STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT NOBLESVILLE SENIOR LIVING	7235 RIVERWALK WAY N, NOBLESVILLE, , 46062

(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: February 2, 3, and 4, 2026 Facility number: 004417 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 9, 2026.	R 0000	The submission of this Plan of Correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulations. This provider respectfully requests that the 2567 Plan of Correction be considered for desk review in lieu of Post Survey Review.	
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.	R 0042	R 042 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the alleged	03/07/2026

	Based on observation and interview, the facility failed to ensure the survey results were available in a readily accessible area for residents and/or resident representatives. Findings include: During an observation, on 2/2/26 at 11:00 a.m., a sign on the left-hand side of the wall at the entrance indicated the survey binder was located at the receptionist desk. During an interview, at the time of the observation, the Receptionist indicated she was unaware of what the survey binder was and where it was located. The Receptionist asked the Business Office Manager (BOM) for assistance. The BOM entered the receptionist's office and looked inside a cabinet behind the receptionist desk. The survey binder was not present. The Receptionist asked the Administrator if he was aware of the location of the survey binder. She brought the survey binder out from the Administrator's office. During an interview, at the time of the observation, the BOM indicated a resident and/or resident representative would need to ask a staff member for assistance in locating the survey binder. During an interview, on 2/4/26 at		deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Survey Binder has been placed at the front Concierge Desk in the reach thru window assessable to all residents, guests, and families. The Survey Binder is clearly viewable to any resident, guest, and family member. The Concierge Desk employees and the Department Heads will be educated to the fact that the Survey Binder must be located in the Concierge Desk reach thru window assessable to all residents, guests,	

	10:15 a.m., the Administrator indicated the facility survey binder should be accessible to all residents, resident representatives, and/or guests at all times without the need for staff assistance. There was not a specific policy for the survey binder. An undated, current facility policy, titled, "Resident Rights", provided by the Administrator on 2/2/26 shortly after the entrance conference, indicated the following: " ...(8) Examine the results of the most recent survey of the facility conducted by the representatives of the Department..." Based on observation and interview, the facility failed to ensure the survey results were available in a readily accessible area for residents and/or resident representatives. Findings include: During an observation, on 2/2/26 at 11:00 a.m., a sign on the left-hand side of the wall at the entrance indicated the survey binder was located at the receptionist desk. During an interview, at the time of the observation, the Receptionist indicated she was unaware of what the survey binder was and where it was located. The Receptionist asked the Business Office Manager (BOM)		and families. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director and/or designee will audit the location of the Survey Binder three times per week for 60-days to ensure the Survey Binder is located in the Concierge reach thru window assessable to all residents, guests, and families. The systemic changes will be completed by March 7, 2026.	

	for assistance. The BOM entered the receptionist's office and looked inside a cabinet behind the receptionist desk. The survey binder was not present. The Receptionist asked the Administrator if he was aware of the location of the survey binder. She brought the survey binder out from the Administrator's office. During an interview, at the time of the observation, the BOM indicated a resident and/or resident representative would need to ask a staff member for assistance in locating the survey binder. During an interview, on 2/4/26 at 10:15 a.m., the Administrator indicated the facility survey binder should be accessible to all residents, resident representatives, and/or guests at all times without the need for staff assistance. There was not a specific policy for the survey binder. An undated, current facility policy, titled, "Resident Rights", provided by the Administrator on 2/2/26 shortly after the entrance conference, indicated the following: " ...(8) Examine the results of the most recent survey of the facility conducted by the representatives of the Department..."			

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 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. Based on record review and interview, the facility failed to ensure the presence of a staff member certified in first aid for 13 of 21 shifts scheduled. This deficiency had to the potential to	R 0117	R 117 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected by the alleged deficient practice. The facility has scheduled first aid certification training to certify nurses and qualified medication assistants in first aid. That certification training will take place on February 24th and February 26th. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. The facility has scheduled first aid certification training to certify nurses and qualified medication assistants in first aid.	03/07/2026

	affect 91 of 91 residents residing in the facility. Findings include: Employee schedules, provided by the DON on 2/3/26 at 3:05 p.m., were reviewed on 2/3/26 at 3:10 p.m., and indicated the following shifts lacked a staff member certified in first aid: On 1/25/26 from 6:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 1/26/26 from 6:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 1/28/26 from 6:00 a.m.- 2:00 p.m., 2:00 p.m.- 10:00 p.m., and 10:00 p.m.- 6:00 a.m., 1/29/26 from 6:00 p.m. - 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 1/30/26 from 6:00 a.m.- 2:00 p.m. and 2:00 p.m.- 6:00 p.m., 1/31/26 from 6:00 a.m.- 2:00 p.m. and 2:00 p.m.- 6:00 p.m. During an interview, on 2/3/26 at 3:55 p.m., the DON indicated a staff member certified in first aid should be scheduled for every shift. During an interview, on 2/4/26 at 10:15 a.m., the Administrator indicated there was no policy to provide for first aid.		That certification training will take place on February 24th and February 26th. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility will utilize a First Aid Binder to keep all nurses and qualified medication assistants current first aid certification. The First Aid Binder will hold all nurses and qualified medication assistants current first aid certification to ensure compliance. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Business Office Manager or designee will audit the First Aid Binder that will contain all nurses and qualified medication assistants first aid certifications monthly times 90-days to ensure compliance. The systemic changes will be	

	Based on record review and interview, the facility failed to ensure the presence of a staff member certified in first aid for 13 of 21 shifts scheduled. This deficiency had to the potential to affect 91 of 91 residents residing in the facility. Findings include: Employee schedules, provided by the DON on 2/3/26 at 3:05 p.m., were reviewed on 2/3/26 at 3:10 p.m., and indicated the following shifts lacked a staff member certified in first aid: On 1/25/26 from 6:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 1/26/26 from 6:00 p.m.- 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 1/28/26 from 6:00 a.m.- 2:00 p.m., 2:00 p.m.- 10:00 p.m., and 10:00 p.m.- 6:00 a.m., 1/29/26 from 6:00 p.m. - 10:00 p.m. and 10:00 p.m.- 6:00 a.m., 1/30/26 from 6:00 a.m.- 2:00 p.m. and 2:00 p.m.- 6:00 p.m., 1/31/26 from 6:00 a.m.- 2:00 p.m. and 2:00 p.m.- 6:00 p.m.		completed by March 7, 2026.	

	During an interview, on 2/3/26 at 3:55 p.m., the DON indicated a staff member certified in first aid should be scheduled for every shift. During an interview, on 2/4/26 at 10:15 a.m., the Administrator indicated there was no policy to provide for first aid.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training 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	R 0120	R 120 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. There were two employees listed under R 120 in the 2567 that had worked more than one year and had less than 3-hours of dementia training. Those two employees were the Dietary Manager and Activity Assistant 4. The Dietary Manager is no longer employed at the Crossings at Noblesville. The Activity Assistant 4 will receive 3-hours of dementia training.	03/07/2026

	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. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review the facility filed ensure employees, who had worked in the facility for longer than one year, had 3 hours of dementia training annually for 2 of 2 long term employees reviewed for dementia education (Dietary Manager and Activity Assistant 4). Findings include: Employee Records were reviewed on 2/3/26 at 11:40 a.m. Information regarding dementia training was not		2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were affected by the alleged deficient practice. There were two employees listed under R 120 in the 2567 that had worked more than one year and had less than 3-hours of dementia training. Those two employees were the Dietary Manager and Activity Assistant 4. The Dietary Manager is no longer employed at the Crossings at Noblesville. The Activity Assistant 4 will receive 3-hours of dementia training. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Business Office Manager or designee will audit all employees that have been employed for one year or more to ensure each employee has 3-hours of dementia	

	complete. Additional information was requested of the facility on 2/3/26 at 11:51 a.m. The employee record for the Dietary Manager was reviewed on 2/3/26 at 11:40 a.m. The Dietary Manager's start of employment date was 9/20/21. The employee record lacked documentation of any dementia training during the 2025 or 2026 year. The employee record for Activity Assistant 4 was reviewed on 2/3/26 at 11:40 a.m. Activity Assistant 4's start of employment date was 4/19/23. The employee record lacked documentation of any dementia training during the 2025 or 2026 year. During an interview on 2/3/26 at 3:19 p.m., the Administrator indicated the facility was unable to provide any documentation for dementia specific education or training for the Dietary Manager or Activity Assistant 4 during the year 2025 or 2026. During an interview on 2/4/26 at 10:25 a.m., the Administrator indicated the facility did not have a policy for dementia training. The facility's plan was to follow state regulations for future dementia training. Based on interview and record review the facility filed ensure		training. Any employee that has less than 3-hours of annual dementia training will be required to complete dementia training until they have reached 3-hours of annual dementia training. The Business Office Manager or designee will be responsible for oversight and monitoring the training compliance to ensure employees that have been employed for one year or more receive 3-hours of annual dementia training. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Dementia specific training will be reviewed and monitored to ensure that compliance is achieved for a sixty (60) day period. The systemic changes will be completed by March 7, 2026.	

	employees, who had worked in the facility for longer than one year, had 3 hours of dementia training annually for 2 of 2 long term employees reviewed for dementia education (Dietary Manager and Activity Assistant 4). Findings include: Employee Records were reviewed on 2/3/26 at 11:40 a.m. Information regarding dementia training was not complete. Additional information was requested of the facility on 2/3/26 at 11:51 a.m. The employee record for the Dietary Manager was reviewed on 2/3/26 at 11:40 a.m. The Dietary Manager's start of employment date was 9/20/21. The employee record lacked documentation of any dementia training during the 2025 or 2026 year. The employee record for Activity Assistant 4 was reviewed on 2/3/26 at 11:40 a.m. Activity Assistant 4's start of employment date was 4/19/23. The employee record lacked documentation of any dementia training during the 2025 or 2026 year. During an interview on 2/3/26 at 3:19 p.m., the Administrator indicated the facility was unable to provide any documentation			

	for dementia specific education or training for the Dietary Manager or Activity Assistant 4 during the year 2025 or 2026. During an interview on 2/4/26 at 10:25 a.m., the Administrator indicated the facility did not have a policy for dementia training. The facility's plan was to follow state regulations for future dementia training.			
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 food was stored, prepared, and served under safe sanitary conditions. This deficient practice had the potential to impact 91 of 91 residents who received meals from the kitchen. Findings include:	R 0273	R 273 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were affected by the alleged deficient practice. 3. What measures will be put into place or what	03/07/2026

	During a kitchen tour, on 2/2/26 at 10:30 a.m., accompanied by the Dietary Manger, the following concerns were identified: a. The hand washing sink did not have paper towel available for drying one's hands. Above the sink was an open paper towel dispenser, which was hanging open. In the open space left from the front of the towel dispenser hanging down was a box of disposable gloves and a totally saturated roll of paper towels. In the dry storage room there were two (2) open boxes of raisins, which had not been dated when opened and had been rolled down but not secured closed. There was also a half bag of corn hips, which had not been dated when opened and was folded over. The folding method left the chips open to air. At this time, the Dietary Manager threw away both items. b. The refrigerator located closed to the entrance door had four trays of sliced lemon meringue pies. The pies were undated and unlabeled and open to air. They was not a method to ensure freshness or prevent contamination. Under the four trays of lemon meringue pies was a large square container of cut pineapple. The container was not dated or		systemic changes the facility will make to ensure that the deficient practice does not recur: The paper towel holder located by the kitchen hand washing sink has been fully repaired and is fully operational and loaded with paper towel. The Dining Services Team will receive additional safe food handling and handwashing training per company policy. The Dining Services Team will also be trained in proper handling of opened food per company policy including labeling, dating, and securely sealing food to open air. The Dining Services Team will be trained regarding proper glove use per company policy and proper utilization of the food production temperature logs. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	

	labeled. The clear plastic wrap on top of the container was not secured. It dipped down, exposing the pineapple to air and did not prevent contamination. c. In the freezer in the food preparation area were an open uncovered container of breaded chicken strips, an open uncovered container of hamburger patties, and a open bag of freezer waffles. One waffle was totally out of the bag and resting on the freezer shelf. During the lunch meal observation on 2/2/26 at 11:23 a.m. to 11:38 a.m., the following concerns were identified: a. The paper towel holder by the hand washing sink was hanging open. There was a fresh roll of paper towels resting in the lid. There was no method to access the paper towel without making contact with the entire roll. b. Cook 5 and Cook 6 were observed serving food. During the food service process they wore single use disposable gloves. With their gloved hands, they mad contact with bread wrappers, slices of bread, sliced deli meat, lettuce, tomatoes, the toasters, toasted breads, refrigerator doors, and freezer doors. After contaminating their gloves they handled multiple items and made direct food		Safe food handling, hand washing, and glove utilization, and labeling, dating, and securely covering food will be monitored for (60) days to ensure the deficient practice is corrected. Team members not following the practice of safe food handling, hand washing, proper glove utilization and labeling, dating, and securely covering food will receive additional training and corrective action for any continued non-compliance. The Dining Services Director and/or designee, in the absence of the Director of Dining Services, will be responsible for overseeing and monitoring the Dining Services Departments safe food handling, handwashing, glove utilization, and labeling, dating, and securely covering food procedures/practices, to ensure that compliance and safe practices are being followed. The Dining Services Department’s compliance documents will be monitored daily to ensure compliance. The systemic changes will be completed by March 7, 2026.	

	contact. After making the food item and placing it on the tray, they removed their gloves, washed their hands, and repeated the process. During an interview at this time, both Cook 5 and Cook 6 expressed they thought they were disposing their gloves and washing their hands frequently enough. During an interview at this time, the Dietary Manger informed the cooks to just not wear gloves and touch the food with their bare hands because in Indiana you may touch food with bare hands. c. The steam table contained hamburgers, chicken, rice, a clear thin soup, and French fries. Review of the food production temperature log for the meal did not list any of the items served. During an interview at this time, the Dietary Manager indicated the sheets were often wrong, so they just did what they could. He indicated they did not write in the correct food items. d. At 11:35 a.m., Cook 6 went to the hand washing sink, washed her hands, and turned off the sink with her bare hands, making contact with the contaminated knobs. She reached towers the paper towels, shook her head and began to shake her hands vigorously. She did not dry her			

	hands. She put on disposable gloves and returned to work. A 2/2/26, facility "Kitchen Production Report", was provided by the Administrator on 2/3/26 at 3:13 p.m. and indicated the following: The food items cauliflower cheese soup, chicken salad croissants, pasta meatball stew, mashed potatoes, broccoli salad, and rice pudding were listed on the preprinted form. Temperatures had been recorded in ink beside the food items. These items were not served during the 2/2/26 lunch. A current, 9/1/2018, facility policy titled "Food Safety" was provided by the Administrator on 2/2/26 at 2:25 p.m. and indicated the following: "...During the food preparation and production process, food is handled by methods to minimize contamination and bacterial growth... A. Food is prepared in a sanitary manner with minimal handling... D. Food is prepared and served with clean tongs, scoops, forks, spoons, spatulas, and other suitable implements so as to avid manual contact...disposable gloves are worn when necessary...If gloves are worn, they are clean, without tears and changed			

	between tasks...." A current 10/1/22 facility policy titled, Dating and Labeling of Food in Production, was provided by the Administrator on 2/2/26 at 2:25 p.m., and indicated the following: "...All food open, prepared and used ...must be dated and labeled...and secured in sealed containers...." A current, 10/1/22, facility policy titled" Hand washing", was provided by the Administrator on 2/3/26 at 3:13 p.m. and indicated: "...All hand washing sinks must be functional, maintained clean, accessible/unobstructed, equipped with hot/cold water, soap, and drying device... Approved hand washing procedure... 5. Immediately following the cleaning procedure with a thorough drying method such as a disposable paper towel...." Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served under safe sanitary conditions. This deficient practice had the potential to impact 91 of 91 residents who received meals from the kitchen.			

	Findings include: During a kitchen tour, on 2/2/26 at 10:30 a.m., accompanied by the Dietary Manger, the following concerns were identified: a. The hand washing sink did not have paper towel available for drying one's hands. Above the sink was an open paper towel dispenser, which was hanging open. In the open space left from the front of the towel dispenser hanging down was a box of disposable gloves and a totally saturated roll of paper towels. In the dry storage room there were two (2) open boxes of raisins, which had not been dated when opened and had been rolled down but not secured closed. There was also a half bag of corn hips, which had not been dated when opened and was folded over. The folding method left the chips open to air. At this time, the Dietary Manager threw away both items. b. The refrigerator located closed to the entrance door had four trays of sliced lemon meringue pies. The pies were undated and unlabeled and open to air. They was not a method to ensure freshness or prevent contamination. Under the four trays of lemon meringue pies was a large square			

	container of cut pineapple. The container was not dated or labeled. The clear plastic wrap on top of the container was not secured. It dipped down, exposing the pineapple to air and did not prevent contamination. c. In the freezer in the food preparation area were an open uncovered container of breaded chicken strips, an open uncovered container of hamburger patties, and a open bag of freezer waffles. One waffle was totally out of the bag and resting on the freezer shelf. During the lunch meal observation on 2/2/26 at 11:23 a.m. to 11:38 a.m., the following concerns were identified: a. The paper towel holder by the hand washing sink was hanging open. There was a fresh roll of paper towels resting in the lid. There was no method to access the paper towel without making contact with the entire roll. b. Cook 5 and Cook 6 were observed serving food. During the food service process they wore single use disposable gloves. With their gloved hands, they mad contact with bread wrappers, slices of bread, sliced deli meat, lettuce, tomatoes, the toasters, toasted breads, refrigerator doors, and freezer doors. After contaminating their			

	gloves they handled multiple items and made direct food contact. After making the food item and placing it on the tray, they removed their gloves, washed their hands, and repeated the process. During an interview at this time, both Cook 5 and Cook 6 expressed they thought they were disposing their gloves and washing their hands frequently enough. During an interview at this time, the Dietary Manger informed the cooks to just not wear gloves and touch the food with their bare hands because in Indiana you may touch food with bare hands. c. The steam table contained hamburgers, chicken, rice, a clear thin soup, and French fries. Review of the food production temperature log for the meal did not list any of the items served. During an interview at this time, the Dietary Manager indicated the sheets were often wrong, so they just did what they could. He indicated they did not write in the correct food items. d. At 11:35 a.m., Cook 6 went to the hand washing sink, washed her hands, and turned off the sink with her bare hands, making contact with the contaminated knobs. She reached towers the paper towels, shook her head and			

began to shake her hands vigorously. She did not dry her hands. She put on disposable gloves and returned to work.

A 2/2/26, facility "Kitchen Production Report", was provided by the Administrator on 2/3/26 at 3:13 p.m. and indicated the following: The food items cauliflower cheese soup, chicken salad croissants, pasta meatball stew, mashed potatoes, broccoli salad, and rice pudding were listed on the preprinted form. Temperatures had been recorded in ink beside the food items. These items were not served during the 2/2/26 lunch.

A current, 9/1/2018, facility policy titled "Food Safety" was provided by the Administrator on 2/2/26 at 2:25 p.m. and indicated the following: "...During the food preparation and production process, food is handled by methods to minimize contamination and bacterial growth...

A. Food is prepared in a sanitary manner with minimal handling...

D. Food is prepared and served with clean tongs, scoops, forks, spoons, spatulas, and other suitable implements so as to avid manual contact...disposable gloves are worn when necessary...If gloves

	are worn, they are clean, without tears and changed between tasks...." A current 10/1/22 facility policy titled, Dating and Labeling of Food in Production, was provided by the Administrator on 2/2/26 at 2:25 p.m., and indicated the following: "...All food open, prepared and used ...must be dated and labeled...and secured in sealed containers...." A current, 10/1/22, facility policy titled" Hand washing", was provided by the Administrator on 2/3/26 at 3:13 p.m. and indicated: "...All hand washing sinks must be functional, maintained clean, accessible/unobstructed, equipped with hot/cold water, soap, and drying device... Approved hand washing procedure... 5. Immediately following the cleaning procedure with a thorough drying method such as a disposable paper towel...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall:	R 0298	R 298	03/07/2026

	(A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. 2. Resident 83's clinical record was reviewed on 2/2/26 at 3:21 p.m. Current diagnoses included Parkinson's Disease, type 2 diabetes mellitus, and hypertension. The resident received medication administration services from the facility. The resident had an 8/13/26 pharmacy drug regimen review. The record lacked documentation of any drug pharmacy regimen review since this date (over 5 months). 3. Resident 78's clinical record was reviewed on 2/3/26 at 1:55 p.m. Current diagnosis included		1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #70’s pharmacy drug regimen review was completed on February 14. Resident #83’s pharmacy drug regimen review was completed on February 14. Resident #78’s pharmacy drug regimen review was completed on February 14. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	

	type 2 diabetes mellitus, altered mental status, and hypokalemia. The resident received medication administration services from the facility. The resident had an 8/13/26 pharmacy drug regimen review. The record lacked documentation of any drug pharmacy regimen review since this date (over 5 months). During an interview, on 2/3/26 at 2:59 p.m., the DON indicated there was not a specific staff member assigned to keep track of pharmacy reviews. The facility received the recommendations and sent them to the appropriate physicians to be reviewed and returned. The facility ownership changed recently and the staff had been locked out of the e-mail system where she might have been able to access this information. She had reached out to the pharmacy directly. During a follow-up interview, on 2/4/26 at 9:05 a.m., the DON indicated the pharmacy sent reviews and recommendations for August 2025 only. She indicated that all residents who required medication administration would need pharmacy reviews every 60 days. She was unable to locate any pharmacy reviews or recommendations in the		All residents have the potential to be affected by the alleged deficient practice. The facility will ensure for residents whose medications are handled by the facility those residents will receive a pharmacy drug regimen review by the pharmacist every 60 days. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Facility's Executive Director and Director of Nursing discussed with the Pharmacy's Director of Operations, Director of Marketing, and Pharmacy Consultant the requirement of residents whose medications are handled by the facility those residents must have a pharmacy drug regimen review by the pharmacist every 60 days. The Pharmacy is aware of this requirement and will ensure compliance. The Director of Nursing or designee will review all pharmacy drug regimen reviews for	

	resident's clinical records. She had reached out again to request additional months' reviews. During an interview, on 2/4/26 at 10:15 a.m., the Administrator indicated there were no additional pharmacy reviews to provide. An undated, current facility policy, titled, "Tutera's Policy for Drug Regimen Reviews", provided by the Administrator on 2/4/26 at 10:15 a.m., indicated the following: "...The consultant pharmacist will perform a drug regimen review on each resident living in this facility at the time of the resident's admission to the facility and at least monthly and when requested by team members of the facility...Attending physician must document in the resident's clinical record that identified irregularity has been reviewed and what, if any, action has been taken to address the irregularity and document rationale for decision(s) in the resident's clinical record...." Based on interview and record review, the facility failed to ensure drug regimens for residents whose medications were handled by the facility were reviewed by the pharmacist every 60 days for 3 of 3 residents reviewed for		residents whose medications are handled by the facility to ensure those reviews are sent to the resident's physician for review and follow up. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing or designee will monitor the receipt of all pharmacy drug regimen reviews for residents whose medications are handled by the facility to ensure the pharmacy drug regimen reviews are received every 60-days. The Director of Nursing or designee will monitor this process for 120 days to ensure compliance. The systemic changes will be completed by March 7, 2026.	

	pharmacy services. (Resident 70, 83, 78) Findings include: 1. Resident 70's clinical record was reviewed on 2/4/26 at 1:40 p.m. Current diagnoses included anxiety, panic disorder, and bipolar disorder. The resident received medication administration services from the facility. The resident had an 8/13/25 pharmacy drug regimen review. The record lacked documentation of any pharmacy drug regimen review since this date (over 5 months). 2. Resident 83's clinical record was reviewed on 2/2/26 at 3:21 p.m. Current diagnoses included Parkinson's Disease, type 2 diabetes mellitus, and hypertension. The resident received medication administration services from the facility. The resident had an 8/13/26 pharmacy drug regimen review. The record lacked documentation of any drug pharmacy regimen review since this date (over 5 months). 3. Resident 78's clinical record was reviewed on 2/3/26 at 1:55 p.m. Current diagnosis included type 2 diabetes mellitus, altered mental status, and hypokalemia.			

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Based on interview and record review, the facility failed to ensure drug regimens for residents whose medications were handled by the facility were reviewed by the pharmacist every 60 days for 3 of 3 residents reviewed for pharmacy services. (Resident 70, 83, 78)

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R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.	R 0407	R 407 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected by the alleged deficient practice. The facility will develop and implement an infection control program which enables the facility to analyze patterns of known infectious symptoms, prevent the spread of	03/07/2026

	(4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to develop and implement an infection control program which enabled the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence of infection. This deficit practice had the potential to impact 91 of 91 residents who resided in the assisted living facility. Findings include: During an interview, on 2/3/26 at 2:19 p.m., the DON indicated she had not been tracking infections or signs and symptoms of infections for several months. She kept meaning to return to the infection control program, but never got around to completing this task. Review of the facility infection control binder, on 2/3/26 at 2:19 p.m., indicated the following: An Infection Control Prevention and Control Program Overview and a list of six residents' names, who had tested positive for COVID-19 in October 2025. A facility policy, dated 2019, titled, "Infection Prevention and Control Program", provided by		infection, and/or develop programs to prevent recurrence of infection. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. The facility will develop and implement an infection control program which enables the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence of infection. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility will ensure that the alleged deficient practice be corrected by updating and continuing to implement the facility infection control program. The infection control	

	the DON on 2/4/26 at 10:18 a.m., indicated the following: "...The primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to regulatory requirements and following accepted national standards...." Based on record review and interview, the facility failed to develop and implement an infection control program which enabled the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence of infection. This deficit practice had the potential to impact 91 of 91 residents who resided in the assisted living facility. Findings include: During an interview, on 2/3/26 at 2:19 p.m., the DON indicated		program will be utilized to analyze patterns of known infectious symptoms, to prevent the spread of infection within the facility and/or to implement measures within the facility to prevent the transmission of infection. The facility will maintain documentation tracking that will be utilized to prevent the spread of infection in the facility, to ensure compliance. The facility will monitor all infectious symptoms via an Infectious Log Binder, to both track infectious symptoms and to implement measures to prevent the spread of infectious symptoms, by analyzing patterns of known infectious symptoms and implementing precaution measures. The facility will provide orientation and education on infection prevention and universal precautions.	

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	according to regulatory requirements and following accepted national standards...."			

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 SIGNATUREDavid Pruett	TITLEExecutive Director	(X6) DATE02/20/2026