

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/24/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE GRANGER		STREET ADDRESS, CITY, STATE, ZIP CODE 430 CLEVELAND RD, GRANGER, , 46530			
(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. This visit included the Investigation of Intake 471291. Intake 471291 - State deficiencies related to the allegations are cited at R0214. Survey dates: 8/21/2026 and 8/24/2026 Facility number: 002656 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 09/01/2026	R 0000			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state	R 0117	R117	09/15/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Corrections from previous timeframes cannot be made. No residents were harmed by this alleged deficient practice.

100% audit of nursing staff personnel files, was completed on 8-24-25 by Business Office Manager (BOM) or designee. The nursing staff who had completed the on-line CPR/First aid/AED have been rescheduled to complete the course with an in-person instructor to recertify. Eight (8) staff members have already been certified and the remaining five (5) nursing staff member will be completed by 9-15-26.

BOM will track CPR/First Aid/ARD licensure renewal and all nursing staff will be scheduled for recertification thirty (30) days prior to expiration.

To assist with ongoing compliance, the BOM or designee will review the certification binder monthly for six (6) months and classes scheduled as necessary.

Completed 9-15-26. BOM/HWD responsible for compliance

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	Based on record review and interview, the facility failed to ensure there was at least one awake staff person with current Cardiopulmonary Resuscitation (CPR) certification, including a hands-on skills competency evaluation, was on site at all times for 7 of 7 days reviewed. This deficient practice had the potential to affect 27 of 27 residents who resided in the facility. Findings include: During a review of the nursing schedule for August 16 - 23 and review of personnel CPR certifications for nursing staff, on 8/21/2026 at 1:00 P.M., 7 of 7 days reviewed indicated theree was no employee on duty with a qualifying CPR certification. All of the employees had received their current CPR certifications from an online-only training source. The online CPR certificaion provider source did not include the required in-person or hands-on CPR skills competency evaluation in their class. During an interview, on 8/21/2026 at 1:30 P.M., the Administrator indicated the facility had had difficulty finding a provider to provide CPR training that included the hands-on component and had accepted the online-only CPR			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	training for staff even though it did meet the regulatory requirements for healthcare staff. A copy of the facility's CPR requirement policy was requested on 8/21/2026 at 2:30 P.M. On 8/24/2026 at 9:40 A.M., a policy for CPR was provided, but the policy failed to indicate specific requirements including certification through a source that included a hands on or in person requirement. No other policy for CPR certifications was received before the survey exit on 8/24/2026.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable.	R 0123	R123 Corrections from previous timeframes cannot be made. No residents were harmed by this alleged deficient practice. The beautician is looking into Indiana licensure and insurance cost. (She is licensed and insured in Michigan). At this time, the Community is looking for an Indiana Licensed beautician and staff members and family are helping keep hair looking great for scheduling appoints at shops off site.	08/25/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	(6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure professional licensure documentation was current and complete for 1 of 1 beautician records reviewed. This deficient practice had the potential to affect residents who received services in the facility hair salon. Findings include: During a licensure record review, on 8/21/2026 at 2:00 P.M., the beautician's professional licensure documentation indicated the beautician had a Michigan cosmetology license. The record lacked documentation of a current Indiana cosmetology license. During an online review of the Indiana Professional Licensing Agency license search, on 8/21/2026 at 2:00 P.M., the		The Community has locate a licensed Indiana beautician. She will begin servicing our residents 9-17-26 BOM will monitor licensure and insurance renews on-going through a monthly licensure binder audit. Completed 8-25-26. BOM/ED responsible	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	beautician was not identified as having a current Indiana cosmetology license. During an interview, on 8/21/2026 at 2:30 P.M., the Business Office Manager confirmed the facility beautician did not have an Indiana cosmetology license. During an interview, on 8/24/2026 at 10:30 A.M., the Executive Director indicated the facility did not have a policy related to the beautician licensing requirements.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review, observation and interview, the facility failed to assess a resident's needs after a wound had been documented in the resident's Electronic Medical Record for 1 of 3 residents who were reviewed. (Resident B)	R 0214	R214 Corrections from previous timeframes cannot be made. No residents were harmed by this alleged deficient practice. Current resident's skin was assessed from 8-21-26 through 9-13-26 and no new skin issues were identified. Licensed Associates were re-educated on the significance of assessing, documenting and reporting any significant changes in a resident's condition as soon as possible. This assessment is required when the "change" results in a new, ongoing, or increased care need that may persist or are anticipated to persist for more	09/13/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	Finding includes: A record review of Resident B was completed on 8/21/2026 at 12:30 P.M. Diagnoses included, but were not limited to: stage two pressure injury of buttocks, anemia, type two diabetes mellitus, hypertension, atrial fibrillation, rhabdomyolysis, chronic kidney disease and morbid obesity. A Nursing Progress Note dated 7/12/2026, indicated a Qualified Medication Aide (QMA) had documented that Resident B had a pressure injury on his right ankle that had changed colors and was now black in color. Resident B's record lacked any documentation to indicate the wound on Resident B's ankle had been assessed by a nurse or doctor before 8/4/2026. A Hospice Assessment, dated 8/4/2026, indicated the resident had a small skin tear on his right ankle. During an interview on 8/24/2026 at 10:10 A.M., the Health and Wellness Director (HWD) indicated there was no charting to indicate the doctor had been notified or that the wound had been assessed by a nurse prior to 8/4/2026. On 8/24/2026 at 11:11 A.M., the		than two weeks. The assessment will be documented in accordance with Brookdale policies and procedures, and the resident's care plan will be reviewed and updated as indicated. Skin observations will be completed with each shower and with monthly skin assessments by a licensed associate. HWD and/or designee to complete random skin assessments on 5 residents monthly for 6 months. Any new skin issues identified will be reported to MD and POA and treated per MD orders. Completed 9-13-26. HWD responsible for compliance	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	Executive Director provided a current policy, dated 8/2022, and titled, "Resident Evaluation Policy." The policy indicated, "...1. An appropriately trained Brookdale associates (e.g. Health Care Coordinator, Executive Director, Community Sales Representative) will complete an evaluation (e.g. Personal Service Assessment-PSA) by move-in, within 30 days after move-in, periodically thereafter, and as soon as possible after a change in condition that results in altered care needs over a period of greater than two weeks. A licensed nurse will be involved during all assessments to evaluate the nursing needs of the resident..." This citation relates to intake 471291.			
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;	R 0217	R217 Corrections from previous timeframes cannot be made. No residents were harmed by this alleged deficient practice. All service plans were audited by 9-11-26 and updated timely per Brookdale policy and procedure, by the HWD or designee and updated per Brookdale policy and procedure, upon move-in, within 30 days after move-in, at 6 months and	09/11/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

(B) frequency; (C) need; and (D) preference; 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 update a Service Plan timely after a resident began receiving Hospice Services for 1 of 7 residents reviewed. (Resident B)		with any change of condition. Service plans will be monitored by the ED, HWD, or designee, daily five (5) times per week for four (4) weeks, weekly for 1 month, bi-monthly for 3 months thereafter and monthly for three (3) months. To assist with ongoing compliance, the ED or designee will review the service plan monitoring results of service plan audits. Completed 9-11-26. HWD/designee responsible for compliance	
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Finding includes:

Resident B's record review was completed on, 8/21/2026 at 12:30 P.M. Diagnoses included, but were not limited to: stage two pressure injury of buttocks, anemia, type two diabetes mellitus, hypertension, atrial fibrillation, rhabdomyolysis, chronic kidney disease and morbid obesity.

A current physician's order, dated 5/29/2026, indicated Resident B was to receive Hospice services.

A current service plan, dated 3/2026, had not been updated after Resident B started receiving Hospice services.

A currently Hospice agreement with Resident B and a local Hospice service had been initiated on 7/31/2026.

During an interview, on 8/21/2026 at 2:30 P.M., the Director of Health and Wellness indicated Resident B's service plan had not been updated after he had started receiving Hospice services, but should have been.

On 8/24/2026 at 11:11 A.M., the Executive Director provided a current policy, dated 8/2024, and titled, "Resident Service Plan." The ED indicated the policy was the one currently

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	used by the facility. The policy indicated, "... The Service Plan will be reviewed and revised as necessary. Following a change of condition in the resident that results in altered care needs over a period of greater than two weeks...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. 2. During the initial tour of the kitchen on 8/21/2026 at 9:00 A.M., the two burners on the gas stove, the grill top and one of the ovens had a heavy build-up of a black substance on them. The reach in refrigerator had the following: -Baked beans dated 8/13/2026 - A container of BBQ sauce with no open or use by date and the expiration from the manufacturer could not be located. -Italian dressing, opened on 4/1/26 and expired on	R 0273	F273 Cross-reference: R273, Finding #1 • All residents receiving meals served by facility staff have the potential to be affected by this deficient practice. The Director of Dining (DOD) provided re-education to all staff who participate in meal service and will monitor meal service to insure compliance. • The DOD or designee immediately re-educated all staff members on 8-24-26 who participate in meal service regarding proper food service sanitation and safe food-handling practices. Reeducation included, but not limited to: • Proper hand hygiene before and during meal service.	09/21/2026

6/17/2026.

-Thousand island dressing, opened on 4/1/2026 and expired on 6/7/2026.

-Balsamic vinaigrette opened, but with no opened on date.

-Honey mustard with a use by date of 4/25/2026.

-An opened container of dairy topping with no opened on or used by date.

-Tomato juice opened without an opened on date.

-A pitcher of tea with a made on date of 8/12/2026.

- A red colored fluid in a clear container without a label or a made on or expiration date.

- A green pitcher with green colored fluid without a made on or use by date.

- A container with a green colored fluid with no made on or use by date.

- A container with two large tea bags without a made on or discard date.

The walk-in cooler had the following:

-Two opened bottles of BBQ sauce without open on dates,

- Proper handling of plates, bowls, cups, utensils, and other tableware.
- Handling plates and bowls only from the outside rim and/or bottom.
- Prohibition of placing hands or fingers on the eating surface of plates, bowls, cups, or other food contact surfaces.
- Avoiding contact between hands, uniforms/clothing, and food or food contact surfaces.
- Proper use of plate covers, when applicable, to maintain appropriate food temperatures.
- Proper procedures for serving residents in a manner consistent with the kitchens Technique: Handling Tableware policy.

All staff assigned to serve meals will receive re-education and competency validation before independently serving residents.

Monitoring:

To assist with ongoing compliance, the DOD and/or designee will conduct direct observations of meal service daily five (5) times per week for four (4) weeks, bi-monthly for two (2) months, then monthly for two (2) months. Observations will verify proper hand hygiene,

-A container of peppered horseradish sauce with a label opened on date of 8/20/2025 and use by date of 12/2025.

-A container of cole slaw dressing opened without an opened date or a use by dates.

-A package of sliced ham, dated 8/14/2026 with a discard date of 8/19/2026.

A review of the "Temperature Log for Food and Beverage" indicated on 8/2/2026 there had been no temperatures of the breakfast meal recorded in the temperature log and on 8/20/2026 there had been no lunch meal temperatures recorded in the temperature log.

A review of the "Temperature Logs for Equipment" indicated the reach in refrigerator temperature had not been taken twice on the evening of 8/20/2026 and had not been taken before breakfast service on 8/21/2026. The log for the walk-in cooler indicated the temperature of the walk-in cooler had not been taken in the evening from 8/17-8/20/2026 and had not had a temperature recorded before the breakfast meal service on 8/21/2026. The log for the walk-in freezer indicated an evening temperatures had not been recorded from 8/17-8/20/2026.

sanitary handling of tableware, avoidance of contact with eating surfaces, and compliance with the facility's tableware-handling procedure.

Any identified concern will be corrected immediately, and additional education and/or competency validation will be provided as indicated. Audit results will be reviewed by the Executive Director and reported through the facility's Quality Assurance/Performance Improvement process as appropriate.

Finding #2 – Kitchen Sanitation / Food Preparation Equipment

Cross reference: R273, Finding #2

The DOD or designee will immediately clean and sanitize all identified kitchen equipment and food-preparation surfaces, including the gas stove burners, grill top, and oven, to remove accumulated residue and insure equipment is maintained in a sanitary condition.

The DOD and/or designee will complete a comprehensive inspection of the kitchen, including food-preparation equipment, work surfaces, food storage areas, and serving areas to identify and immediately correct any

During an interview on 8/21/2026 at 9:10 A.M., Cook 2 indicated the burners on the gas stove, the inside of the oven and the grill top should have been cleaned daily. Cook 2 also indicated all opened food and beverages should be labeled with a made on date and should be discarded after five days. Cook 2 indicated the facility should have been checking and recording refrigerator and freezer temperatures every four hours and recording meal temperatures before each meal service. Finally, Cook 2 indicated the temperature log with the missing breakfast date had been for the 8/2/2026 breakfast.

During an interview with the Director of Dietary (DOD) services on 8/24/2026 at 9:50 A.M., he indicated the entire kitchen staff was new and he had been training staff on the cleaning schedules and correct labeling/dating system. The DOD indicated the cooking equipment should have been cleaned daily and any food or beverage that had been opened should have been labeled with a made on date and an expired date. In addition, there should not have been any food kept in the refrigerator past the use by date. The DOD indicated staff should have been recording temperatures of the refrigerator

additional sanitation concerns, on-going.

The facility's **Kitchen Cleaning** policy was reviewed by the DOD or designee with all dietary staff. Dietary staff will be re-educated on food service equipment to be cleaned according to the established cleaning schedule and sanitized as required following use.

A cleaning schedule/checklist will be maintained by the DOD or designee to document completion of required cleaning and sanitation activities. The DOD and/or designee will review the kitchen cleaning documentation for completeness and address any missed or incomplete tasks.

Monitoring:

To assist with ongoing compliance, the DOD and/or designee will conduct a review of kitchen documentation daily five (5) times per week for one month, weekly for four (4) weeks, then bi monthly for two months then monthly for two months. Inspections will include cooking equipment, food preparation surfaces, and other food service areas.

Any concerns identified by the DOD or designee will be addressed, with staff re-education provided as

and freezers every four hours, as indicated by the temperature logs.

A review of the Temperature Log for Food and Beverages policy was completed on 8/24/2026 at 10:00 A.M. The Temperature Log for Food and Beverages policy indicated, "Food temperatures must be recorded at the beginning of meal service..."

A review of the Temperature Log for Equipment policy was completed on 8/24/2026 at 10:00 A.M. The Temperature Log for Equipment policy indicated, "...Food holding equipment temperatures must be monitored and recorded every four hours during operating hours...."

On 8/24/2026 at 10:09 A.M. a current, undated, policy, titled, "Technique: Handling Tableware" was provided by the ED. The policy indicated, "...Handle plates and bowls from the outside rim and bottom. Use a cloth napkin when carrying hot plates, if necessary. Ensure that plate covers are used to ensure meals stay at correct temperature. Do not place your hands or fingers on the eating surface of any plate, bowl, cup, etc...."

On 8/21/2026 at 2:00 P.M., the Executive Director (ED)

indicated. Monitoring results will be reported to ED or designee.

Finding #3 Food Labeling, Dating, and Expiration

Cross-reference: R273, finding #2 Reach-In Refrigerator

The DOD or designee immediately inspected the entire reach – in refrigerator and all other food storage areas. Any expired, improperly labeled, undated, or otherwise improperly stored food was discarded or corrected in accordance with facility policy and applicable food safety requirements.

All dietary staff were re-educated by the DOD or designee, regarding the facility's **Labeling** policy, including the requirement that food items be labeled and dated before storage.

Re-education included identification of prepared foods, including the name of the item, date/time prepared, preparer identification as required by facility policy, and discard/use-by date.

provided a current policy dated, 7/2024, and titled, "Kitchen Cleaning." The policy indicated, "Food service equipment is cleaned per cleaning schedule and sanitized after each use..."

On 8/21/2026 at 2:00 P.M., the ED provided a current policy dated, 3/2026, and titled, "Labeling." The ED indicated the policy was the one currently used by the facility. The policy indicated, "...All food items must be labeled and dated before storing... 2. All prepared items must have a label with the name of item, date and time prepared, by whom, and discard/use by date...."

Based on observation, interview, and record review, the facility failed store food and prepare meals in a sanitary kitchen for 1 of 1 kitchens observed and failed to serve meals in a safe and sanitary manner for 9 of 19 residents who ate lunch in the dining room.

Findings include:

1. During an observation of the lunch meal service in the dining room, on 8/21/2026 at 12:11 P.M., LPN 3 and the Life Enrichment Director served plates of food to 9 residents after having touched their uniforms and/or with their thumbs touching the eating

Dietary staff has been instructed by the DOD or designee to verify food labels and expiration, use by dates as part of routine food storage practices.

The DOD or designee will conduct routine refrigerator inspections to verify:

- Food is properly labeled and dated.
- Prepared food contains the required identifying information.
- Discard/use-by dates are present and current.
- Expired food is promptly removed.
- Food is stored appropriately and maintained in a sanitary condition.

Monitoring:

To assist with ongoing compliance, the refrigerator and food storage audits will be conducted by the DOD or designee daily, five (5) times per week for one month, weekly for four weeks, then monthly for two months. Any variance identified will be corrected by the DOD or designee, and additional staff re-education will be provided as necessary by the DOD or designee.

surface of the plates as the plates were placed in front of the residents.

During an interview on 8/21/2026 at 12:20 P.M., the ED indicated they had recently switched from hired servers to utilizing nursing staff to serve meals and the staff had not yet been trained.

Finding #4 – Food Temperature Monitoring

Cross reference: R273, Food and Nutritional Services

The DOD or designee will implement immediate re-education of all applicable dietary staff regarding food temperature monitoring requirements.

Re-education will include compliance with the facility's **Food and Beverages Temperature Log** policy, including the requirement that food temperatures be recorded **at the beginning of meal service.**

The DOD or designee will also re-educate dietary staff regarding the kitchens **Equipment Temperature Log**, policy, including the requirement that food holding equipment temperatures be monitored and documented **every four hours during operating hours.**

The DOD and/or designee will verify that the appropriate temperature logs are available, completed accurately and timely, and maintained according to facility policy.

Any temperature identified to be outside the kitchens established acceptable range will be addressed immediately by the

DOD or designee, according to facility policy, including corrective action regarding the food or equipment as appropriate.

Monitoring:

To assist with ongoing compliance, the DOD and/or designee will review food and food holding equipment temperature logs daily for four weeks, weekly for four weeks, bi-monthly review for two (2) months, to verify that required temperatures are obtained and documented at the required frequency.

Any missing, incomplete, or inaccurate documentation will result in immediate follow up, correction, and staff re-education.

Systemic Staff Education and Competency

Cross reference: R273, findings #1-#4

The DOD or designee will provide re-education to all dietary staff and all non-dietary staff who participate in meal service. Re-education will address:

- Safe food handling and sanitation
- Proper handling of plates

			and tableware. • Hand hygiene and prevention of contamination. • Kitchen cleaning and sanitation. • Food Labeling and dating. • Identification and removal of expired food. • Food temperature monitoring. • Food holding equipment temperature monitoring. • Documentation requirements. • Compliance with applicable facility food service policies. Staff will demonstrate understanding of the procedures through competency validation and/or return demonstration as applicable. New Staff who will participate in meal service will receive the applicable education during orientation and prior to independently performing meal service duties. Quality Assurance / On going Monitoring Cross reference: R273 Findings #1-#4 The Administrator, DOD, and HWD, and/or designated designee will oversee implementation of the corrective	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

actions.

Monitoring will include direct observation of meal service, kitchen sanitation inspections, refrigerator/food storage inspections and review of food and equipment temperature logs.

Audits will be conducted according to the monitoring schedules identified above. Trends and identified concerns will be reviewed through the facilities Quality Assurance/Performance improvement process. If a pattern of noncompliance is identified, the facility will implement additional corrective action, including re-education, competency validation, increased monitoring, and/or revision of processes indicated.

Responsible Persons:

The Executive Director, Dietary Manager, Health and Wellness Director, and/or designated designees will be responsible for implementation and oversight of the corrective actions outlined in the Plan of Correction.

Completion Date:

All corrective actions will be completed by:9-21-26

To assist with ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

			compliance the BOM or designee will maintain documentation of education, competency validation, cleaning and inspection records, temperature logs, audit results, and follow up corrective actions.	
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 SIGNATURESusan Tipton-Huttel		TITLEExecutive Director		(X6) DATE09/14/2026