STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN OAKS OF VALPARAISO	2550 MORTHLAND DRIVE, VALPARAISO, , 46383

(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 465935. Intake 465935 - State deficiencies related to the allegations are cited at R0217. Unrelated deficiencies are cited. Survey date: February 2, 3, and 4, 2026 Facility number: 015426 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0028	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(c) (c) Residents have the right to exercise any or all of the enumerated rights without: (1) restraint;	R 0028	Plan of Correction 2/18/26 Facility ID: 015426 R028	03/04/2026

	(2) interference; (3) coercion; (4) discrimination; or (5) threat of reprisal; by the facility. These rights shall not be abrogated or changed in any instance, except that, when the resident has been adjudicated incompetent, the rights devolve to the resident ' s legal representative. When a resident is found by his or her physician to be medically incapable of understanding or exercising his or her rights, the rights may be exercised by the resident ' s legal representative. Based on record review and interview, the facility failed to ensure residents were able to exercise their rights without interference, coercion, discrimination or threat of reprisal related to intimidating behavior and verbal altercations with administrative staff (The Executive Director). This had the potential to affect all 110 residents residing in the facility. Finding includes: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of		1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1. 110 of 110 residents had potential to be affected by the unusual occurrence of the alleged incident. 2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** 1. All residents that reside in the community had the potential to be affected by the alleged deficient practice.All staff, in assisted living, including nursing, dietary, maintenance, housekeeping and administrative have since been in-serviced by the ED and/or Designee about our grievance process, how we report grievances and the follow up required. (Attachment A) 3. **What measures will be put into place or what systemic changes the**	

	which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were well-received or resolved and she continued to get multiple calls from residents with the same concerns. During a confidential interview, the person indicated, "they have monthly meetings and residents would have specific concerns that were written down and brought in by a staff member. The Executive Director (ED) would receive the concerns and make the remark that they [residents or staff] were just lying. During a confidential interview, the person indicated "a resident got into a screaming match in the hallway with a staff member,		**facility will make to ensure that the deficient practice does not recur:** 1. ED and/or DON or designee will thoroughly review grievance binder 5 times per week for 4 weeks, 1 time weekly for 2 months, bi-weekly for 3 months to ensure community is properly following up on ALL grievance concerns. 2. Regional Director of Operations/Regional Director of HR will connect with ED/DON or Designee on any NAVEX complaints brought forward by residents or staff. 3. Grievance Binder review will be added to QAPI process to ensure team is following up on all resident/staff grievances in a timely manner. 4. All residents that reside in the community will be educated on the grievance process, where to find them, how to fill them out, our expected follow-up time and how to address the situation if your	

	and when asked about it the resident just said it did not happen because they were scared of retaliation...Residents fill out grievances a lot, but nothing seems to get addressed. Both residents and the staff feel that way. Residents are too intimidated to say anything and some residents tell me they don't want to waste their time filing a grievance...Nothing gets addressed so I just try to solve it myself if I can..." During a confidential interview, the person indicated, "the ED has his window blacked out, he acts as if he is bothered if you need to talk to him for any reason. He's very intimidating and has made a comment to the staff that he leads by intimidation. A lot of the residents here won't say anything because they are afraid of getting kicked out. When residents have concerns and bring them to the ED he would be dismissive and tell them that their view was not the way it happened. The residents are not getting the respect that they deserve." During a confidential interview, the person indicated they had helped a resident fill out a grievance form and she followed up with the resident and it had never been addressed.		grievance isn't being handled. (Attachment B) 5. Residents and staff will be educated on the NAVEX concern hotline- direct path to corporate office to submit concerns if grievances at the site aren't being resolved. 6. ED will receive coaching and mentoring from Regional Director of Operations and Designees on Gallup Strengths, customer service and overall professional expectations. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** 1. ED and/or DON or designee will review grievance binder 5 times per week for 4 weeks, 1 time weekly for 2 months, bi-weekly for 3 months to ensure we are meeting expectations. Results to be reviewed at monthly QI meetings for 6 months and make further	

	"Residents do not feel comfortable." During an interview on 2/2/26 at 3:05 p.m., Resident B indicated there had been an incident with another resident recently. She had gone down to the room to play bingo and her hands were freezing. Resident E was nearby and heard her say that her hands were cold and so he told her to come over by him. She went over and he reached up, grabbed her hands, and pulled her hands to his crotch. She immediately pulled her hands away and said "don't you ever do that again." The resident indicated the resident was inappropriate with her and felt that the incident was sexual abuse. She talked to the activity lady and she told me to file a grievance form. Two nurses came to talk to me about it the next day. The resident indicated she also talked to a therapist and was told she needed to report the incident. The resident indicated the Executive Director had spoken to her approximately a week ago and asked how she was doing. He indicated to the resident that he had reported the incident to state and said that her reaction and her history caused the incident to be a bigger deal than it really was. The resident indicated she felt the Executive Director made it out to be all her		recommendations based on audit results. 5. **By what date will the systematic changes be completed** 1. Education and in-service will be provided to staff between now and concluding on _March 4, 2026_____.	

	fault. The resident was very upset by the Executive Director's reaction. During a confidential interview, the person indicated the ED had accused him of stealing money from a resident, however the resident denied anyone took anything from him. The ED and the resident's family member were going to retrieve video footage from the bank that he allegedly got the money from, which as far as they knew, the ED and family member never retrieved. The person talked to the ED about the situation and indicated he had told the ED, "as far as I'm concerned, let's call the police, let's make a report, why not. [ED] refused to make a police report for the incident." The person never heard anything about the incident until four to five months later. The person indicated, "[ED] was talking to me like I was a piece of s***. I said you got to do what you got to do and was leaving the office. He [ED] continued to yell at me to shut the door...I don't talk to him [ED] now. He's very rude to people. He pulls this intimidation thing on you...I go out to smoke and he yells at me, [Name] you smoking? You better follow the rules! He [ED] talks to you like you're a child...You can't feel heard, you just get cut off."			

	During a confidential interview, the person indicated they were treated like a child by the ED. They had a joke with the ED because of some items he owned that had references to drugs. The ED had called him the "facility druggie," which was a joke. However, he [ED] would yell that at the individual in the parking lot so other people would hear it and now other people are making comments accusing him of being a druggie. They indicated it was not a big deal to them at the time, it had started as a joke and then just has not stopped and has gone beyond a joke. During a confidential interview, the person indicated they felt the ED was trying to isolate her from her family. They felt they had been targeted for at least the last 3 months and did not understand why this was happening. They had a family member that would frequently visit and help her and other residents with things they needed around the apartment or go shopping for them. The person already has one person that was not allowed at the facility and the ED had been witnessed threatening that another family member "was next," meaning the ED was trying to find a reason to get another family member banned from the facility. They indicated,			

	"We have a housekeeper that comes and cleans. I was at lunch. 15 minutes after I returned, [ED] and [Staff Member] showed up in my apartment asking to look in my closet. Neither of them told me why they had just come in there to search my apartment." The person indicated they felt that the incident was an invasion of privacy and lack of respect. There had been another incident when the person, a resident, and family member were going to the store and the ED seemed to be following them. When they entered the parking lot, he arrived and was just watching them. They indicated, "I felt that he was stalking us. Lately, I don't come out of my room because I'm afraid I'll run into him...He harasses me all of the time about my family. I have considered moving out because he has no respect for us...[ED] just has this I don't care attitude...This has caused me to be fearful and apprehensive." During a confidential interview, the person indicated, "[ED] would not speak to me. He disparages my reputation to other people. I have never talked to him about it because you can't start a conversation with him because he just shuts it down."			

	During a confidential interview, the person indicated, "I was asleep in my recliner when [Staff] was standing at the foot of my recliner and told me to wake up. [ED] and [Staff] need to talk to you right now. [Staff] comes back and yells at me that we have to talk to you right now. The Business Office Manager took me by the shoulders and redirected me to the ED's office. We went in there and the ED proceeded to talk to me about whatever, I was being chastised about something..." They indicated, "I had been in the hospital with a respiratory infection and pneumonia and 3 days after I came back, two nurses were told by [ED] that they needed to do 2 hour checks on me to make sure that I was not smoking in my room. I have never smoked in my room...I have been on Chantix for 3 months and hardly smoke at all...He [ED] is hollering at me in the hallway and residents down the hall have heard it. Now I can't sleep at night because staff are always coming at my door. I am now on sleeping medication because of this. The man [ED] has never had a civil word to me...There's no accountability for any of the staff and no follow through for anything including by [ED]...He [ED] is always threatening to kick me out of here and is condescending to me... I			

	reported when someone tried to intentionally trip me twice and there was never any follow up with it...[Maintenance Director] was told to take all of my stuff down off the walls, but no one else had their stuff taken down. [Maintenance Director] told me he was instructed by [ED] to do it. I feel harassed and discriminated against...I have had dishes taken out of my room. The staff never filled out the grievance when I told them about it...I don't feel safe here. I'm anxious and fearful because of this." During a confidential interview, the person indicated she had been keeping a log of when staff members came into her apartment. They had asked [ED] about how often they were supposed to get checked on, to which he responded, twice a day. They showed the logs to the ED and he was dismissive about the situation and said that they were wrong and lying. They had filed a grievance related to the actions of a staff member in the facility. They indicated "it was a waste of paper."[ED] has raised his voice at me out in the front area when I was trying to talk to him about the kitchen always running out of food. His [ED] response was that it was the first time he had heard about this. We have had town hall meetings and food			

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	Based on record review and interview, the facility failed to ensure residents were able to exercise their rights without interference, coercion, discrimination or threat of reprisal related to intimidating behavior and verbal altercations with administrative staff (The Executive Director). This had the potential to affect all 110 residents residing in the facility. Finding includes: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were			

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	staff members came into her apartment. They had asked [ED] about how often they were supposed to get checked on, to which he responded, twice a day. They showed the logs to the ED and he was dismissive about the situation and said that they were wrong and lying. They had filed a grievance related to the actions of a staff member in the facility. They indicated "it was a waste of paper."[ED] has raised his voice at me out in the front area when I was trying to talk to him about the kitchen always running out of food. His [ED] response was that it was the first time he had heard about this. We have had town hall meetings and food management meetings that the ED was part of. His voice just kept creeping up. He talks down to people to scare or whatever he can get out of it. He [ED] tries to convince you that he's right...I feel like I'm fighting most of the time. Now I just stay in my apartment so that I don't get upset and argue with [ED]...I feel safe here 50/50, if I just stay in my apartment then it's fine..." A facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention", dated 7/2025, indicated "Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff			

	members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community..."			
R 0039	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(n) (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on record review and interview, the facility failed to provide residents with adequate responses to grievances without fear of reprisal or interference. This had the potential to affect all 110 residents residing in the facility. Findings include: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the	R 0039	Plan of Correction 2/18/26 Facility ID: 015426 R039 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** • 110 of 110 residents had potential to be affected by the unusual occurrence of the alleged incident. 2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** • All residents that reside in the community had the potential to be affected by the	03/04/2026

	facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were well-received or resolved and she continued to get multiple calls from residents with the same concerns. During a confidential interview, the person indicated, "they have monthly meetings and residents would have specific concerns that were written down and brought in by a staff member. The Executive Director (ED) would receive the concerns and make the remark that they [residents or staff] were just lying. Staff are able to fill out grievances too, but grievances are a joke they are never answered." During a confidential interview, the person indicated "residents fill out grievances a lot, but		alleged deficient practice.All grievances have been reviewed, and concerns have been addressed; education about overnight visits will be reviewed at the next resident town hall. 3. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** • ED and/or DON or designee will thoroughly review the Grievance process section during lease signing to ensure family and residents are understanding of this procedure. • All residents and staff will be educated on the grievance policy with emphasis on response time from management and there is no concern for reprisal and interference. Additionally, the training will include company policy on overnight visits allowed per year. (Attachment C) 4. **How the corrective action(s) will be monitored to ensure**	

	nothing seems to get addressed. Both residents and the staff feel that way. Residents are too intimidated to say anything and some residents tell me they don't want to waste their time filing a grievance...Nothing gets addressed so I just try to solve it myself if I can." During a confidential interview, the person indicated, "a lot of the residents here won't say anything because they are afraid of getting kicked out." When residents have concerns and bring them to the ED, he would be dismissive and tell them that their view was not the way it happened. The residents had started getting copies of their grievances because they were not being answered. The residents and staff both received the responses of "we'll work on it" and it never went anywhere. During a confidential interview, the person indicated they had helped a resident fill out a grievance form and she followed up with the resident and it had never been addressed. "Residents do not feel comfortable. We'll just deal with it because writing it down does nothing." During a confidential interview, the person indicated, "the		**the deficient practice will not recur, i.e. what quality assurance program will be put into place:** • ED and/or DON or designee will provide this education as part of any person-centered care concerns ongoing. Concerns will be addressed via one-on-one meetings with residents and family or during any care conferences going forward. Audits and compliance will be reviewed during monthly QAPI meetings for the next 6 months. 5. **By what date will the systematic changes be completed** 1. Education and in-service will be provided to staff between now and concluding on 3/4/26	

	residents are feeling demeaned and yell at. Staff in the community have witnessed the responses the residents receive back. The residents are uncomfortable. The grievances go to the Executive Director. He [ED] turns his back to residents. The grievances are ignored. The residents are ignored...He says I don't have time for this s***. Someone has a damaged item they are reporting, he ignores them. An incident related to sexual abuse was ignored. He [ED] did not want to report it because of the resident's history. He dismissed it. He was seen accusing a resident of being a drunk. I still hear and see a lot of residents saying nothing will get done if I talk to [ED]." During a confidential interview, the person indicated they had filed grievances in the past and they never received a response. They no longer felt that filing a grievance would go anywhere. They indicated, "You can't feel heard, he [ED] just cuts you off."			

	During a confidential interview, the person indicated the residents concerns are not addressed. If someone has a grievance, the [ED] would get very defensive about anything brought up, talk over you, and make you feel unheard. Filing a grievance did not go anywhere. During a confidential interview, the person indicated they were not comfortable around the Executive Director as he had never had a civil word to her. He was always threatening to kick them out and spoke very condescending to them. The ED never followed through on anything. I reported when someone tried to intentionally trip me twice and there was never any follow up with it. During a confidential interview, the person indicated they had filed a grievance two separate times in the last few months regarding missing items and one about staff. She felt she was being singled out. There was never any follow up with either of them. During a confidential interview, the person indicated she had been keeping a log of when staff members came into her apartment. They had asked [ED] about how often they were supposed to get checked on, to which he responded, twice a			

	day. They showed the logs to the ED and he was dismissive about the situation and said that they were wrong and lying. They had filed a grievance related to the actions of a staff member in the facility. They indicated "it was a waste of paper." They indicated that they have requested copies of grievances that they have filed before and received the reply, "I'll check into it," but never received all of the copies of the grievances. The grievances were never followed up on. They indicated, "there has been a couple of grievances I wanted to submit, but I figured what's the point anymore." A grievance log was requested on 2/2/26. There was a grievance filed on 11/9/25, 12/2/5, 12/22/25, and 1/5/26. The grievances were unrelated to anything discussed during the interviews. A facility policy titled, "Resident Grievance Policy and Procedure," indicated, "All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the			

	Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of Gardant Management Solutions., the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any corrective action taken. Such a report shall be provided within 10 days of the date of the Administrator's report. If the concern still has not been resolved, then the Director of Operations or President of Gardant Management Solutions shall convene a "mediating Committee", consisting of at least three of the facility residents. This committee shall evaluate the issue in question and recommend a non-binding resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will			

	produce these records for review by the HFS staff when requested..." Based on record review and interview, the facility failed to provide residents with adequate responses to grievances without fear of reprisal or interference. This had the potential to affect all 110 residents residing in the facility. Findings include: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were			

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	them that their view was not the way it happened. The residents had started getting copies of their grievances because they were not being answered. The residents and staff both received the responses of "we'll work on it" and it never went anywhere. During a confidential interview, the person indicated they had helped a resident fill out a grievance form and she followed up with the resident and it had never been addressed. "Residents do not feel comfortable. We'll just deal with it because writing it down does nothing." During a confidential interview, the person indicated, "the residents are feeling demeaned and yell at. Staff in the community have witnessed the responses the residents receive back. The residents are uncomfortable. The grievances go to the Executive Director. He [ED] turns his back to residents. The grievances are ignored. The residents are ignored...He says I don't have time for this s***. Someone has a damaged item they are reporting, he ignores them. An incident related to sexual abuse was ignored. He [ED] did not want to report it because of the resident's history. He dismissed it. He was seen accusing a			

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	A facility policy titled, "Resident Grievance Policy and Procedure," indicated, "All residents shall have the right to voice concerns and/or complaints which affect their lives at the facility without fear of discrimination or reprisal. Resident concerns and/or complaints should be presented to the appropriate management staff member. The appropriate department head will initiate the Resident Grievance Form. Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint. If such action is not satisfactory to the affected Resident, the Regional Director of Gardant Management Solutions., the management company of the facility, shall further investigate the issue and shall provide the Resident with a written report of his/her analysis and any corrective action taken. Such a report shall be provided within 10 days of the date of the Administrator's report. If the concern still has not been resolved, then the Director of Operations or President of Gardant Management Solutions			

	shall convene a "mediating Committee", consisting of at least three of the facility residents. This committee shall evaluate the issue in question and recommend a non-binding resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested..."			
R 0041	Residents' Rights - Deficiency 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 record review and interview, the facility failed to implement their policies for investigating and responding to complaints and grievances by	R 0041	Plan of Correction 2/18/26 Facility ID: 015426 R041 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1. 110 of 110 residents had potential to be affected by the unusual occurrence of the alleged incident. 2. **How the facility will identify other residents having the potential to be affected by the same**	03/04/2026

	residents. This had the potential to affect all 110 residents residing in the facility. Findings include: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were well-received or resolved and she continued to get multiple calls from residents with the same concerns. During a confidential interview, the person indicated, "they have monthly meetings and residents would have specific concerns		**deficient practice and what corrective will be taken** 1. ED and/or DON or designee will review grievance binder for potential reportable incidents. Grievances deemed reportable will be submitted to the ISDH website in accordance with ISDH reporting guidelines. 2. Community will request regular check ins from the Area Ombudsman to ensure communication is frequent and trust is rebuilt between the Ombudsman, the community and the residents. 3. All residents that reside in the community as well as staff had the potential to be affected by the alleged deficient practice. 3. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 1. All residents and staff will be educated on our policies and procedures in dealing with resident	

	that were written down and brought in by a staff member. The Executive Director (ED) would receive the concerns and make the remark that they [residents or staff] were just lying. Staff are able to fill out grievances too, but grievances are a joke they are never answered." During a confidential interview, the person indicated "residents fill out grievances a lot, but nothing seems to get addressed. Both residents and the staff feel that way. Residents are too intimidated to say anything and some residents tell me they don't want to waste their time filing a grievance...Nothing gets addressed so I just try to solve it myself if I can."		grievance and completing investigations into concerns to ensure overall understanding of the steps. 2. Staff will be educated on the ISDH Reporting guidelines and expectations around what to report and the timeliness of those reports to meet ISDH guidelines. 3. All staff will be educated on the role of the ombudsman as a resident advocate, including where to find their contact information if it is requested by residents or family members.(Attachment D) 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** 1. ED and/or DON or designee will review the grievance binder 5 days per week for reportable incidents for 4 weeks, Weekly for 2 months and monthly for 3 months. Staff and residents will also be educated	

	During a confidential interview, the person indicated, "a lot of the residents here won't say anything because they are afraid of getting kicked out." When residents have concerns and bring them to the ED, he would be dismissive and tell them that their view was not the way it happened. The residents had started getting copies of their grievances because they were not being answered. The residents and staff both received the responses of "we'll work on it" and it never went anywhere. During a confidential interview, the person indicated they had helped a resident fill out a grievance form and she followed up with the resident and it had never been addressed. "Residents do not feel comfortable. We'll just deal with it because writing it down does nothing." During a confidential interview, the person indicated, "the residents are feeling demeaned and yell at. Staff in the community have witnessed the responses the residents receive back. The residents are uncomfortable. The grievances go to the Executive Director. He [ED] turns his back to residents. The grievances are ignored. The residents are ignored...He says I don't have time for this		to notify leadership as needed per grievance or potential reportable incident. (Attachment E) Audits will be reviewed at monthly QAPI meetings and make recommendations as necessary. 2. ED will initiate bi-weekly checks for 6 months with the ombudsman to be proactive in working through any upcoming and ongoing concerns. 5. **By what date will the systematic changes be completed** 1. Education and in-service will be provided to staff between now and concluding on ___March 4, 2026_____.	

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	and recommend a non-binding resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested..." Based on record review and interview, the facility failed to implement their policies for investigating and responding to complaints and grievances by residents. This had the potential to affect all 110 residents residing in the facility. Findings include: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had			

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	During a confidential interview, the person indicated she had been keeping a log of when staff members came into her apartment. They had asked [ED] about how often they were supposed to get checked on, to which he responded, twice a day. They showed the logs to the ED and he was dismissive about the situation and said that they were wrong and lying. They had filed a grievance related to the actions of a staff member in the facility. They indicated "it was a waste of paper." They indicated that they have requested copies of grievances that they have filed before and received the reply, "I'll check into it," but never received all of the copies of the grievances. The grievances were never followed up on. They indicated, "there has been a couple of grievances I wanted to submit, but I figured what's the point anymore." A grievance log was requested on 2/2/26. There was a grievance filed on 11/9/25, 12/2/5, 12/22/25, and 1/5/26. The grievances were unrelated to anything discussed during the interviews. A facility policy titled, "Resident Grievance Policy and Procedure," indicated, "All residents shall have the right to voice concerns and/or			

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	and recommend a non-binding resolution to the Resident and the facility management staff. The facility Administrator will be responsible for maintaining records pertaining to Resident Grievances filed within the facility. The Administrator will produce these records for review by the HFS staff when requested..."			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to protect residents' rights to be free from verbal abuse related to ongoing verbal abuse and intimidation by a staff member (the Executive Director (ED)) towards residents, which resulted in residents being fearful, feeling unsafe, anxious, apprehensive, and secluding themselves to their apartments. This had the potential to affect all 110 residents residing in the facility. Finding includes: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times	R 0053	Plan of Correction 2/19/26 Facility ID: 015426 R053 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1. 110 of 110 residents had potential to be affected by the unusual occurrence of the alleged incident. 2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** 1. All residents that reside in the	03/04/2026

	from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were well-received or resolved and she continued to get multiple calls from residents with the same concerns. During a confidential interview, the person indicated "a resident got into a screaming match in the hallway with a staff member, and when asked about it the resident just said it did not happen because they were scared of retaliation...Residents fill out grievances a lot, but nothing seems to get addressed. Both residents and the staff feel that way. Residents are too intimidated to say anything and some		community as well as staff had the potential to be affected by the alleged deficient practice.All residents and staff will be educated on our policies and procedures concerning verbal abuse, reporting abuse, and ensuring safety of residents. 3. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 1. ED and/or DON or designee will conduct education for all staff and residents about abuse in a semi-annual training and as needed. 2. ED will complete 6 months of ongoing training and personalized coaching to improve his ability to lead the community both in a safe and heathy way for all staff and residents. Training will be signed off on and completed monthly for 6 months, then ongoing as needed. 3. Executive Director will complete coaching to improve his ability to	

	residents tell me they don't want to waste their time filing a grievance...Nothing gets addressed so I just try to solve it myself if I can..." During a confidential interview, the person indicated, "the residents are feeling demeaned and yelled at. Staff in the community have witnessed the responses the residents receive back from the ED. The residents are uncomfortable. He was seen accusing and berating a resident of being a drunk. I still hear and see a lot of residents saying nothing will get done if I talk to [ED]." During a confidential interview, the person indicated, "He's [the ED] very rude to people. He pulls this intimidation thing on you...I go out to smoke and he yells at me, [Name] you smoking? You better follow the rules! He [ED] talks to you like you're a child...You can't feel heard, you just get cut off." During a confidential interview, the person indicated the residents' concerns are not addressed. If someone has a grievance, the [ED] would get very defensive about anything brought up, talk over you, and make you feel unheard. Filing a grievance did not go anywhere. The ED had been witnessed being unruly towards guests and		lead the community staff and residents, while creating a safe and healthy environment. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** 1. ED and/or DON or designee will ensure education of all staff and residents educated on abuse. (Attachment F) 2. Regional Director of Operations, or designee will complete and sign off on education with Executive Director monthly for six months with an emphasis on improving his leadership at the site to create a safe and healthy atmosphere. Education provided ongoing as needed. 5. **By what date will the systematic changes be completed** 1. Education and in-service will be provided to staff	

	residents in the facility. During a confidential interview, the person indicated, "I was asleep in my recliner when [Staff] was standing at the foot of my recliner and told me to wake up. [ED] and [Staff] need to talk to you right now. [Staff] comes back and yells at me that we have to talk to you right now. The Business Office Manager took me by the shoulders and redirected me to the ED's office. We went in there and the ED proceeded to talk to me about whatever, I was being chastised about something..." They indicated, "I had been in the hospital with a respiratory infection and pneumonia and 3 days after I came back, two nurses were told by [ED] that they needed to do 2 hour checks on me to make sure that I was not smoking in my room. I have never smoked in my room...I have been on Chantix for 3 months and hardly smoke at all...He [ED] is hollering at me in the hallway and residents down the hall have heard it. Now I can't sleep at night because staff are always coming at my door. I am now on sleeping medication because of this. The man [ED] has never had a civil word to me...There's no accountability for any of the staff and no follow through for anything including by [ED]...He [ED] is always threatening to		between now and concluding on _March 4, 2026_____.	

	kick me out of here and is condescending to me... I reported when someone tried to intentionally trip me twice and there was never any follow up with it...[Maintenance Director] was told to take all of my stuff down off the walls, but no one else had their stuff taken down. [Maintenance Director] told me he was instructed by [ED] to do it. I feel harassed and discriminated against...I have had dishes taken out of my room. The staff never filled out the grievance when I told them about it...I don't feel safe here. I'm anxious and fearful because of this." During a confidential interview, the person indicated she had been keeping a log of when staff members came into her apartment. They had asked [ED] about how often they were supposed to get checked on, to which he responded, twice a day. They showed the logs to the ED and he was dismissive about the situation and said that they were wrong and lying. They had filed a grievance related to the actions of a staff member in the facility. They indicated "it was a waste of paper." They indicated that they have requested copies of grievances that they have filed before and received the reply, "I'll check into it," but never received all of the copies of the grievances.			

	The grievances were never followed up on. They indicated, "there has been a couple of grievances I wanted to submit, but I figured what's the point anymore... [ED] has raised his voice at me out in the front area when I was trying to talk to him about the kitchen always running out of food. His [ED] response was that it was the first time he had heard about this. We have had town hall meetings and food management meetings that the ED was part of. His voice just kept creeping up. He talks down to people to scare or whatever he can get out of it. He [ED] tries to convince you that he's right...I feel like I'm fighting most of the time. Now I just stay in my apartment so that I don't get upset and argue with [ED]...I feel safe here 50/50, if I just stay in my apartment then it's fine..." On 2/4/26 at 8:09 a.m., the Regional Director of Operations was notified of the allegations of verbal abuse and intimidation by the administrator towards residents and indicated he was unable to take notes at the time. A follow-up call was made to the Regional Director of Operations on 2/4/26 at 9:00 a.m. He indicated he was having a meeting with his supervisiors to determine the next course of action. The ED was still			

	currently at the facility. On 2/4/26 at 10:36 a.m., the Director of Nursing indicated the Executive Director had just left the building and to direct any questions to her at that time. A list of reportables and grievances was requested on 2/2/26. There were no reportables or grievances related to staff-to-resident abuse or mistreatment in the last 3 months. A facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention", dated 7/2025, indicated "Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...PREVENTION, TRAINING, AND IDENTIFICATION...The community will make every effort to prevent abuse, neglect, or financial exploitative staff behavior through staff training. In-service education for staff will be provided at the time of hire and every six months thereafter. The educational material will include, but not be limited to,			

	general information, information on defining behaviors, identification of behaviors, procedures for reporting incidents, and ramifications...REPORTING...It is mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their Department Manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manger will immediately inform the Executive Director. Once an allegation of abuse has been reported, the accused individual will be immediately removed from the community and suspended pending the outcome of the investigation...INVESTIGATION ...The Department Manger along with the Executive Director will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Executive Director. Documentation of the investigation will be maintained by the Executive Director. The community will suspend staff involved in the incident pending provider investigation. It is required that the Executive			

	Director report the reported incident to the applicable Adult Protective Services...The Indiana Department of Health will be notified..." Based on record review and interview, the facility failed to protect residents' rights to be free from verbal abuse related to ongoing verbal abuse and intimidation by a staff member (the Executive Director (ED)) towards residents, which resulted in residents being fearful, feeling unsafe, anxious, apprehensive, and secluding themselves to their apartments. This had the potential to affect all 110 residents residing in the facility. Finding includes: During a telephone interview on 2/2/26 at 9:34 a.m., the Ombudsman indicated she had been contacted over 90 times from various residents regarding concerns in the facility, some of which included the mistreatment of residents by the staff at the facility. There were grievances that were going unheard. It was also reported that the grievances were being shredded. The ED was being aggressive with the female residents and he was not reporting abuse after multiple female residents had complained of a male resident's			

	actions. Residents had complaints of the ED targeting residents and trying to keep residents' families away with no reason as to why. He was observed yelling at residents. A meeting was held with administration, she did not feel her concerns for residents were well-received or resolved and she continued to get multiple calls from residents with the same concerns. During a confidential interview, the person indicated "a resident got into a screaming match in the hallway with a staff member, and when asked about it the resident just said it did not happen because they were scared of retaliation...Residents fill out grievances a lot, but nothing seems to get addressed. Both residents and the staff feel that way. Residents are too intimidated to say anything and some residents tell me they don't want to waste their time filing a grievance...Nothing gets addressed so I just try to solve it myself if I can..." During a confidential interview, the person indicated, "the residents are feeling demeaned and yelled at. Staff in the community have witnessed the responses the residents receive back from the ED. The residents are uncomfortable. He was seen			

	accusing and berating a resident of being a drunk. I still hear and see a lot of residents saying nothing will get done if I talk to [ED]." During a confidential interview, the person indicated, "He's [the ED] very rude to people. He pulls this intimidation thing on you...I go out to smoke and he yells at me, [Name] you smoking? You better follow the rules! He [ED] talks to you like you're a child...You can't feel heard, you just get cut off." During a confidential interview, the person indicated the residents' concerns are not addressed. If someone has a grievance, the [ED] would get very defensive about anything brought up, talk over you, and make you feel unheard. Filing a grievance did not go anywhere. The ED had been witnessed being unruly towards guests and residents in the facility. During a confidential interview, the person indicated, "I was asleep in my recliner when [Staff] was standing at the foot of my recliner and told me to wake up. [ED] and [Staff] need to talk to you right now. [Staff] comes back and yells at me that we have to talk to you right now. The Business Office Manager took me by the shoulders and redirected me to the ED's office.			

	We went in there and the ED proceeded to talk to me about whatever, I was being chastised about something..." They indicated, "I had been in the hospital with a respiratory infection and pneumonia and 3 days after I came back, two nurses were told by [ED] that they needed to do 2 hour checks on me to make sure that I was not smoking in my room. I have never smoked in my room...I have been on Chantix for 3 months and hardly smoke at all...He [ED] is hollering at me in the hallway and residents down the hall have heard it. Now I can't sleep at night because staff are always coming at my door. I am now on sleeping medication because of this. The man [ED] has never had a civil word to me...There's no accountability for any of the staff and no follow through for anything including by [ED]...He [ED] is always threatening to kick me out of here and is condescending to me... I reported when someone tried to intentionally trip me twice and there was never any follow up with it...[Maintenance Director] was told to take all of my stuff down off the walls, but no one else had their stuff taken down. [Maintenance Director] told me he was instructed by [ED] to do it. I feel harassed and discriminated against...I have had dishes taken out of my			

	room. The staff never filled out the grievance when I told them about it...I don't feel safe here. I'm anxious and fearful because of this." During a confidential interview, the person indicated she had been keeping a log of when staff members came into her apartment. They had asked [ED] about how often they were supposed to get checked on, to which he responded, twice a day. They showed the logs to the ED and he was dismissive about the situation and said that they were wrong and lying. They had filed a grievance related to the actions of a staff member in the facility. They indicated "it was a waste of paper." They indicated that they have requested copies of grievances that they have filed before and received the reply, "I'll check into it," but never received all of the copies of the grievances. The grievances were never followed up on. They indicated, "there has been a couple of grievances I wanted to submit, but I figured what's the point anymore... [ED] has raised his voice at me out in the front area when I was trying to talk to him about the kitchen always running out of food. His [ED] response was the first time he had heard about this. We have had town hall meetings and food management			

	meetings that the ED was part of. His voice just kept creeping up. He talks down to people to scare or whatever he can get out of it. He [ED] tries to convince you that he's right...I feel like I'm fighting most of the time. Now I just stay in my apartment so that I don't get upset and argue with [ED]...I feel safe here 50/50, if I just stay in my apartment then it's fine..." On 2/4/26 at 8:09 a.m., the Regional Director of Operations was notified of the allegations of verbal abuse and intimidation by the administrator towards residents and indicated he was unable to take notes at the time. A follow-up call was made to the Regional Director of Operations on 2/4/26 at 9:00 a.m. He indicated he was having a meeting with his supervisiors to determine the next course of action. The ED was still currently at the facility. On 2/4/26 at 10:36 a.m., the Director of Nursing indicated the Executive Director had just left the building and to direct any questions to her at that time. A list of reportables and grievances was requested on 2/2/26. There were no reportables or grievances related to staff-to-resident abuse or mistreatment in the last 3			

	months. A facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention", dated 7/2025, indicated "Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times. Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...PREVENTION, TRAINING, AND IDENTIFICATION...The community will make every effort to prevent abuse, neglect, or financial exploitative staff behavior through staff training. In-service education for staff will be provided at the time of hire and every six months thereafter. The educational material will include, but not be limited to, general information, information on defining behaviors, identification of behaviors, procedures for reporting incidents, and ramifications...REPORTING...It is mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their Department Manager. Documentation will be initiated			

	by the Department Manager at the time of the initial report. The Department Manger will immediately inform the Executive Director. Once an allegation of abuse has been reported, the accused individual will be immediately removed from the community and suspended pending the outcome of the investigation...INVESTIGATION ...The Department Manger along with the Executive Director will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Executive Director. Documentation of the investigation will be maintained by the Executive Director. The community will suspend staff involved in the incident pending provider investigation. It is required that the Executive Director report the reported incident to the applicable Adult Protective Services...The Indiana Department of Health will be notified..."			
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	R 0090	Plan of Correction 2/19/26 Facility ID: 015426	03/04/2026

	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. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:		R090 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 1. 110 of 110 residents had potential to be affected by the unusual occurrence of the alleged incident. 2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** 1. All residents that reside in the community had the potential to be affected by the alleged deficient practice.All staff, in assisted living, including nursing, dietary, maintenance, housekeeping and administrative have since been in-serviced by the ED and DON regarding Resident Rights and Abuse and Neglect as well as, reporting alleged abuse and neglect. 3. **What measures will be**	

	(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 record review and interview, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) timely for 1 of 1 resident reviewed for abuse. (Resident B) Finding includes: A Facility Reported Incident, dated 1/13/26 at 5:01 p.m., indicated Resident E had touched Resident B inappropriately during an activity. The investigation was ongoing. There were no injuries. Resident E was advised to stay away from Resident B. The		**put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** 1. ED and/or DON or designee will thoroughly investigate each report or suspicion of abuse. The ED and/or DON or designee will interview, at a minimum, 3 residents, 3 staff. All residents and staff will be educated to alert the ED and/or DON to any potential abuse or neglect. (Attachment G) 2. Audits will be completed to confirm all areas including abuse and neglect are being reported timely according to ISDH guidelines. Audits will be completed weekly for one month, bi-weekly for 2 month and then monthly for 3 months. (Attachment H) 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what**	

	Executive Director (ED) also reminded Resident E of the community code of conduct. The ED was interviewing staff and residents who were present at the event. Resident B alleging the inappropriate incident refused to have the police contacted or to press charges. Both residents would be monitored in activities and advised not to participate in the same activities at the same time. Resident E insisted that the incident did not occur. The family, Director of Nursing and the ED were notified. Both of the residents were monitored for signs and symptoms of distress and their services plans were to be updated as needed. The Follow up was added on 1/22/26, which indicated Resident B alleged Resident E touched her inappropriately during an activity. Resident E was advised to stay away from Resident B. The ED also reminded Resident E of the community code of conduct. The ED was interviewing staff and residents who were present at the event. Resident B alleging the inappropriate incident refused to have the police contacted or to press charges. Resident E insists that the that the incident did not occur. The family, Director of Nursing and ED were notified. Resident E stated, "we were in		**quality assurance program will be put into place:** 1. ED and/or DON or designee will review training platform to ensure all Residents Rights and Abuse training are completed upon hire and during semi-annual training ongoing thereafter. Audits to be reviewed at monthly QI meetings for 6 months and make further recommendations based on audit results. 5. **By what date will the systematic changes be completed** 1. Education and in-service will be provided to staff between now and concluding on __March 4, 2026_____.	

	the activities room before bingo, and she stated that her hands were cold. I replied, "I know a place where you can warm them up. I never tried to force or move her hands from the table towards my crotch. She pulled her hand away and slapped me in the back of the head. The next day I apologized for what I said and she accepted my apology. We were even sitting in the hall talking after this incident because she locked herself out of her apartment and I was waiting with her until someone came to let her in." Resident E acknowledged that his comment was inappropriate and ED educated him on the community conduct policy. Resident B did not want to contact the police and said, "the interaction between us brought up old memories from childhood. I pulled my hand away and slapped him in the back of the head." Interviews were conducted from other residents that were in the activities room and there was no report of any inappropriate behavior between the two residents. Resident B confirmed that Resident E apologized and she felt safe and had no other concerns. Both resident were to be monitored in activities and advised not to participate in the same activities at the same time.			

	During an interview on 2/2/26 at 3:05 p.m., Resident B indicated there had been an incident with another resident recently. She had gone down to the room to play bingo and her hands were freezing. Resident E was nearby and heard her say that her hands were cold and so he told her to come over by him. She went over and he reached up, grabbed her hands, and pulled her hands to his crotch. She immediately pulled her hands away and said "don't you ever do that again." The resident indicated the resident was inappropriate with her and felt that the incident was sexual abuse. I talked to the activity lady and she told me to file a grievance form. Two nurses came to talk to me about it the next day. The resident indicated she also talked to a therapist and was told she needed to report the incident. The resident indicated the Executive Director had spoke to her approximately a week ago and asked how she was doing. He indicated to the resident that he had reported the incident to state and said that her reaction and her history caused the incident to be a bigger deal than it really was. The resident indicated she felt the Executive Director made it out to be all her fault. The resident was very upset by the Executive Director's reaction.			

	Resident B's record was reviewed on 2/2/26 at 10:53 a.m. Diagnoses included, but were not limited to, anxiety and depression. Resident B's Service Plan, dated 1/27/26, indicated the resident was cognitively intact. A Progress Note, dated 1/7/26 at 2:05 p.m., indicated [Psychiatry Services] reported to the nurse a claim of sexual harassment. Resident B indicated on Monday, 1/5/26 at approximately 3:00 p.m., she was in the activity room with other community members and stated out loud that her hands were cold. Another community member stated "[Resident B] come over here." The other resident pulled her hands down to his penis. Resident B yanked her hands away and smacked the back of his head making his hat fall off and said "Don't ever touch me like that." She then walked away. The resident stated that she had avoided the resident since, but has ran into him. The other resident had apologized for the incident, but Resident B felt victimized. Resident B indicated she had informed the Activity Director on 1/6/26, who recommended filling out a grievance towards the other resident. Resident B was visibly upset. [Psychiatry Services] planned to follow-up			

	with the resident. During an interview on 2/2/26 at 4:45 p.m., the Executive Director indicated he would report abuse immediately. With that incident, he started the investigation first and determined it was not sexual abuse after interviews with residents and Resident B did not want to file a police report. He indicated the situation was "blown up out of proportion" after the Ombudsman visited. A facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention", dated 7/2025, indicated "The Department Manger along with the Executive Director will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Executive Director. Documentation of the investigation will be maintained by the Executive Director. The community will suspend staff involved in the incident pending provider investigation. It is required that the Executive Director report the reported incident to the applicable Adult Protective Services...The Indiana Department of Health will be notified..."			

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	investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Executive Director. Documentation of the investigation will be maintained by the Executive Director. The community will suspend staff involved in the incident pending provider investigation. It is required that the Executive Director report the reported incident to the applicable Adult Protective Services...The Indiana Department of Health will be notified..."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference;	R 0217	2/19/26 Plan of Correction R217 R 217 Seizure disorder was not marked as a disease diagnosis on the Service Plan. There were no "Services" or "Objectives" listed on the Service Plan related to a history of seizure disorders requiring interventions. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	03/04/2026

	of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure a Service Plan was updated to reflect the resident's health status and seizure disorder for 1 of 6 resident records reviewed. (Resident B) Finding includes: Resident B's record was reviewed on 2/2/26 at 10:53 a.m. Diagnoses included, but were not limited to, unspecified		1. Resident B Service Plan was updated to reflect the diagnosis and Services provided. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. 2a. Residents with seizure diagnosis have potential to be affected by alleged deficient practice. 2b. Director of Nursing and/or designee will audit residents with seizure disorder and update Service Plan as needed. · What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. 1. Director of Nursing and/or designee will review admissions, re-admissions and change of conditions for new seizure diagnosis and update service plans as needed. · How the corrective action(s) will be monitored to ensure the deficient practice will not	

	convulsions and myoclonus (rapid, involuntary muscle contractions). The Service Plan, dated 1/27/26, indicated the resident had modified independence for making decisions regarding tasks of daily life. Her disease diagnoses listed included hypertension, arthritis, other fractures, osteoporosis, anxiety disorder, depression, cataracts, and glaucoma. Seizure disorder was not marked as a disease diagnosis on the Service Plan. There were no "Services" or "Objectives" listed on the Service Plan related to a history of seizure disorders requiring interventions. The February 2026 Physician Order Summary indicated the resident received clonazepam (benzodiazepine medication to treat seizures) 0.5 milligram tablets three times a day as needed (PRN) for convulsions. A Progress Note, dated 1/1/26 at 6:54 p.m., indicated the resident had requested PRN clonazepam at 4:30 p.m. after having gabapentin administered at 2:39 p.m. A visit was made to the resident to explain resident must wait at least four hours between sedating medications. The resident was lying in bed		recur, i.e., what quality assurance program will be put into place. 2. Director of Nursing and/or designee will audit new admissions, re-admissions and change of conditions diagnosis list weekly x 4 weeks, then monthly x 5 months. QAPI committee will review audits monthly x 5 months and make recommendation as needed. · By what date the systemic changes will be completed March 4, 2026	

with jerking movements of arms and legs observed and the resident stated she was having a seizure and was very upset that she could not have clonazepam. The resident was able to carry on a full conversation. The nurse offered to send the resident to the hospital, but she turned the offer down.

She said the facility had her medication that could help her and she could not have it when she needed it, and she wanted to take her medications back over. The resident stated her jaw was clenching up and her tremors were horrible. She was crying stating she was scared. The resident was notified she would get clonazepam when the correct amount of time had passed. The nurse later returned with clonazepam to give to the resident. The resident was lying on her side in bed with extreme arm and leg jerking movements. The resident turned over to get medication and movements were noticed to lessen. The resident appeared calmer by the time the nurse left.

During an interview on 2/4/26 at 2:26 p.m., the Director of Nursing indicated the resident had a seizure disorder and diagnoses of myoclonus and convulsions since she had

admitted to the facility. That was the reason for her PRN clonazepam order. The resident having seizures was nothing out of her normal and was her baseline coming into the facility so it was not added to the service plan. The resident had an order from her neurologist that all sedating medications had to be administered a least four hours after one another because of a history of oversedation and required the facility to administer medications.

This citation relates to Intake 465935.

Based on record review and interview, the facility failed to ensure a Service Plan was updated to reflect the resident's health status and seizure disorder for 1 of 6 resident records reviewed. (Resident B)

Finding includes:

Resident B's record was reviewed on 2/2/26 at 10:53 a.m. Diagnoses included, but were not limited to, unspecified convulsions and myoclonus (rapid, involuntary muscle contractions).

The Service Plan, dated 1/27/26, indicated the resident had modified independence for making decisions regarding tasks of daily life. Her disease

diagnoses listed included hypertension, arthritis, other fractures, osteoporosis, anxiety disorder, depression, cataracts, and glaucoma.

Seizure disorder was not marked as a disease diagnosis on the Service Plan.

There were no "Services" or "Objectives" listed on the Service Plan related to a history of seizure disorders requiring interventions.

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A Progress Note, dated 1/1/26 at 6:54 p.m., indicated the resident had requested PRN clonazepam at 4:30 p.m. after having gabapentin administered at 2:39 p.m. A visit was made to the resident to explain resident must wait at least four hours between sedating medications. The resident was lying in bed with jerking movements of arms and legs observed and the resident stated she was having a seizure and was very upset that she could not have clonazepam. The resident was able to carry on a full conversation. The nurse offered to send the resident to the

hospital, but she turned the offer down.

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	that all sedating medications had to be administered a least four hours after one another because of a history of oversedation and required the facility to administer medications. This citation relates to Intake 465935.			

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 SIGNATUREJarrett Mitchell	TITLEExecutive Director	(X6) DATE02/22/2026