head on the headboard when being pulled up. Resident B's representative indicated although ED 7 and staff denied the resident had fallen on 6/12/26, starting on 6/14/26, ED 7 planned and paid for the resident to have a personal sitter every morning for 4 hours. The caregiver would help from 6:00 a.m. - 10:00 a.m. with bathing, dressing, hygiene assistance, toileting assistance, transfer assistance, and light housekeeping. Resident B's Representative provided the video surveillance in Resident B's room, dated 6/12/26. On 6/12/26 at 12:13 a.m., Resident B was seen going to the bathroom and then			

	she crawled back to bed at 1:04 a.m. The resident was next seen leaving the bed and walking towards the bathroom on 6/12/26 at 1:17 a.m., and there was no movement in the room until 6:55 a.m. when CNAs 10 and 11 were viewed walking into her room. There was no movement on the camera again until 6/12/26 at 7:34 a.m., when CNAs 10 and 11 were observed dragging Resident B across the floor back to her bed. on a blue mechanical lift pad that was positioned under her from her shoulders to above her knees, and the resident was holding up her own unsupported head. CNAs 10 and 11 were pulling the resident by using cloth straps that were attached on the ends of the pad, and the resident was seen grasping an upper strap with her right hand. Once stopped beside the bed, CNA 10 who was positioned at the resident's head dropped his straps to the floor, and CNA 11 who was positioned near the resident's legs, flung the straps onto the resident's lower abdomen/groin area. The video then skipped to a view of the resident being balanced in a supine position on the edge of the bed and grimacing as the staff members forcefully yanked on the straps multiple times which caused the resident's arms to flop outward and her head and body to jerk up and			

	down. Once the resident's upper body was near the center of the bed with her head positioned hyperextended backwards over a pillow, the two staff members yanked the straps several times to get her lower body and legs onto the bed. After the resident's body was positioned towards the center of the bed, she was left uncovered wearing only a nightgown that was bunched up above her waist, a soiled adult brief, and dark colored socks as staff were observed leaving the room. The last frame before the video ended was of the resident attempting unsuccessfully to pull the sides of a paper incontinence pad over her legs and position herself onto her left side. The staff members were heard mumbling, but the exact words could not be heard. Resident B's clinical record was reviewed on 7/7/26 at 12:45 p.m. Diagnoses on Resident B's profile included Alzheimer's disease, generalized anxiety disorder, and status-post surgical repair of a femoral neck fracture (upper part of the femur - thigh bone). A service plan for Resident B, dated 5/4/26, indicated the resident was independent with grooming and personal hygiene. She was at a moderate potential for falls and encouraged to use			

	the call light for assistance as needed. The resident was independent with emergency response and did not need assistance using the community response system. Resident B was dependent for medication administration, and the staff would administer or assist the resident with administration of all medications. The service plan was not updated after the resident returned to the facility on 6/11/26, to live in the secure memory care unit, where she required assistance and/or oversight with all activities of daily living. An Incident Type fall list, dated May, June, and July 2026, indicated Resident B was documented as having fallen on 5/24/26. The report did not reflect the 2 additional falls on 6/12/26, as the residents representative alleged seeing on the video surveillance in the resident's room. Physician's orders, undated paper orders from the resident's paper chart, indicated acetaminophen (pain medication) 650 milligrams (mg) insert 1 suppository as needed (prn) every 6 hours for pain or fever, bisacodyl (laxative) 10 mg insert 1 suppository prn once daily for constipation, and hyoscyamine (antispasmodic medication used to treat			

	gastrointestinal cramps, irritable bowel syndrome) 0.125 mg give 1 tab sublingual every 4 hours prn for secretions. Physician's orders, dated 6/11/26, indicated Seroquel (antipsychotic) 25 mg give 1 by mouth (po) at bedtime (HS) for agitation, Zofran (antiemetic medication used to prevent and treat nausea and vomiting) 4 mg give 1 po every 8 hours for nausea and vomiting, hydrocodone (pain medication for severe pain) 5-325 mg give 1 po every 6 hour prn for pain, Pyridium (prescription medication used to relieve lower urinary tract discomfort such as pain, burning, urgency, and frequency) 100 mg give 1 po three times a day (TID) for 2 days for bladder spasms, cephalexin (antibiotic) 500 mg give 1 po twice daily (BID) for 6 days for a urinary tract infection (UTI), Lorazepam (antianxiety medication) 1 mg give 1 po TID for anxiety, and Imodium (medication used to control symptoms of diarrhea) 1 mg give 2 tablets po one time, then give 1 tablet after each loose stool for a maximum of 4 tablets /24 hour for loose stools. Physician's orders dated 6/11/26, (no time documented), indicated admit to a local hospice group, (physician's name) will be attending,			

	discontinue all scheduled labs, therapy orders, radiology orders, do not hospitalize, and weight monthly. Call the hospice group with any needs, concerns, or changes in orders/condition. Oxygen at 2-4 liters (L) per nasal cannula (NC) prn. Vital signs on 6/11/26 at 4:12 p.m., indicated blood pressure 96/60, pulse 88, breathing rate 16, temperature 97.1 Fahrenheit (F), and oxygen saturation 97%. A progress note, dated 6/11/26 at 4:21 p.m., indicated Resident B was admitted to the unit upon her return from rehab. She was accompanied by family and hospice was available. The family reported the resident had been having loose stools, and an order for Imodium 2 mg was received. A progress note, dated 6/12/26 at 10:50 a.m., indicated Resident B had experienced rectal bleeding and loose stools. Hospice personnel were notified and had completed an assessment of the resident. Following the assessment, a new order was received for a change in the resident's morphine dosage. Qualified Medication Aide (QMA) 6 faxed the updated order to the preferred facility pharmacy for processing. Resident B's family expressed concerns regarding			

	the resident's care. QMA 6 listened to and acknowledged the family's concerns, then notified Executive Director (ED) 7 and Director of Health Services (DHS) 8 of the family's concerns for awareness and follow-up as appropriate. Physician's orders, dated 6/12/26, (no time documented), indicated morphine sulfate (narcotic pain reliever) 20 mg/ml give 0.25 ml po sublingual every 6 hours for pain/shortness of breath (SOB) and prn. A Medication Administration Record (MAR), dated June 2026, lacked documentation Imodium had been administered for loose stools. A progress note by QMA 12, dated 6/12/26 at 5:28 p.m., indicated "fall". The resident's record lacked additional information related to the fall. Vital signs on 6/13/26 at 10:05 p.m., indicated blood pressure 100/58, pulse 99, temperature 97.8 F, and oxygen saturations 95%. A progress note dated 6/14/26 at 7:24 a.m., indicated Resident B was restless and weak, and kept insisting on going to the bathroom. The resident was too weak to sit or stand and			

	required a mechanical lift. Resident B's clinical record lacked documentation that facility staff had monitored the resident's diarrhea or rectal bleeding or had treated her with Imodium per order for loose stools. There was no documentation to indicate where or when the resident had fallen on 6/12/26, was assessed by staff post fall, that a root cause had been determined, if she had an injury, that fall preventions were put into place, or that the MD/NP, hospice nurse, or resident representative were notified A progress note by QMA 9, dated 6/16/26 at 7:45 a.m., indicated she had received report that Resident B had passed on 6/15/26. Resident B's clinical record lacked documentation of circumstances of Resident B being found deceased on 6/15/26, or that the MD/NP, hospice nurse, or resident representative had been notified. Resident B's clinical file lacked hospice documentation during the record review. Attempts to contact the hospice nurse for interview during the survey were unsuccessful. A confidential interview during			

	the survey process indicated Resident B had been in a skilled nursing facility post-hospitalization for about 3 weeks where she received therapy after a fall with fracture. The resident had been highly functional although she was demented and needed supervision. She could be independent with transfers, wore pull-ups due to being incontinent of bladder and bowel, and would try to toilet herself as she did not remember to call for help. On 6/11/26, Resident B had required a shower before transferring back to the facility and it was assumed she had experienced an episode of diarrhea. During an interview on 7/7/26 at 1:07 p.m., the local County Coroner indicated after viewing video footage of Resident B's care on 6/12/26, he had concerns for neglect. He had subpoenaed medical records for Resident B's fall on 6/12/26 and was told by ED 7 that no nurse's notes or incident reports existed. The Coroner had requested that a statement be submitted that no fall reports existed, and he received the written statement. A second subpoena for documentation going back to 6/9/26 was requested regarding the resident's condition prior to the fall. Progress notes on 6/12/26			

	at 10:48 a.m., indicated the resident was experiencing diarrhea and rectal bleeding, and there was no documented follow up regarding the resident having severe diarrhea. An order had been given for Imodium, but no documentation that the medication had been administered. The initial autopsy showed the resident had an extensive GI bleed that contributed to her death, and there was no other diagnoses to contribute to her death.			

	During an interview on 7/8/26 at 2:21 p.m., ED 2 indicated she had started work in the facility on 6/29/26. On 7/6/26 she had found a subpoena from the coroner's office that had requested medical records for Resident B. On 7/7/26, the Regional Director of Operations told her he had been informed by ED 7 on 6/26/26 upon his departure that there was a video of concern for Resident B. ED 2 indicated she had been unable to find documentation to indicate the allegations of abuse and undignified care of Resident B had been investigated or reported. She had also not been able to find supporting documentation to justify the termination of CNAs 10 and 11. ED 2 indicated she had not inquired if corporate staff had been involved or completed the investigation.			

	Review of CNA 10's employee file included an acknowledgement where he signed and dated that he had received training regarding abuse and neglect. A Terminate Employee Event form, dated 6/12/26, indicated the termination was involuntary due to unsatisfactory job performance. A comment section indicated the employee was witnessed performing unsatisfactory work and undignified care to a resident. Review of CNA 11's employee file included an acknowledgement where she signed and dated that she had received training regarding abuse and neglect. A Terminate Employee Event form, dated 6/12/26, indicated the termination was involuntary due to unsatisfactory job performance. A comment section indicated the employee was witnessed performing unsatisfactory work and undignified care to a resident. During an interview on 7/8/26 at 11:53 a.m., the Operations Specialist indicated Resident B's hard chart was missing, and old closed out charts were stored and kept, they were not scanned into the Electronic Medical Record (EMR). The Operations Specialist indicated that some staff members were			

	more comfortable with handwritten charting versus electronic charting, and potentially additional documentation would have been available regarding monitoring of the resident's condition, fall follow up, and her death if the hard chart could have been found. Review of the EMR with ED 2 and the Operations Specialist, and there was no additional information available. On 7/8/26 at 1:05 p.m., ED 2 provided documentation for Resident B that she indicated had just been faxed from a local hospice provider. A skilled hospice nurse progress note, dated 6/12/26 at 8:54 a.m., indicated a facility nurse called and reported an episode with diarrhea with blood in stool. Facility staff stated the patient had fallen in the bathroom that morning. No injuries were seen upon assessment. The patient stated she was uncomfortable and dizzy. Patient also stated she "just wants to die." No meds had been given to the patient due to orders that had not been put in by the night nurse. The skilled hospice nurse requested the patient be given Imodium stat (immediately). New orders for Morphine 0.25 ml every 6 hours had been ordered. On 7/8/26 at 1:52 p.m., ED 2			

	provided a Falls Management/Head Injury Policy, dated 4/2026, and indicated the policy was not one currently being used by the facility. The policy indicated, residents have the potential to fall and therefore the facility has identified universal fall precautions applicable to residents. A witnessed or reported unwitnessed fall, with or without injury, is reported in the facility incident tracking system. Residents who fall should have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury. Notify the resident's physician/health care provider for evaluation, care, and treatment if indicated and document in the notes section. Notify the resident's family/responsible party and document in the notes section. Document the residents fall/injuries, resident response, and interventions taken on the notes section. Update the Service Plan as necessary. Falls are tracked and trended as a clinical indicator for quality improvement opportunities. On 7/8/26 at 1:38 p.m., ED 2 provided an Abuse, Neglect, Exploitation, Reporting, and Investigation policy, dated 4/2026, and indicated the policy was not one currently being			

	used by the facility. The policy indicated, "All reports of suspected abuse or neglect are promptly and thoroughly investigated by community leadership ...1. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain, or mental anguish; or deprivation by an individual, including a caregiver ...1. The Executive Director, Healthcare Director or designee is promptly notified of suspected abuse or incidents of abuse ...2. The following are notified of a suspected abuse incident: a. Residents Responsible Party/POA, b. Law Enforcement Officials if applicable, c. Residents Attending Physician, d. Regional Vice President of Operations, Regional Director of Clinical Services, Home office support team ...8. Should the investigation reveal that abuse occurred, the Executive Director reports the findings to the state licensing agency, and others as may be required by state and local laws within the required time frame. 9. The Executive Director provides a written report of the results of the investigation and action[s] taken to the state survey agency within the required time frame." On 7/8/26 at 12:52 p.m., ED 2 provided a Resident			

	Assessment Policy, dated 4/2026, and indicated the policy was not one currently being used by the facility. The policy indicated, "Residents should be assessed to determine the level of care and services needed or requested utilizing various systems and processes, including resident specific physician/healthcare orders. The assessment will be used to determine the appropriate level of care and individual needs of the resident for the assistance with bathing, dressing, grooming, medications, laundry, orientation, etc., and other requests by the resident and family/responsible party. Once service needs are determined, specifics of the service required and/or requested will be documented in the service plan ...." Cross reference R41, R90, and R357. This citation relates to Intakes 470438 and 470642.			
R 0090	Administration and Management - Deficiency 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:	R 0090		07/28/2026

	(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. (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 interview and record review, the facility failed to ensure a resident representative's allegation of abuse was documented, investigated, and reported to the Indiana Department of Health within 24 hours for 1 of 1 residents reviewed for abuse (Resident B). Findings include: An allegation during the survey process indicated, on 6/12/26, Resident B's representative witnessed a recorded video incident involving two facility employees responding after Resident B had fallen and was found on the bathroom floor. Staff had been observed using			

	what appeared to be a sling device and were dragging Resident B across the floor to her bed. Resident B's representative indicated, she observed what she believed to be "rough and improper handling" and felt the resident "was moved in an inhumane, abrupt, and forceful manner, and the transfer onto the bed appeared uncontrolled and aggressive." During an interview on 7/7/26 at 12:12 p.m., Resident B's representative indicated on 6/11/26, Resident B was moved back to the facility and placed in a room on the secured memory care unit. Family had requested the resident receive more assistance and staff were supposed to check on Resident B more often as she was weak and had just returned from therapy, but the resident's family members were told that staff would only see the resident when administering her medications. Resident B's representative indicated video surveillance in the resident's room showed the resident repeatedly getting up by herself the day of and day after she had returned to the facility from a skilled nursing rehabilitation center. She assumed the resident fell at least twice on 6/12/26 since Resident B was seen crawling back to bed once			

	and then being dragged back to bed by two CNAs. The representative was upset that she could see her mother crying and when she heard the 2 staff members laughing on the video as they were jerking the resident into bed and she hit her head on the headboard when being pulled up. Resident B's representative indicated although ED 7 and staff denied the resident had fallen on 6/12/26, starting on 6/14/26, ED 7 planned and paid for the resident to have a personal sitter every morning for 4 hours. The caregiver would help from 6:00 a.m. - 10:00 a.m. with bathing, dressing, hygiene assistance, toileting assistance, transfer assistance, and light housekeeping. The Indiana Department of Health on-line reporting system, dated June 2026, lacked documentation that allegations regarding Resident B had been reported. Resident B's clinical record was reviewed on 7/7/26 at 12:45 p.m. Diagnoses on Resident B's profile included Alzheimer's disease, generalized anxiety disorder, and status-post surgical repair of a femoral neck fracture (upper part of the femur - thigh bone). A progress note by QMA 12,			

	dated 6/12/26 at 5:28 p.m., indicated "fall". The resident's record lacked additional information related to the fall. Resident B's clinical record lacked documentation that family concerns for improper handling of the resident during care on 6/12/26 had been acknowledged, investigated, or reported. During an interview on 7/8/26 at 9:03 a.m., ED 2 indicated she had searched her office and been unable to locate any reportable incident files, reports for allegations of abuse, or abuse follow-up documentation for 2026. An attempt to reach out to ED 7, who had separated from employment with the facility on 6/26/26, had been unsuccessful.			

	Review of CNA 10's employee file included an acknowledgement where he signed and dated that he had received training regarding abuse and neglect. A Terminate Employee Event form, dated 6/12/26, indicated the termination was involuntary due to unsatisfactory job performance. A comment section indicated the employee was witnessed performing unsatisfactory work and undignified care to a resident. Review of CNA 11's employee file included an acknowledgement where she signed and dated that she had received training regarding abuse and neglect. A Terminate Employee Event form, dated 6/12/26, indicated the termination was involuntary due to unsatisfactory job performance. A comment section indicated the employee was witnessed performing unsatisfactory work and undignified care to a resident. On 7/8/26 at 1:05 p.m., ED 2 provided documentation for Resident B that she indicated had just been faxed from a local hospice provider. A skilled hospice nurse progress note, dated 6/12/26 at 8:54 a.m., indicated a facility nurse called and reported an episode with diarrhea with blood in stool.			

	Facility staff stated the patient had fallen in the bathroom that morning. No injuries were seen upon assessment. The patient stated she was uncomfortable and dizzy. Patient also stated she "just wants to die." No meds had been given to the patient due to orders that had not been put in by the night nurse. The skilled hospice nurse requested the patient be given Imodium stat (immediately). New orders for Morphine 0.25 ml every 6 hours had been ordered. Long-Term Care Abuse and Incident Reporting Policy, effective dates 12/8/22 - 12/8/23, indicated, "Rules Related to Abuse and Incident Reporting ...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 ...C. Types of Incidents reportable under state rules ...1. Abuse ...13. Mistreatment: Staff treating a resident inappropriately or exploiting a resident. Examples include but are not limited to rough treatment ..." On 7/8/26 at 1:38 p.m., ED 2 provided an Abuse, Neglect, Exploitation, Reporting and Investigation policy, dated			

	4/2026, and indicated the policy was the one currently being used by the facility. The policy indicated, "All reports of suspected abuse or neglect are promptly and thoroughly investigated by community leadership ...Reporting: 1. The Executive Director, Healthcare Director or designee is promptly notified of suspected abuse or incidents of abuse ...2. The following are notified of a suspected abuse incident: a. Residents Responsible Party/POA, b. Law Enforcement Officials if applicable, c. Residents Attending Physician, d. Regional Vice President of Operations, Regional Director of Clinical Services, Home office support team ...8. Should the investigation reveal that abuse occurred, the Executive Director reports the findings to the state licensing agency, and others as may be required by state and local laws within the required time frame. 9. The Executive Director provides a written report of the results of the investigation and action[s] taken to the state survey agency within the required time frame." Cross reference tag R52. This citation relates to Intakes 470438 and 470642.			
R 0357	Clinical Records - Noncompliance	R 0357		07/28/2026

410 IAC 16.2-5-8.1(j)(1-3)

(j) If a death occurs, information concerning the resident ' s death shall include the following:

(1) Notification of the physician, family, responsible person, and legal representative.

(2) The disposition of the body, personal possessions, and medications.

(3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death.

Based on interview and record review, the facility failed to document information concerning a resident's death for 1 of 3 residents reviewed for death (Resident B).

Findings include:

Resident B's clinical record was reviewed on 7/7/26 at 12:45 p.m. Diagnoses on Resident B's profile included Alzheimer's disease, generalized anxiety disorder, and status-post surgical repair of a femoral neck fracture (upper part of the femur - thigh bone).

A progress note by Qualified Medication Aide (QMA) 9, dated 6/16/26 at 7:45 a.m., indicated she had received report that Resident B had passed on

	6/15/26. Resident B's clinical record lacked documentation to indicate the date and time of the resident's death, disposition of the body, or that notifications had been made to the physician/Nurse Practitioner, resident representative, or hospice representative. During an interview on 7/7/26 at 12:12 p.m., Resident B's representative indicated the resident had died on 6/15/26 at approximately 9:35 a.m., and the family had been informed that morning by a hospice representative. There was no facility policy provided during the survey process regarding documentation of a resident's death. Executive Director (ED) 2 indicated the facility followed state and local laws. Cross reference R52. This citation relates to Incidents 470438 and 470642.			

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 SIGNATURE	TITLE	(X6) DATE