STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANDLER PLACE	2879 S LIMA RD, KENDALLVILLE, , 46755

(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: November 12, 13 and 14, 2025 Facility number: 004440 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 18, 2025	R 0000		
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	R 0217	**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction***	12/01/2025

	appropriate to the: (A) scope; (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.		***does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Care Plan meetings immediately arranged for all residents to coordinate care with res/families and obtain care plan signatures. ***2)How the facility identified other residents:*** All residents have the potential to be affected. None identified. **3)Measures put into place/ System changes:** Care Plan signatures to be obtained upon admission and with any change in condition	

	Based on interview and record review, the facility failed to ensure signed service plans were current for 3 of 5 residents reviewed (Resident 20, Resident 30 and Resident 40.) Findings include: 1. Resident 20's record was reviewed on 11/13/25 at 1:45 PM. Resident 20's record did not include a signed service plan. 2. Resident 30's record was reviewed on 11/13/25 at 11:18 AM. Resident 30's record did not include a signed service plan. 3. Resident 40's record was reviewed on 11/14/25 at 11:26 AM. Resident 30's record did not include a signed service plan. In an interview on 11/14/25 at 11:45 AM, the Director of Nursing (DON) indicated they were unaware of the requirement to maintain current dated service plans. A current facility policy, dated 6/10/24, indicated each resident would sign and date the agreed upon service plan. The policy indicated a signed copy of the service plan would be kept in each resident's record. Based on interview and record review, the facility failed to		**4)How the corrective actions will be monitored:** ED/ DHW/ Designee will be responsible for this plan of correction. ED/DHW/Designee to audit 5 random residents to ensure care plans are signed weekly x6 weeks, bi-weekly x3 weeks and monthly indefinitely. **5)Date of compliance:12/01/25**	

	ensure signed service plans were current for 3 of 5 residents reviewed (Resident 20, Resident 30 and Resident 40.) Findings include: 1. Resident 20's record was reviewed on 11/13/25 at 1:45 PM. Resident 20's record did not include a signed service plan. 2. Resident 30's record was reviewed on 11/13/25 at 11:18 AM. Resident 30's record did not include a signed service plan. 3. Resident 40's record was reviewed on 11/14/25 at 11:26 AM. Resident 30's record did not include a signed service plan. In an interview on 11/14/25 at 11:45 AM, the Director of Nursing (DON) indicated they were unaware of the requirement to maintain current dated service plans. A current facility policy, dated 6/10/24, indicated each resident would sign and date the agreed upon service plan. The policy indicated a signed copy of the service plan would be kept in each resident's record.			
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i)	R 0412	R412 Infection Control	11/20/2025

(i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray.

Based on interview and record review, the facility failed to ensure communicable disease screenings were completed for 2 of 5 residents reviewed (Resident 30 and Resident 40).

Findings include:

1. Resident 30's record was reviewed on 11/13/25 at 1:18 PM. Resident 30's record did not include an annual screening for tuberculosis.

2. Resident 40's record was reviewed on 11/14/25 at 11:26 AM. Resident 40's record did not include an annual screening for tuberculosis.

In an interview on 11/14/25 at 11:45 AM, the Director of Nursing (DON) indicated they were unable to locate annual tuberculosis screenings for Resident 30 and Resident 40.

The facility requests paper compliance for this citation.

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

1)Immediate actions taken for those residents identified:

TB test immediately administered to residents identified.

2)How the facility identified other residents:

All residents have the potential to be affected.

Full audit completed of all residents and staff to ensure compliance

3)Measures put into place/ System changes:

Full audit completed for all residents/staff to ensure compliance

Nursing staff educated on TB

	The DON provided annual screenings for Resident 30 and Resident 40, dated 11/14/25. A current facility policy, dated 6/10/24 indicated all residents would be screened for tuberculosis yearly. Based on interview and record review, the facility failed to ensure communicable disease screenings were completed for 2 of 5 residents reviewed (Resident 30 and Resident 40). Findings include: 1. Resident 30's record was reviewed on 11/13/25 at 1:18 PM. Resident 30's record did not include an annual screening for tuberculosis. 2. Resident 40's record was reviewed on 11/14/25 at 11:26 AM. Resident 40's record did not include an annual screening for tuberculosis. In an interview on 11/14/25 at 11:45 AM, the Director of Nursing (DON) indicated they were unable to locate annual tuberculosis screenings for Resident 30 and Resident 40. The DON provided annual screenings for Resident 30 and Resident 40, dated 11/14/25.		during admission/hire process 4)How the corrective actions will be monitored: DHW/Designee will develop tracking system for when TB assessments are due and will update with all new admissions/hires. ED to audit tracking system monthly to ensure compliance and that all new residents are present. ED/DHW to audit all new residents/hires weekly x5 weeks, then bi-weekly x3 weeks, then monthly indefinitely to ensure compliance. 5) Date of compliance: 11/20/25	

	A current facility policy, dated 6/10/24 indicated all residents would be screened for tuberculosis yearly.			

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 SIGNATUREAlyssa Pender	TITLEExecutive Director	(X6) DATE01/09/2026