STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLES FORD MEMORIAL HOME INC	920 S MAIN ST, NEW HARMONY, , 47631

(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 a State Residential Licensure Survey. Survey dates: October 22 and 23, 2025 Facility number: 001123 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 27, 2025.	R 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance for deficiency R 302 effective October 29, 2025 and deficiency R 120 effective November 29, 2025 to the state findings of the State Residential Licensure Survey conducted on October 23, 2025.	
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training	R 0120	R 120 *The corrective action taken for those*	10/29/2025

	program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants.		*residents found to have been affected by the deficient practice is that* no specific residents were identified however all residents with dementia have the potential to be affected by this deficient practice. The staff members identified as resident assistant 4 and LPN 5 will have completed their initial six hours of dementia training by the above date of compliance. These identified staff members will also continue to receive three hours of dementia specific training annually for each continued year of employment at this facility. *The corrective action taken for the* *other residents that have the potential to be affected by the same deficient* *practice is that* all residents with dementia have the potential to be affected by this deficient practice. All staff members are now receiving six hours of dementia specific training with six months of employment as well as three hours of dementia training each additional year of employment. There is documentation in each staff members employee file to verify	

	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff who had contact with residents with dementia were provided the minimum hours of dementia training after being hired for 2 of 5 employee records reviewed. (Resident Assistant 4 and Licensed Practical Nurse 5) Finding includes: On 10/23/25 at 8:21 A.M., The Administrator in Training (AIT) provided employee in-services completed in the last year. Resident Assistant (RA) 4 was hired on 11/25/24 and had completed zero hours of dementia training. Licensed Practical Nurse (LPN) 5 was hired on on 3/20/25 and had completed zero hours of dementia training. On 10/23/25 at 10:22 A.M., the AIT indicated staff should have six hours of dementia training within six months of their hire date. On 10/23/25 at 10:21 A.M., the AIT provided an undated policy titled Orientation and Training		this required training. *The measures that have been put into* *place to ensure that the deficient practice does not recur is that* the facility administrative team have revised the training schedule that each employee must complete within their initial six months of employment that includes six hours of dementia specific training. An revised training schedule has also been developed and implemented for each staff member that they are required to complete annually which includes three hours of dementia specific training. Administrative staff will ensure that there is supportive documentation of each training completed in their respective employee file. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation in the employees' files of the completed required dementia training. This tool will monitor to ensure that each employee has completed their	

	that indicated "Schedule targeted in-service training is scheduled routinely based on state/local regulations and the developmental needs of the staff members." Based on record review and interview, the facility failed to ensure staff who had contact with residents with dementia were provided the minimum hours of dementia training after being hired for 2 of 5 employee records reviewed. (Resident Assistant 4 and Licensed Practical Nurse 5) Finding includes: On 10/23/25 at 8:21 A.M., The Administrator in Training (AIT) provided employee in-services completed in the last year. Resident Assistant (RA) 4 was hired on 11/25/24 and had completed zero hours of dementia training. Licensed Practical Nurse (LPN) 5 was hired on on 3/20/25 and had completed zero hours of dementia training. On 10/23/25 at 10:22 A.M., the AIT indicated staff should have six hours of dementia training within six months of their hire date. On 10/23/25 at 10:21 A.M., the AIT provided an undated policy titled Orientation and Training		initial six hours of dementia training within six months of employment and three hours of dementia training annually thereafter. This tool will be completed by the Assistant Administrator/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. Any identified deficiencies will be immediately brought to the attention of the Executive Director so that appropriate action can be taken.	

	that indicated "Schedule targeted in-service training is scheduled routinely based on state/local regulations and the developmental needs of the staff members."			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure the proper labeling of medications for 1 of 1 medication carts during a random observation for medication storage. Over the counter medications lacked physician names on label. (Resident 3, Resident 9) Findings include:	R 0302	R 302 *1.) The corrective action taken for* *those residents found to have been affected by the deficient practice is that* all of the over the counter medications for the resident identified as resident 3 were labeled with all of the required information immediately upon identification of the concern on the day of survey. *2.) The corrective action taken for* *those residents found to have been affected by the deficient practice is that* all of the over the counter medications for the resident identified as resident 9 were labeled with all of the required information immediately upon identification of the concern on the day of survey. *The corrective action taken for*	10/29/2025

On 10/22/25 at 9:15 A.M., during a random observation of the medication cart with Licensed Practical Nurse (LPN) 2 the following was observed:

Resident 3 drawer

1 bottle of Vitamin D with no physician name on label

1 bottle of Turmeric supplement with no physician name on label

1 bottle of CoQ10 supplement with no physician name on label

1 bottle of Calcium 600 milligrams (mg) with Vitamin D3 with no physician name on label

1 bottle of Vitamin C 500 mg with no physician name on label

Resident 9

1 bottle of MiraLAX with no physician name on label

1 bottle of Tylenol 500 mg with no physician name on label

1 bottle of Allergy Relief with no physician name on label

1 bottle of Melatonin with no physician name on label

1 bottle of Woman's Multivitamin with no physician name on label

1 bottle of Probiotics with no physician name on label

1 bottle of Calcium 600 Mg with

the
other residents that have the potential to be affected by the same deficient
practice is that all residents have the potential to be affected by
this deficient practice. A housewide
audit has now been conducted to ensure that each over the counter medication
utilized by the resident has the appropriate label applied to the medication
bottle that includes all the required information.

The measures that have been put into
place to ensure that the deficient practice does not recur is that a
mandatory in-service has now been provided for all QMAs and licensed nurses on
the facility's labeling practice of over the counter medications. The staff was instructed on utilizing the
appropriate labels that include all the required information. The staff was also reminded of their responsibility to ensure that the appropriate labels were applied to each over
the counter medication received into the facility before placing the medication
in the med cart.

	Vitamin D3 with no physician name on label 1 bottle of Prevagen with no physician name on label 1 bottle of Acidophilus with no physician name on label 1 bottle of Super B complex vitamins with no physician name on label During an interview on 10/23/25 at 8:30 A.M., the Director of Nursing (DON) indicated there were two types of labels that staff could have used to label medications, one with name and Date of Birth (DOB) and the other with resident name, DOB, and MD name. She indicated the staff should use the label with the physician's name on it and that she would instruct the staff to use this one. On 10/23/25 at 10:21 A.M., the Administrator in Training produced a current, non-dated policy "Medication Labels". The policy indicated "...each ...medication label includes...resident name...prescriber's name..." Based on observation and interview, the facility failed to ensure the proper labeling of medications for 1 of 1 medication carts during a random observation for medication storage. Over the counter medications lacked		*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the labeling of over the counter medications. This tool will monitor to ensure that each over the counter medication label contains all of the required information including the physician’s name. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. Any identified deficiencies will be immediately corrected by the Director of Nursing and/or their designee.	

physician names on label. (Resident 3, Resident 9)

Findings include:

On 10/22/25 at 9:15 A.M., during a random observation of the medication cart with Licensed Practical Nurse (LPN) 2 the following was observed:

Resident 3 drawer

1 bottle of Vitamin D with no physician name on label

1 bottle of Turmeric supplement with no physician name on label

1 bottle of CoQ10 supplement with no physician name on label

1 bottle of Calcium 600 milligrams (mg) with Vitamin D3 with no physician name on label

1 bottle of Vitamin C 500 mg with no physician name on label

Resident 9

1 bottle of MiraLAX with no physician name on label

1 bottle of Tylenol 500 mg with no physician name on label

1 bottle of Allergy Relief with no physician name on label

1 bottle of Melatonin with no physician name on label

1 bottle of Woman's Multivitamin with no physician name on label

1 bottle of Probiotics with no physician name on label

1 bottle of Calcium 600 Mg with Vitamin D3 with no physician name on label

1 bottle of Prevagen with no physician name on label

1 bottle of Acidophilus with no physician name on label

1 bottle of Super B complex vitamins with no physician name on label

During an interview on 10/23/25 at 8:30 A.M., the Director of Nursing (DON) indicated there were two types of labels that staff could have used to label medications, one with name and Date of Birth (DOB) and the other with resident name, DOB, and MD name. She indicated the staff should use the label with the physician's name on it and that she would instruct the staff to use this one.

On 10/23/25 at 10:21 A.M., the Administrator in Training produced a current, non-dated policy "Medication Labels". The policy indicated "...each ...medication label includes...resident name...prescriber's name..."

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 SIGNATUREAmy Knopf Koch	TITLEHFA, Executive Director	(X6) DATE11/07/2025