STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was allowed to return to the facility after a psychiatric hospitalization for 1 of 3 residents reviewed for transfer and discharge (Resident E). Findings include:Resident E's record was reviewed on 4/24/26 at 11:12 a.m. Census information indicated the resident was admitted to the facility on [DATE] and discharged on 11/25/25. The resident was hospitalized from [DATE] to 7/25/25 and 7/31/25 to 8/28/25. Diagnoses on the resident's profile included, but were not limited to schizoaffective disorder bipolar type a chronic mental health condition combining symptoms of schizophrenia [hallucinations and delusions] with mood episodes), dementia (decline in mental ability severe enough to interfere in daily life) in other diseases classified elsewhere unspecified severity with behavioral disturbance, and post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events). The facility assessment, dated 6/27/24, indicated the facility provided care for residents with bipolar disorder, schizophrenia, post-traumatic stress disorder, and behavior that required interventions. A history and physical, dated 6/2/25, indicated the resident had safety risk factors including a history of childhood maltreatment, impulsive tendencies, and history of aggression. The treatment plan included diagnoses of schizoaffective disorder bipolar type, major neurocognitive disorder due to other medical condition with behavioral disturbance, and post-traumatic stress disorder. A comprehensive Minimum Data Set (MDS) assessment, dated 9/4/25, indicated the resident had a severe cognitive impairment and exhibited verbal behavioral symptoms directed towards others one to three days of the assessment period. A progress note, dated 7/3/25 at 2:10 a.m., indicated the resident stood at the exit door punching in numbers to attempt to exit. The nurse asked the resident if she wanted a snack, and the resident told the nurse to shut up. A progress note, dated 7/3/25 at 3:15 a.m., indicated the resident continued to try to put in the numbers on the keypad to exit the unit. The resident had placed the walker in front of the door blocking staff from entering or exiting the unit. When staff asked the resident to move, the resident became angry and refused. The resident said if staff did not quit asking them to move there would be trouble. A progress note, dated 7/3/25 at 1:21 p.m., indicated the resident had been sitting by the door all day and refused to take their medicine or eat any meals. The staff called administration to the unit to attempt to calm the resident down. The resident cursed at staff, called them names, and threatened to spray staff with a bottle of body wash. A progress note, dated 7/3/25 at 4:45 p.m., indicated the resident was at the door banging on it to get out. When other residents walked by or spoke to her the resident jumped up with fist drawn up and stated, I will hit you. Staff redirected residents away from the resident. A progress note, dated 7/3/25 at 5:56 p.m., indicated the resident stated she was in labor and needed to go to the hospital. If anyone approached the resident, she stated she would punch them. The staff attempted to contact the resident's power of attorney (POA), but there was no answer. A progress note, dated 7/3/25 at 7:35 p.m., indicated the resident tried to go out the door with staff. The resident pushed the walker into the staff member several times and raised her fist. A progress note, dated 7/3/25 at 7:55 p.m., indicated, .Staff was waiting on other staff (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to bring her supplies. Staff open the door and DON [Director of Nursing] and police was at the door. Police escort resident out of the door. A progress note, dated 7/25/25, indicated the resident was re-admitted to the facility.A progress note, dated 7/31/25 at 3:04 a.m., indicated the resident was observed attempting to push a chair into another resident. Staff was present and intervened. The resident went to her room and stayed there. A progress note, dated 7/30/25 at 1:31 p.m., indicated the resident had verbal aggression, including profanity towards staff, during the shift. The resident threatened staff, made unrealistic demands, asked to exit the unit several times, stood by the door, and refused all medications except Haldol (antipsychotic medication). Management was notified. A progress note, dated 7/31/25 at 3:04 a.m., indicated the resident was observed attempting to push a chair into another resident. Staff was present and intervened. The resident went to her room and stayed there. A progress note, dated 7/31/25 at 4:50 a.m., indicated the resident was transferred to an acute psychiatric hospital. A progress note, dated 8/28/25, indicated staff went to the acute psychiatric facility to transport the resident back to the facility. The resident was resistant to the transport, hit and kicked staff members, and kicked the seats in the van. The resident yelled curse words and threatened to kill the staff members. An interdisciplinary note, dated 11/7/25, indicated the resident exhibited a pattern of challenging behaviors including approaching the nurse's station demanding unavailable food items. When the resident was notified they were unable to provide the items, the resident became verbally aggressive, using profanity and making threats. The resident loudly accused fellow residents of drug use, threatened a new staff member, was found screaming in her room demanding popcorn and claiming to have five babies in her tummy. The resident refused medication and became verbally aggressive when approached by staff. The resident answered the phone when another resident's family called and used inappropriate language. The resident called 911 and claimed she was being poisoned. The resident was physically aggressive including throwing items and threatening to overturn the medication cart when her food requests were not met. The note lacked documentation a 30-day notice of transfer or discharge was issued due to the resident's behaviors. A care plan note, dated 11/18/25, indicated a care plan meeting was conducted with the resident's representative. The resident's behaviors were discussed, and the staff requested information from the resident's representative regarding what interventions worked previously. The note lacked documentation the resident's representative was issued a 30-day notice of transfer or discharge or was told the resident needed to seek alternative placement. A progress note, dated 11/25/25 at 1:15 p.m., indicated the nurse came into the door of the resident's unit when the resident attempted to get out of the door. The nurse tried to stop the resident's exit when the resident hit the nurse in the face with a closed fist and grabbed the top of the nurse's head. The nurse called for help, 911 was called, and the resident was transferred to a behavior facility. The daughter was called and made aware of the transfer. The note lacked documentation the daughter was provided the notice of transfer and discharge, including information on how to appeal the discharge, or the bed hold policy. A discharge MDS assessment, dated 11/25/25, indicated the resident had an unplanned discharge to a short-term hospital, with return anticipated. A Social Services Director (SSD) progress note, dated 11/25/25 at 2:21 p.m., indicated, This note serves to document the recent incident involving the resident, who exhibited aggressive behavior resulting in the need for emergency intervention. The resident was transported to [hospital name] following an aggressive outburst that involved striking two staff members. Incident Details: The resident has a history of aggressive outbursts, and it is important to note that upon their return from a previous psychiatric hospitalization, both the resident and their Power of Attorney (POA) were informed of the facility's policy regarding violence. Specifically, it was communicated that any escalation to violent behavior towards staff or other residents would necessitate an immediate discharge to a hospital, with no option for return to our facility. Communication with POA: Upon the recent incident, the Interdisciplinary Team (IDT) attempted to contact the resident's POA to discuss the situation and inform them of the necessary actions being taken. Unfortunately, the POA did not respond. Consequently, IDT reached out to the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's second daughter to explain the circumstances and the decision to transport the resident to the hospital. The daughter expressed a desire to pick up the resident, but it was clarified that without explicit consent from the POA for her to do so, the facility must proceed with the transport to the hospital. We informed the daughter that she would have the option to sign an Against Medical Advice (AMA) form if she chooses to take the resident from the hospital instead of admitting her. Next Steps: 1. Transport to [name of local hospital] Hospital: The resident will be safely transported to the hospital for evaluation and care. 2. Communication with Family: We will continue to attempt to communicate with the POA to ensure they are informed and involved in the ongoing care decisions for the resident. Conclusion: The safety of our residents and staff is our utmost priority. We will adhere to our established protocols in managing aggressive behavior and will ensure that all appropriate parties are kept informed throughout this process. Further updates will be provided as more information becomes available. The following Social Worker progress notes were provided by the acute psychiatric hospital. -A note, dated 11/28/25, indicated the Social Worker placed a call to the facility to speak with the DON to find out if the resident was able to return to the facility. The DON did not answer, and the Social Worker left a message. -A note, dated12/1/25, indicated the Social Worker called the facility and asked to speak to the DON. The DON was in a meeting, and the Social Worker left a voicemail. -A note, dated 12/2/25 at 2:25 p.m., indicated the Social Worker called the facility and requested to speak to the DON. The DON did not answer. The Social Worker called the facility a second time and again requested to speak to the DON. The receptionist indicated the DON was busy and also indicated the resident was not allowed back. The receptionist indicated the resident had been asked not to come back and her representative came and picked up her belongings. -A note, dated 12/2/25 at 3:28 p.m., indicated the Social Worker spoke with the DON at the facility. The DON stated she was busy and she did not like the Social Worker being rude to her. The Social Worker indicated she was not rude to her and had, in fact, been trying to reach the DON for a week. The DON requested the Social Worker send her the clinical information for the resident. -A note, dated 12/2/25 at 4:01 p.m., indicated the Social Worker received a return call from the resident's representative. The representative stated the resident was supposed to return to the facility and she had not received a 30-day notice of transfer or discharge. -A note, dated 12/5/25, indicated the Social Worker called the facility and requested to speak to the DON. The DON did not answer, and the Social Worker left a voicemail. The Social Worker also sent an e-mail and faxed the clinical information as the DON had previously requested. -A note, dated 12/8/25, indicated the Social Worker called the facility and spoke with the DON. The DON indicated the resident was still taking intramuscular (IM) (injections into the muscle), and the resident had refused IM medications at the facility. -A note, dated 12/10/25 at 9:50 a.m., indicated the Social Worker called the facility and was told the resident was removed from their care. The Social Worker asked to speak to the DON but was told she was busy. The Social Worker left a voicemail for the DON to ask if they had made other arrangements for the resident. -A note, dated 12/10/25 at 12:11 p.m., indicated the DON called the Social Worker and stated the facility would not take the resident back until she was stabilized with oral medications. The DON also stated the resident had been aggressive while at the acute psychiatric facility. The Social Worker asked where in the notes it had stated the resident was aggressive, but the DON stated she did not have time for this to look. The Social Worker told the DON the resident had not exhibited aggressive behavior at the psychiatric facility. -A note, dated 12/16/25, indicated a care conference was held with the Social Worker and the facility. The facility attendees included the Administrator, Nurse Practitioners (NPs), and the Clinical Director. They reviewed the resident's medical record and the plan for the resident to receive monthly injections. The facility said the resident had been discharged to the community. The Social Worker told them this had not been mentioned before, and the resident had been in the acute psychiatric facility since 11/25/25. The facility would not confirm if they had officially discharged the resident or not. -An e-mail from the DON to the Social Worker, dated 1/9/26, indicated she was checking to see if there were any updates regarding the resident. The Social (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Worker responded with the clinical update and asked how long the facility wanted the resident compliant on her medications. -A note, dated 1/15/26, indicated the Social Worker called the facility and asked to speak to the DON. The DON was not available. -A note, dated 2/3/26 at 2:45 p.m., indicated the Social Worker called the facility to speak with the DON. The DON had not responded to the Social Worker's emails or calls. The Social Worker was hung up on. -A note, dated 2/3/26 at 2:55 p.m., indicated the Social Worker received a call back from the Social Services Director (SSD) at the facility. The SSD indicated she had been sending out referrals for the resident for awhile. During an interview, on 4/27/26 at 10:12 a.m., the Administrator indicated they had not re-admitted the resident to the facility because she was admitted to another skilled nursing facility (SNF). She had been discharged from the acute psychiatric hospital to another SNF. During an interview, on 4/27/26 at 11:22 a.m., the psychiatric hospital Social Worker indicated the resident was never discharged to another SNF, and she had never been notified of another SNF willing to accept the resident. The resident had been in their care at the acute psychiatric facility since 11/25/25 because the facility refused to re-admit her. The facility had not provided any assistance with a discharge plan for the resident. The Social Worker had repeatedly tried to contact them, but they would not answer her phone calls, and eventually they stopped responding completely. The resident was stable, and there was not much else they were able to do for her. The psychiatric hospital had given the resident's representative a deadline, of 5/8/26, to find alternative placement for the resident as the hospital was not a long-term care placement. The Social Worker was not sure where the resident was going to be discharged . During an interview, on 4/27/26 at 11:58 a.m., the SSD indicated they had a care plan meeting with the resident and the resident's representative where they discussed what would happen if the resident's aggressive behaviors continued. On 11/25/25, the interdisciplinary team determined the resident was not going to be re-admitted to the facility after the hospitalization due to the previous conversation they had with the resident's representative about the resident's behavior. The DON told the SSD the resident had been discharged to another SNF, and she thought that was where the resident currently resided. She was not aware the resident was still at the acute psychiatric hospital. During an interview, on 4/27/26 at 1:52 p.m., the DON indicated she thought the resident was discharged from the acute psychiatric hospital to another SNF. She had received a call from the SNF at least a month ago and told the acute psychiatric hospital. The DON indicated she was not aware the resident remained in the acute psychiatric hospital. The DON was not able to provide documentation regarding another SNF contacting the DON or the DON notifying the acute psychiatric hospital. During an interview, on 4/27/26 at 2:00 p.m., the psychiatric hospital Social Worker indicated the resident would have most likely been able to be discharged mid-December 2025 if the facility had accepted her back. The other SNF never accepted the resident. The Social Worker indicated she had a contact which was a liaison for the other SNF's corporation, and they had never accepted the resident. The DON told her she had reached out to this other SNF, but there was never an acceptance. Around mid-December, the facility ceased communication with her. During an interview, on 4/28/26 at 11:28 a.m., the resident's representative indicated she had never been talked to about the other SNF by the facility or the acute psychiatric hospital. There was never a plan for the resident to discharge to another SNF. On 4/27/26 at 10:30 a.m., the Regional Director of Operations provided an undated document titled, Transfer and Discharge Policy and Procedure and indicated it was the policy currently being used by the facility. The policy indicated, .The facility will provide provisions for continuity of care and in non-emergency situations a care plan meeting will be held with the appropriate parties to determine a relocation plan. On 4/27/26 at 10:30 a.m., the Regional Director of Operations provided an undated document titled, Transfer and Discharge Policy and Procedure and indicated it was the policy currently being used by the facility. The policy indicated, .GUIDELINE: The facility shall permit each resident to remain in the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care; to receive necessary care and services and to participate in the development of the Comprehensive Care Plan and in (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recognition of the rights of other residents in the facility. PROCEDURE.2. Non-emergency transfers or discharges not within the same certified facility will receive notice 30 days before transfer or discharge. Notice will be given to the resident/ responsible party.5. The resident may be transferred from the facility when it's been determined that: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.7. Before a facility transfers a resident to a hospital or a therapeutic leave, the nursing facility will provide information to the resident/responsible party that specifies the duration of the bed-hold policy and the facility's policies regarding bed-holds. This citation is related to Intake 2695301.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a notice of transfer or discharge (required notice which instructs how to appeal a discharge) and bed hold policy were provided to a resident's representative at the time of a hospital discharge and a 30-day notice was provided for a facility-initiated discharge for 1 of 3 residents reviewed for discharge (Resident E). Findings include:Resident E's record was reviewed on 4/24/26 at 11:12 a.m. Census information indicated the resident was admitted to the facility on [DATE] and discharged on 11/25/25. Diagnoses on the resident's profile included, but were not limited to schizoaffective disorder bipolar type a chronic mental health condition combining symptoms of schizophrenia [hallucinations and delusions] with mood episodes), dementia (decline in mental ability severe enough to interfere in daily life) in other diseases classified elsewhere unspecified severity with behavioral disturbance, and post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events). A history and physical, dated 6/2/25, indicated the resident had safety risk factors including a history of childhood maltreatment, impulsive tendencies, and history of aggression. The treatment plan included diagnoses of schizoaffective disorder bipolar type, major neurocognitive disorder due to other medical condition with behavioral disturbance, and post-traumatic stress disorder. A comprehensive Minimum Data Set (MDS) assessment, dated 9/4/25, indicated the resident had a severe cognitive impairment and exhibited verbal behavioral symptoms directed towards others one to three days of the assessment period. An interdisciplinary note, dated 11/7/25, indicated the resident exhibited a pattern of challenging behaviors including approaching the nurse's station demanding unavailable food items. When the resident was notified they were unable to provide the items, the resident became verbally aggressive, using profanity and making threats. The resident loudly accused fellow residents of drug use, threatened a new staff member, was found screaming in her room demanding popcorn and claiming to have five babies in her tummy. The resident refused medication and became verbally aggressive when approached by staff. The resident answered the phone when another resident's family called and used inappropriate language. The resident called 911 and claimed she was being poisoned. The resident was physically aggressive including throwing items and threatening to overturn the medication cart when her food requests were not met. The note lacked documentation a 30-day notice of transfer or discharge was issued due to the resident's behaviors. A care plan note, dated 11/18/25, indicated a care plan meeting was conducted with the resident's representative. The resident's behaviors were discussed, and the staff requested information from the resident's representative regarding what interventions worked previously. The note lacked documentation the resident's representative was issued a 30-day notice of transfer or discharge or was told the resident needed to seek alternative placement. A progress note, dated 11/25/25 at 1:15 p.m., indicated the nurse came into the door of the resident's unit when the resident attempted to get out of the door. The nurse tried to stop the resident's exit when the resident hit the nurse in the face with a closed fist and grabbed the top of the nurse's head. The nurse called for help, 911 was called, and the resident was transferred to a behavior facility. The daughter was called and made aware of the transfer. The note lacked documentation the daughter was provided the notice of transfer and discharge, including information on how to appeal the discharge, or the bed hold policy. A discharge MDS assessment, dated 11/25/25, indicated the resident had an unplanned discharge to a short-term hospital, with return anticipated. A bed hold policy, dated 11/25/25, indicated the resident was being transferred to the hospital due to physical aggression towards a staff member. The bed hold policy was provided to the resident. The form lacked documentation the bed hold policy was provided to the resident representative considering the resident's cognitive status. The resident's record lacked documentation a notice of transfer or discharge was provided with the hospitalization. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Services Director (SSD) progress note, dated 11/25/25 at 2:21 p.m., indicated, This note serves to document the recent incident involving the resident, who exhibited aggressive behavior resulting in the need for emergency intervention. The resident was transported to [hospital name] following an aggressive outburst that involved striking two staff members. Incident Details: The resident has a history of aggressive outbursts, and it is important to note that upon their return from a previous psychiatric hospitalization, both the resident and their Power of Attorney (POA) were informed of the facility's policy regarding violence. Specifically, it was communicated that any escalation to violent behavior towards staff or other residents would necessitate an immediate discharge to a hospital, with no option for return to our facility. Communication with POA: Upon the recent incident, the Interdisciplinary Team (IDT) attempted to contact the resident's POA to discuss the situation and inform them of the necessary actions being taken. Unfortunately, the POA did not respond. Consequently, IDT reached out to the resident's second daughter to explain the circumstances and the decision to transport the resident to the hospital. The daughter expressed a desire to pick up the resident, but it was clarified that without explicit consent from the POA for her to do so, the facility must proceed with the transport to the hospital. We informed the daughter that she would have the option to sign an Against Medical Advice (AMA) form if she chooses to take the resident from the hospital instead of admitting her. Next Steps: 1. Transport to [name of local hospital] Hospital: The resident will be safely transported to the hospital for evaluation and care. 2. Communication with Family: We will continue to attempt to communicate with the POA to ensure they are informed and involved in the ongoing care decisions for the resident. Conclusion: The safety of our residents and staff is our utmost priority. We will adhere to our established protocols in managing aggressive behavior and will ensure that all appropriate parties are kept informed throughout this process. Further updates will be provided as more information becomes available. The note lacked documentation the notice of transfer or discharge or bed hold policy were provided to the resident's representative at the time of the transfer or later. The note lacked documentation a 30-day notice of transfer or discharge had been issued to the resident's representative prior to the hospital transfer. The SSD note, dated 11/25/25, was the last progress note in the resident's record. The record lacked documentation of further communication with the resident's representative or the psychiatric facility. A Social Worker's note from the acute psychiatric facility, dated 12/2/25, indicated the Social Worker received a return call from the resident's representative. The representative stated the resident was supposed to return to the facility and she had not received a 30-day notice of transfer or discharge. A Social Worker's note from the acute psychiatric facility, dated 12/8/25, indicated the Social Worker called the facility and spoke with the DON. The DON indicated the resident was still taking intramuscular (IM) (injections into the muscle), and the resident had refused IM medications at the facility. The Social Worker told the DON they needed to give the resident's representative a 30-day notice of transfer or discharge and speak to the resident's representative. During an interview, on 4/27/26 at 10:12 a.m., the Administrator indicated a 30-day notice of transfer or discharge was not issued. During an interview, on 4/27/26 at 11:22 a.m., the psychiatric hospital Social Worker indicated the resident was still at their facility and had been there since November 2025. Their facility is supposed to be short term, but the nursing facility refused to re-admit the resident. The resident's daughter had not received any discharge paperwork or a 30-day notice of transfer or discharge prior to the hospitalization. During an interview, on 4/27/26 at 11:58 a.m., the Social Services Director (SSD) indicated the resident was confused. The SSD thought when a confused resident was sent to the hospital, the notice of transfer or discharge and bed hold policy were sent with the ambulance. She was not sure if they were provided to the resident representatives at a later time. The SSD thought the resident had been admitted to another nursing facility and was not aware the resident remained in the psychiatric facility. The SSD indicated she thought the intent was for the resident to return to the facility from the psychiatric unit, and then the facility would have issued the 30-day notice of transfer or discharge. During an interview, on 4/27/26 at 1:52 p.m., the DON indicated the (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's representative was not provided with the notice of transfer or discharge or bed hold policy with this transfer because the resident's family member had not come into the facility. The DON indicated the notice of transfer or discharge and bed hold policy should have been provided with all hospitalizations. The forms were normally given to the resident if they were alert and oriented or to the resident's representative if the resident was confused. The resident had not been issued a 30-day notice of transfer or discharge. During an interview, on 4/28/26 at 11:28 a.m., the resident's representative indicated they were not provided any paperwork, including a notice of transfer or discharge or bed hold policy, when the resident was transferred on 11/25/25. The resident had been in the psychiatric hospital since 11/25/25. The resident's representative indicated they would have appealed the facility's discharge of the resident if they had known it was an option, or how to appeal, but they had not received the notice of transfer of discharge with the appeal information. The resident was not issued a 30-day notice of transfer or discharge. On 4/27/26 at 10:30 a.m., the Regional Director of Operations provided an undated document titled, Transfer and Discharge Policy and Procedure and indicated it was the policy currently being used by the facility. The policy indicated, .GUIDELINE: The facility shall permit each resident to remain in the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care; to receive necessary care and services and to participate in the development of the Comprehensive Care Plan and in recognition of the rights of other residents in the facility. PROCEDURE.2. Non-emergency transfers or discharges not within the same certified facility will receive notice 30 days before transfer or discharge. Notice will be given to the resident/ responsible party.5. The resident may be transferred from the facility when it's been determined that: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.7. Before a facility transfers a resident to a hospital or a therapeutic leave, the nursing facility will provide information to the resident/responsible party that specifies the duration of the bed-hold policy and the facility's policies regarding bed-holds. On 4/28/27 at 2:05 p.m. the Indiana Department of Health (IDOH) form titled, Notice of Transfer or Discharge, was accessed at https://forms.in.gov. The form included resident information, information regarding where the resident was being transferred, and the reason for the transfer. The form indicated, Bed Hold Policy: The facility must attach a copy of the facility's bed hold policy to this Notice of Transfer or Discharge and provide contact information for a facility employee to contact about the bed hold policy.Appeal Rights: You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana State Department of Health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge, unless the facility is authorized to transfer you as an emergency transfer.If you wish to appeal this transfer or discharge, please fill out the attached State Form.and return to the address below. This citation is related to Intake 2695301. 410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(iii) 410 IAC 16.2-3.1-12(a)(26)