STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON AT SOUTHPORT THE	7212 US HWY 31 S, INDIANAPOLIS, , 46227

(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: December 22 and 23, 2025 Facility number: 003283 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 29, 2025.	R 0000		
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items.	R 0155	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings	12/23/2025

	Based on observation, interview, and record review, the facility failed to ensure the ground around the dumpster area was free from rubbish for 1 of 2 observations. Findings include: During the initial facility tour with the Dietary Manager on 12/22/25 at 8:55 a.m., two dumpster containers, located approximately 20 yards from the kitchen's rear door, were observed. The following was observed lying on the ground next to the dumpster containers: multiple used plastic gloves, a large unidentifiable wooden piece of furniture, a broken stuffed recliner chair, and multiple small metal screws and metal washers. Approximately five yards from the dumpster containers were multiple long wooden boards and multiple pieces of vinyl lying on the ground. No staff were visible near the dumpster containers at that time. During an interview on 12/22/25 at 9:00 a.m., the Dietary Manager indicated the dumpster container area was to be kept clean and free of debris. On 12/23/25 at 9:20 a.m., the Executive Director provided an undated copy of the Dining Service "Quick Check" checklist		constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 3. What measures will be put into place or what systemic changes will the	

	document, and indicated it was the current checklist in use by the facility. A review of the document indicated, "...dumpsters are closed and area is free of clutter/trash..." On 12/22/25 at 3:15 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-26, effective April 16, 2025, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..." Based on observation, interview, and record review, the facility failed to ensure the ground around the dumpster area was free from rubbish for 1 of 2 observations. Findings include: During the initial facility tour with the Dietary Manager on 12/22/25 at 8:55 a.m., two dumpster containers, located approximately 20 yards from the kitchen's rear door, were observed. The following was observed lying on the ground next to the dumpster containers: multiple used plastic gloves, a large unidentifiable wooden piece of furniture, a broken		facility make to ensure that the deficient practice does not recur? 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 5. By what date the systemic changes will be completed. **R0155** 1. The items observed lying on the ground next to the dumpsters or near the dumpsters have been removed. 2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3. An in-service will be conducted with Dining staff, the Dining Services Director, and the Maintenance Director to ensure they are educated on how the dumpster area should be kept clean. 4. The Executive Director or designee will inspect the dumpster weekly for eight weeks and monthly for three months to ensure compliance.	

	stuffed recliner chair, and multiple small metal screws and metal washers. Approximately five yards from the dumpster containers were multiple long wooden boards and multiple pieces of vinyl lying on the ground. No staff were visible near the dumpster containers at that time. During an interview on 12/22/25 at 9:00 a.m., the Dietary Manager indicated the dumpster container area was to be kept clean and free of debris. On 12/23/25 at 9:20 a.m., the Executive Director provided an undated copy of the Dining Service "Quick Check" checklist document, and indicated it was the current checklist in use by the facility. A review of the document indicated, "...dumpsters are closed and area is free of clutter/trash..." On 12/22/25 at 3:15 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-26, effective April 16, 2025, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..."		5. Systemic changes: 12/23/2025	

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. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 4 of 4 observations. Staff hair was not covered while in the kitchen food preparation and serving area and the an uncovered prepared food plate was delivered to two different residents. (Dietary Manager, Cook 2, Dining Assistant 3) Finding includes: 1. During the initial kitchen observation with the Dietary Manager (DM), on 12/22/25 from 8:35 a.m. to 8:50 a.m., the following was observed: - Cook 2 was observed walking throughout the kitchen area and near the steam table that held the breakfast foods. Cook 2 was observed wearing a hair net that covered the hair just above the ears and approximately two inches above the neckline to the top of his head. Cook 2's hair,	R 0273	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. 1. What corrective action(s) will be accomplished for	12/23/2025

	approximately one inch in length, in front of the ears, above the ears and below the hair net to the neckline was observed to not be covered. Cook 2 also had facial hair, approximately one-fourth inch in length, above the upper lip area that was observed to not be covered. - The DM was observed walking throughout the kitchen area and near the steam table that held the breakfast foods. The DM was observed to have facial hair, approximately one-half inch in length, above the upper lip and in front of the ears. The hair was observed to not be covered. During a follow-up kitchen observation, on 12/22/25 from 11:50 a.m. to 12:02 p.m., the following was observed: - Cook 2 was observed working at the steam table that held the noon meal foods, recorded the starting food temperatures, and plated the resident's noon meal. Cook 2 was observed wearing a hair net that covered hair just above the ears and approximately two inches above the neckline to the top of his head. Cook 2's hair, approximately one inch in length, in front of the ears, above the ears and below the hair net to the neckline was observed to not be covered.		those residents found to have been affected by the deficient practice? 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 5. By what date the systemic changes will be completed. **R0273** 1. Cook 2 hair and facial hair are covered while in the kitchen and during meal prep. DM's facial hair is covered while in the kitchen. Dining Assistant 3 will not serve previously delivered and refused meals to another resident. 2. The Community reviewed each resident’s record to determine which	

	Cook 2 also had facial hair, approximately one-fourth inch in length, above the upper lip area that was observed to not be covered. - The DM was observed walking throughout the kitchen area and near the steam table that held the noon meal foods. The DM was observed to have facial hair, approximately one-half inch in length, above the upper lip and in front of the ears. The hair was observed to not be covered. During a follow-up kitchen observation, on 12/22/25 from 12:30 p.m. to 12:35 p.m., the following was observed:		residents, if any, could be affected by the alleged deficient practice. 3. An in-service will be conducted with the Dining Services Director and dining staff to ensure they are educated on the proper head and facial coverings and not reserving previously refused uncovered meals to other residents. 4. The Executive Director or designee will perform walkthroughs of the kitchen area to ensure that proper head/face coverings are in use and will monitor the serving of residents to ensure refused uncovered meals are not offered to other residents. Said walkthroughs and monitoring will be conducted twice weekly for eight weeks and then monthly for an additional three months. 5. Systemic changes: 12/23/2025	

	- Cook 2 was observed working at the steam table that held the noon meal foods, was plating the resident's noon meal and was taking the ending food temperatures. Cook 2 was observed wearing a hair net that covered hair just above the ears and approximately two inches above the neckline to the top of his head. Cook 2's hair, approximately one inch in length, in front of the ears, above the ears and below the hair net to the neckline was observed to not be covered. Cook 2 also had facial hair, approximately one-fourth inch in length, above the upper lip area that was observed to not be covered. - The DM was observed walking throughout the kitchen area and near the steam table that held the noon meal foods. The DM was observed to have facial hair, approximately one-half inch in length, above the upper lip and in front of the ears. The hair was observed to not be covered. During an interview on 12/22/25 at 12:38 p.m., Cook 2 indicated staff's hair was to be kept covered while in the kitchen area and facial hair above the lips was not required to be covered. During an interview on 12/22/25 at 12:40 p.m., the DM indicated			

	staff hair, including facial hair, was to be kept covered while in the kitchen preparation areas and while in the serving areas. 2. On 12/22/25 from 12:14 p.m. to 12:17 p.m., during the noon meal service the following was observed: - Cook 2 was observed plating the noon meal for the residents who were eating in the dining room. The plated foods were placed on the ledge through the serving window. The staff in the dining room then retrieved the uncovered plates and delivered them to the residents in the dining room. - The DM picked up an uncovered plated noon meal from the serving window and delivered it to a resident who was sitting at a table in the dining room. As the DM placed the plate in front of the resident, the resident indicated she did not want the entire meal as she only wanted the broccoli. - The DM picked up uncovered plated noon meal and returned it to the serving window.			

	- Dining Assistant 3 asked if the uncovered plated noon meal had been touched by the resident who refused the plate. The DM indicated she had not touched it and so it could be delivered to another resident for consumption. - Dining Assistant 3 delivered the same uncovered plated noon meal to another resident in the dining room. During an interview on 12/23/25 at 10:05 p.m., the DM indicated plated foods were not to be retrieved from one resident and given to another resident for consumption. During an interview on 12/23/25 at 10:15 a.m., the Executive Director indicated the facility lacked a policy regarding the delivery of plated foods to the residents. On 12/22/25 at 2:35 p.m., the Business Office Manager provided a copy of the "Food Service Safety Rules policy, dated March 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...hair must be restrained..." On 12/23/25 at 9:20 a.m., the Executive Director provided an undated copy of the Dining Service "Quick Check" checklist document, and indicated it was the current checklist in use by			

	the facility. A review of the document indicated, "...hair adequately restrained with hairnet/hat/beard restraint..." On 12/22/25 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-26, effective April 16, 2025, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food...food that is unused or returned by the consumer may not be offered as food for human consumption..." Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 4 of 4 observations. Staff hair was not covered while in the kitchen food preparation and serving area and the an uncovered prepared food plate was delivered to two different residents. (Dietary Manager, Cook 2, Dining Assistant 3) Finding includes: 1. During the initial kitchen observation with the Dietary Manager (DM), on 12/22/25 from 8:35 a.m. to 8:50 a.m., the following was observed: - Cook 2 was observed walking			

	throughout the kitchen area and near the steam table that held the breakfast foods. Cook 2 was observed wearing a hair net that covered the hair just above the ears and approximately two inches above the neckline to the top of his head. Cook 2's hair, approximately one inch in length, in front of the ears, above the ears and below the hair net to the neckline was observed to not be covered. Cook 2 also had facial hair, approximately one-fourth inch in length, above the upper lip area that was observed to not be covered. - The DM was observed walking throughout the kitchen area and near the steam table that held the breakfast foods. The DM was observed to have facial hair, approximately one-half inch in length, above the upper lip and in front of the ears. The hair was observed to not be covered. During a follow-up kitchen observation, on 12/22/25 from 11:50 a.m. to 12:02 p.m., the following was observed: - Cook 2 was observed working at the steam table that held the noon meal foods, recorded the starting food temperatures, and plated the resident's noon meal. Cook 2 was observed wearing a hair net that covered hair just above the ears and			

	approximately two inches above the neckline to the top of his head. Cook 2's hair, approximately one inch in length, in front of the ears, above the ears and below the hair net to the neckline was observed to not be covered. Cook 2 also had facial hair, approximately one-fourth inch in length, above the upper lip area that was observed to not be covered. - The DM was observed walking throughout the kitchen area and near the steam table that held the noon meal foods. The DM was observed to have facial hair, approximately one-half inch in length, above the upper lip and in front of the ears. The hair was observed to not be covered. During a follow-up kitchen observation, on 12/22/25 from 12:30 p.m. to 12:35 p.m., the following was observed: - Cook 2 was observed working at the steam table that held the noon meal foods, was plating the resident's noon meal and was taking the ending food temperatures. Cook 2 was observed wearing a hair net that covered hair just above the ears and approximately two inches above the neckline to the top of his head. Cook 2's hair, approximately one inch in length, in front of the ears,			

above the ears and below the hair net to the neckline was observed to not be covered. Cook 2 also had facial hair, approximately one-fourth inch in length, above the upper lip area that was observed to not be covered.

- The DM was observed walking throughout the kitchen area and near the steam table that held the noon meal foods. The DM was observed to have facial hair, approximately one-half inch in length, above the upper lip and in front of the ears. The hair was observed to not be covered.

During an interview on 12/22/25 at 12:38 p.m., Cook 2 indicated staff's hair was to be kept covered while in the kitchen area and facial hair above the lips was not required to be covered.

During an interview on 12/22/25 at 12:40 p.m., the DM indicated staff hair, including facial hair, was to be kept covered while in the kitchen preparation areas and while in the serving areas.

2. On 12/22/25 from 12:14 p.m. to 12:17 p.m., during the noon meal service the following was observed:

- Cook 2 was observed plating the noon meal for the residents who were eating in the dining room. The plated foods were

placed on the ledge through the serving window. The staff in the dining room then retrieved the uncovered plates and delivered them to the residents in the dining room.

- The DM picked up an uncovered plated noon meal from the serving window and delivered it to a resident who was sitting at a table in the dining room. As the DM placed the plate in front of the resident, the resident indicated she did not want the entire meal as she only wanted the broccoli.

- The DM picked up uncovered plated noon meal and returned it to the serving window.

- Dining Assistant 3 asked if the uncovered plated noon meal had been touched by the resident who refused the plate. The DM indicated she had not touched it and so it could be delivered to another resident for consumption.

- Dining Assistant 3 delivered the same uncovered plated noon meal to another resident in the dining room.

During an interview on 12/23/25 at 10:05 p.m., the DM indicated plated foods were not to be retrieved from one resident and given to another resident for consumption.

During an interview on 12/23/25

	at 10:15 a.m., the Executive Director indicated the facility lacked a policy regarding the delivery of plated foods to the residents. On 12/22/25 at 2:35 p.m., the Business Office Manager provided a copy of the "Food Service Safety Rules policy, dated March 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...hair must be restrained..." On 12/23/25 at 9:20 a.m., the Executive Director provided an undated copy of the Dining Service "Quick Check" checklist document, and indicated it was the current checklist in use by the facility. A review of the document indicated, "...hair adequately restrained with hairnet/hat/beard restraint..." On 12/22/25 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-26, effective April 16, 2025, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food...food that is unused or returned by the consumer may not be offered as food for human consumption..."			

R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure a discharged resident's drug disposition was completed for 1 of 2 closed records reviewed. (Resident 71)	R 0306	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. 1. What corrective action(s) will be accomplished for	12/23/2025

Finding includes:

On 12/22/23 at 11:00 a.m., the clinical record for Resident 71 was reviewed. The diagnosis included, but was not limited to, dementia.

A Nurses Note, dated 11/27/25 at 1:00 p.m., indicated Resident 71 was not returning to the facility.

The most recent physician orders, dated November 2025, included but was not limited to:

- Amantadine (an anti-Parkinson's medication) 100 mg (milligrams)

- Anoro Ellipta (an inhaled medication used to treat chronic obstructive pulmonary disease) 62.5-25 mcg (micrograms)

- Aricept (a medication used to treat dementia) 10 mg

- Buspar (an anti-anxiety medication) 15 mg

- Trazodone (an anti-depressant medication) 50 mg

The clinical record lacked a completed drug disposition record.

During an interview on 12/22/25 at 1:30 p.m., the Director of Nursing indicated the drug disposition record was not available and should have been

those residents found to have been affected by the deficient practice?
2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?
4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
5. By what date the systemic changes will be completed.

R0306

1. Resident 71's medications were returned to the family.
2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice.
3. An in-service will be conducted with the Director of Nursing and floor nurses to ensure

documented at the time of discharge.

On 12/23/25 at 8:41 a.m., the Director of Nursing provided a policy titled Drug Disposal, dated August 2017, and indicated it was the current policy being used by the facility. A review of the policy indicated "1. all unused medications must be returned to the pharmacy or disposed of and a record kept in the Resident's Service Record of such disposal or return."

Based on interview and record review, the facility failed to ensure a discharged resident's drug disposition was completed for 1 of 2 closed records reviewed. (Resident 71)

Finding includes:

On 12/22/23 at 11:00 a.m., the clinical record for Resident 71 was reviewed. The diagnosis included, but was not limited to, dementia.

A Nurses Note, dated 11/27/25 at 1:00 p.m., indicated Resident 71 was not returning to the facility.

The most recent physician orders, dated November 2025, included but was not limited to:

- Amantadine (an anti-Parkinson's medication)

they are educated on how and when the drug disposition form should be completed.

4. The Director of Nursing and or designee will audit all discharge residents' files to ensure drug disposition forms are filled out.
5. Systemic changes: 12/23/2025

100 mg (milligrams)

- Anoro Ellipta (an inhaled medication used to treat chronic obstructive pulmonary disease) 62.5-25 mcg (micrograms)

- Aricept (a medication used to treat dementia) 10 mg

- Buspar (an anti-anxiety medication) 15 mg

- Trazodone (an anti-depressant medication) 50 mg

The clinical record lacked a completed drug disposition record.

During an interview on 12/22/25 at 1:30 p.m., the Director of Nursing indicated the drug disposition record was not available and should have been documented at the time of discharge.

On 12/23/25 at 8:41 a.m., the Director of Nursing provided a policy titled Drug Disposal, dated August 2017, and indicated it was the current policy being used by the facility. A review of the policy indicated "1. all unused medications must be returned to the pharmacy or disposed of and a record kept in the Resident's Service Record of such disposal or return."

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 SIGNATUREKeisha	TITLEDube	(X6) DATE01/09/2026