STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altenheim Health & Living Community	3525 E Hanna Ave Indianapolis, IN 46237

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident diagnosed with bipolar disorder received mental health services to attain the highest practicable mental and psychosocial well-being for 1 of 3 residents reviewed for behavioral health services. (Resident B) Findings include:During an interview, on [DATE] at 8:47 a.m. Resident B indicated she thought she had refused a medication for insomnia and had been sent to the hospital because she didn't care if she died.The clinical record for Resident B was reviewed, on [DATE] at 9:03 a.m. Diagnoses included, but were not limited to, bipolar disorder, morbid obesity, and diabetes.A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident B was not cognitively impaired.The physician's orders indicated:- Started, on [DATE] and discontinued, on [DATE], indicated administer trazodone (antidepressant used to treat insomnia) 50 milligrams (mg) tablet orally once daily at bedtime for insomnia.The Medication Administration Record (MAR), dated [DATE] at 12:00 a.m., through [DATE] at 11:59 p.m., indicated Resident B had refused to take trazodone 50mg tablet, on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. A behavioral health note, dated [DATE], indicated Resident B presented to the emergency department for passive suicidal ideations. Resident B had several stressors in her life and had felt more emotional that day. Resident B reported inconsistencies with her antidepressant medication.A progress note, dated [DATE] at 2:17 p.m., indicated late entry from early February. Resident B had declined to take trazodone 50mg which had been discussed in her care plan meeting, on [DATE]. During an interview, on [DATE] at 11:20 a.m., the Social Service Director (SSD) indicated he was not aware of the details of Resident B refusing to take trazodone 50mg.During an interview, on [DATE] at 1:10 p.m., the Social Service Assistant indicated she was not aware Resident B had refused trazodone 50mg. The Social Service Assistant hadn't been made aware that Resident B had been prescribed trazodone 50mg. Normally any medication refusals are discussed in the clinical meetings, but Resident B's refusal of trazodone had not been discussed that she was aware of. The Social Service Assistant should have been made aware of the refusals. The clinical record for Resident B lacked documentation that the physician had been notified that Resident B had been refusing to take trazodone until [DATE] when trazodone was discontinued.On [DATE] at 2:17 p.m., the Director of Nursing provided a copy of a facility policy, titled Charting and Documentation, dated 4/2008, and indicated this was the current policy used by the facility. A review of the policy indicated all services performed and changes in condition must be recorded to ensure consistency between family, physicians, and social services. This Federal citation relates to Intake 2747635 410 IAC 16.2-3.1-37(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. Building B. Wing	03/25/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure documentation on the Medication Administration Record was complete and accurate for 1 of 3 residents reviewed for documentation. (Resident B) Findings include:The clinical record for Resident B was reviewed, on 3/24/26 at 9:03 a.m. Diagnoses included, but were not limited to, bipolar disorder, morbid obesity, and diabetes.The physician's orders indicated:- Started on 9/12/25, administer amlodipine 10 milligrams (mg) tablet orally once daily for hypertension. There was no discontinue date noted.- Started, on 9/12/25, and discontinued, on 3/9/26, administer aspirin 81mg tablet orally once daily for heart failure.- Started, on 1/6/26, administer buspirone 15mg tablet orally three times daily for anxiety. There was no discontinue date noted.- Started, on 2/3/26, administer cholecalciferol 125 microgram (mcg) tablet once daily for vitamin D deficiency. There was no stop date noted.- Started, on 2/3/26, and discontinued, on 3/2/26, administer divalproex 250mg orally twice daily for bipolar disorder.- Started, on 9/12/25, administer metoprolol succinate 50mg orally once daily for hypertension. There was no stop date noted.- Started, on 9/15/25, administer polyethylene glycol 3350 powder; 17 gram with 240 milliliters (ml) of water once daily for constipation. There was no stop date noted.The MAR, dated 2/1/26 at 12:00 a.m., until 2/28/26 at 11:59 p.m., lacked documentation as follows:- amlodipine 10 milligrams (mg) tablet orally once daily for hypertension was left blank, on 2/12/26 on morning shift and 2/19/26 on morning shift.- aspirin 81mg tablet orally once daily for heart failure was left blank, on 2/12/26 on morning shift and 2/19/26 on morning shift.- buspirone 15mg tablet orally three times daily for anxiety was left blank, on 2/12/26 at 12:00 p.m.- divalproex 250mg orally twice daily for bipolar disorder was left blank, on 2/12/26 on morning shift and 2/19/26 on morning shift.- metoprolol succinate 50mg orally once daily for hypertension was left blank, on 2/12/26 on morning shift and 2/19/26 on morning shift.- polyethylene glycol 3350 powder; 17 gram with 240 milliliters (ml) of water once daily for constipation was left blank, on 2/12/26 on morning shift and 2/19/26 on morning shift.During an interview, on 3/24/26 at 2:00 p.m. Licensed Practical Nurse (LPN) 1 indicated the documentation should have been completed on the MAR.On 3/24/26 at 2:17 p.m., the Director of Nursing provided a copy of a facility policy, titled Charting and Documentation, dated 4/2008, and indicated this was the current policy used by the facility. A review of the policy indicated documentation medication administration must be documented. This Federal citation relates to complaint 2747635410 IAC 16.2-3.1-50(a)