STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT KESSLER	5011 KESSLER BLVD E, INDIANAPOLIS, , 46220

(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 Intakes IN00464032 and IN00464245. Intakes IN00464032 - State deficiencies related to the allegations are cited at R0052. Intakes IN00464245 - State deficiencies related to the allegations are cited at R0029 and R0091. Survey dates: August 25 and 26, 2025 Facility number: 010064 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 2, 2025.	R 0000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance.	

R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure a cognitively impaired resident's dignity was maintained for 1 of 3 residents reviewed for reportable incidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/25/25 at 1:00 p.m. The diagnoses included, but were not limited to, dementia. The resident resided in the memory care unit. A reportable incident to the Indiana Department of Health, dated 8/21/25, indicated alleged abuse of Resident B involving Certified Nurse Aide (CNA) 1, Home Health Aide (HHA) 4, and Licensed Practical Nurse (LPN) 2. The brief description of the incident indicated, "Dietary Aide [5] and Memory Care Director [MCD] came to ED [Executive Director] office on Thursday at 5:00 p.m. Dietary Aide said that she suspected verbal abuse against resident [B]. Dietary Aide stated that she saw one CNA [1] with her hands on resident chin and yelling at her	R 0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B was assessed immediately following the allegation. No Physical harm noted. Resident B was provided emotional support and reassurance by the Memory Care Director. CNA 1, LPN 2, and HHA 4 were immediately removed from direct resident care pending investigation. 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 in the Memory Care Unit were assessed for signs of distress, abuse, or neglect. No other residents were found to have been adversely affected. Residents and families were provided with information on how to report concerns directly to the administration or the Indiana Department of Health.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff received immediate re-education on Residents Rights, dignity and respect, and abuse/neglect reporting requirements. Special emphasis placed on communication strategies with cognitively impaired residents. Any staff found to engage in disrespectful or abusive behavior will be subject to disciplinary action, up to termination. Supervisors will perform daily rounds in the	09/15/2025

	to hush. Dietary Aide [5] also stated that LPN [2] and HHA [4] both have been yelling at residents to sit down and be quiet..." An interview was conducted with MCD on 8/26/25 at 9:54 a.m. She indicated she had not witnessed any staff abusing any of residents in the memory care unit. Resident B does have a habit of repeating herself a lot, which causes the staff to be rude and disrespectful towards her. CNA 1 and LPN 2 were the staff that were rude to her. Some of the residents in the memory care unit are "feisty." Some CNAs and nursing staff will bicker and argue with the residents who are "feisty". "It's unnecessary." She reported the incidents to the ED. She responds, she will talk with them. It gets better for a while and then goes back to the staff being rude and disrespectful towards the residents. "It goes in waves." An interview was conducted with Dietary Aide 5 on 8/26/25 at 10:45 a.m. She indicated CNA 1, LPN 2, and HHA 4 were rude and disrespectful on a daily basis with the residents on the memory care unit. During a Confidential Interview, they indicated they had not observed any staff being abusive toward the residents on		Memory Care Unit to observe staff-resident interactions. The Resident Rights and Abuse Policy were reviewed with staff to ensure consistent compliance.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place;The Executive Director or designee will conduct random weekly observations of staff-resident interactions in the Memory Care Unit for 12 weeks. Findings will be documented and reviewed during the clinical meetings. Any identified concerns will result in immediate retraining and corrective action.	

the memory care unit, but LPN 2 has been curt and unfriendly towards the residents.

During an interview with the Director of Nursing (DON) and ED on 8/26/25 at 11:31 a.m., they indicated the staff nor visitors have reported any concerns with staff being rude and disrespectful to the residents on the memory care unit. The camera video and audio footage were viewed on the evening of 8/19/25. They did not observe any abuse that evening.

A resident rights policy was provided by the ED on 8/25/25 at 12:30 p.m. It indicated, "...In accordance with this right to dignity and respect, residents are entitled to all of the freedom and privileges of any other citizen...5. Personal Treatment. Every Resident Shall Have The Right to...B. Courteous treatment in address and handling..."

This citation relates to Intake IN00464245.

Based on interview and record review, the facility failed to ensure a cognitively impaired resident's dignity was maintained for 1 of 3 residents reviewed for reportable incidents. (Resident B)

Findings include:

	The clinical record for Resident B was reviewed on 8/25/25 at 1:00 p.m. The diagnoses included, but were not limited to, dementia. The resident resided in the memory care unit. A reportable incident to the Indiana Department of Health, dated 8/21/25, indicated alleged abuse of Resident B involving Certified Nurse Aide (CNA) 1, Home Health Aide (HHA) 4, and Licensed Practical Nurse (LPN) 2. The brief description of the incident indicated, "Dietary Aide [5] and Memory Care Director [MCD] came to ED [Executive Director] office on Thursday at 5:00 p.m. Dietary Aide said that she suspected verbal abuse against resident [B]. Dietary Aide stated that she saw one CNA [1] with her hands on resident chin and yelling at her to hush. Dietary Aide [5] also stated that LPN [2] and HHA [4] both have been yelling at residents to sit down and be quiet..." An interview was conducted with MCD on 8/26/25 at 9:54 a.m. She indicated she had not witnessed any staff abusing any of residents in the memory care unit. Resident B does have a habit of repeating herself a lot, which causes the staff to be rude and disrespectful towards her. CNA 1 and LPN 2 were the staff that were rude to her. Some of the residents in the			

	memory care unit are "feisty." Some CNAs and nursing staff will bicker and argue with the residents who are "feisty". "It's unnecessary." She reported the incidents to the ED. She responds, she will talk with them. It gets better for a while and then goes back to the staff being rude and disrespectful towards the residents. "It goes in waves." An interview was conducted with Dietary Aide 5 on 8/26/25 at 10:45 a.m. She indicated CNA 1, LPN 2, and HHA 4 were rude and disrespectful on a daily basis with the residents on the memory care unit. During a Confidential Interview, they indicated they had not observed any staff being abusive toward the residents on the memory care unit, but LPN 2 has been curt and unfriendly towards the residents. During an interview with the Director of Nursing (DON) and ED on 8/26/25 at 11:31 a.m., they indicated the staff nor visitors have reported any concerns with staff being rude and disrespectful to the residents on the memory care unit. The camera video and audio footage were viewed on the evening of 8/19/25. They did not observe any abuse that evening.			

	A resident rights policy was provided by the ED on 8/25/25 at 12:30 p.m. It indicated, "...In accordance with this right to dignity and respect, residents are entitled to all of the freedom and privileges of any other citizen...5. Personal Treatment. Every Resident Shall Have The Right to...B. Courteous treatment in address and handling..." This citation relates to Intake IN00464245.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident remained free from neglect by not timely addressing a resident's change in condition. This resulted in the resident experiencing severe pain and later being diagnosed with a fracture for 1 of 2	R 0052	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Pain management interventions will be reviewed and updated following hospital discharge recommendations. 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 additional residents were identified as having unaddressed complaints of pain. - Any resident reporting new or worsening pain will have immediate nurse assessment and, if indicated, provider notification. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	09/15/2025

	residents reviewed for discharge (Resident C). Findings include: The clinical record for Resident C was reviewed on 8/25/25 at 2:20 p.m. The diagnoses included, but were not limited to, anemia and hypothyroidism (underactive thyroid). A physician's order, dated 8/20/24, indicated Resident C could receive acetaminophen (over the counter pain medication) 325 milligrams (mg) one to two tablets as needed every four to six hours. A physician's order, dated 3/20/25, indicated Resident C was to receive acetaminophen 500 mg three times daily. A service plan, dated 7/1/25, indicated Resident C required standby assistance of staff with transfers and standby assistance with being escorted to meals and activities using a walker. A progress note, dated 8/4/25 at 3:40 p.m., indicated Resident C was moaning and screaming in pain regarding the right groin. Resident C had no recent falls noted. The physician was notified, and a new order was received for an x-ray of the pelvis and sacrum. A progress note, dated 8/5/25 at		recur; - Staff were re-educated on proper use and documentation of PRN pain medications, including timely administration when indicated. - DON/designee will review all pain assessments daily for 30 days, then weekly for 30 days, to ensure timely physician notification and follow-up. - Incident reporting and family notification requirements were reinforced with all licensed nurses and CNAs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place; - The DON/designee will conduct random audits of 5 residents per week for 30 days, reviewing documentation of pain assessments, interventions, and timely provider notification. - The Executive Director (ED) will review findings and adjust monitoring as necessary to ensure ongoing compliance.	

	10:30 a.m., indicated Resident C complained of right groin pain, unable to stand or bear weight on the right leg. A new order was received for an x-ray of pelvis and sacrum (triangular bone at base of spine). Resident C was unable to determine the nature of how or where the pain originated from. A progress note, dated 8/5/25 at 11:15 a.m., indicated Resident C was up in a wheelchair for breakfast and received his morning medications. Resident C complained of right groin pain. An x-ray technician arrived to do the ordered x-ray. The Nurse Practitioner (NP) was notified and a new order for a right hip x-ray STAT (right away) was received. The x-ray results concluded that Resident C had an acute right femoral basicervical neck fracture (fractured right hip). The NP was notified, and a new order was received to send Resident C to the hospital for evaluation and treatment. Resident C's son was notified and emergency services transferred him to an acute care hospital. During an interview on 8/25/25 at 2:43 p.m., Family Member (FM) 20 indicated his family had been informed, on 8/5/25, that Resident C had a fractured hip. The family had not been informed of any problems with Resident C until the phone call			

	about the hip fracture. Resident C had been complaining about pain for couple of days and nothing was done for him. Resident C had to have been in pain due to the fractured hip, and the family was informed of nothing prior to the call, on 8/5/25, informing them that Resident C was being sent to the hospital for the hip fracture. On 8/25/25 at 3:18 p.m., the Executive Director (ED) provided the Incident Report filed with the Indiana Department of Health on 8/5/25, and the investigation file related to Resident C's hip fracture. The investigation file contained the Incident Report that indicated Resident C had complained of right groin pain. The type of injury was a fractured right hip. The immediate action taken was that x-rays were done, and Resident C was sent to an acute care hospital. The Power of Attorney (POA), physician, Executive Director (ED), and Director of Nursing (DON) were notified. A written statement from Certified Nurse Aide (CNA) 15 was included in the investigation file. The written statement indicated on the evening shift of Saturday, 8/2/25, Resident C was "okay" and had no complaints of pain anywhere. He was able to walk and get into			

	his chair. On Sunday, 8/3/25, CNA 15 received a report that Resident C was complaining of pain and needed more assistance. CNA 15 had provided assistance for Resident C, and he was barely able to put weight on his right leg and was "screaming" in pain. A written statement from CNA 16 indicated that on Saturday, 8/2/25, Resident C had requested to use his walker to move about the facility. He had no complaints of pain or discomfort. On Sunday, 8/3/25, Resident C was "crying" in pain and could not stand on his leg. A typed statement from Licensed Practical Nurse (LPN) 17, dated 8/5/25, indicated on Saturday, 8/2/25, Resident C had used his walker and had no issues or complaints of pain. LPN 17 had left the facility, on 8/2/25 at around 8:30 p.m., and no concerns had been reported to her about Resident C. On Sunday 8/3/25, LPN 17 had pushed Resident C closer to the television in the sitting area on the second floor. LPN 17 noticed Resident C "cried out in pain". LPN 17 had done an assessment of Resident C, having him stand and had asked which leg hurt. Resident C had indicated his right leg hurt. Resident C's right leg was not inverted, swollen, red, or			

	warm to touch. Resident C did not recall falling. LPN 17 was concerned and had notified the Wellness Director (DON). During an interview on 8/26/25 at 11:06 a.m., LPN 17 indicated she had personally walked with Resident C using his walker on Saturday, 8/2/25, and there had been no concerns with pain or abnormal gait. Upon returning to work on 8/3/25, the CNA had informed her that Resident C was complaining his leg was hurting. LPN 17 had assisted the CNA with taking Resident C to the bathroom. Resident C had complained of pain but was able to bear weight and pivot onto the toilet. LPN 17 examined Resident C and found no bruising and the leg was not inverted. LPN 17 had reported to the DON that Resident C was complaining of a lot of pain. LPN 17 had not been made aware that Resident C had been screaming in pain. If she had known he was screaming in pain, she would have notified the physician. LPN had administered scheduled acetaminophen to Resident C. During an interview on 8/26/25 at 11:21 a.m., CNA 16 indicated on Sunday morning, 8/3/25, Resident C was having pain in his leg and trouble moving. CNA 16 had touched Resident C's leg, and he could not move it and screamed that his leg hurt.			

	CNA 16 had told the nurse on duty, who assessed Resident C. CNA 16 had told the nurse that Resident C was crying and in pain. Once Resident C had finished eating his lunch, he had been put in his recliner to hopefully help him be more comfortable. During an interview on 8/26/25 at 11:27 a.m., CNA 15 indicated Resident C had "moaned and groaned" about pain during her shift on 8/3/25. She had informed the Qualified Medication Aide who was working with her that evening. She had also informed the DON. The August 2025 Medication Administration Record indicated that Resident C did not receive any as needed acetaminophen pain medication on 8/2/25, 8/3/25, 8/4/25, or 8/5/25. During an interview on 8/26/25 at 12:04 p.m., the DON indicated she had been made aware of Resident C's pain on Sunday morning, 8/3/25. He was having issues standing and bearing weight. He had an issue in the past with his legs and dementia. He had an order for scheduled acetaminophen. The nurse on duty had done an assessment and there were no signs of a fracture. The physician should have been notified if Resident C was			

	screaming out in pain. During an interview on 8/26/25 at 1:48 p.m., Nurse Practitioner 18 indicated she had been told about Resident C being in pain on Monday, 8/4/25, and had ordered x-rays. If Resident C was screaming in pain, the nurses should have informed the provider on call. This citation relates to Intake IN00464032. Based on interview and record review, the facility failed to ensure a resident remained free from neglect by not timely addressing a resident's change in condition. This resulted in the resident experiencing severe pain and later being diagnosed with a fracture for 1 of 2 residents reviewed for discharge (Resident C). Findings include: The clinical record for Resident C was reviewed on 8/25/25 at 2:20 p.m. The diagnoses included, but were not limited to, anemia and hypothyroidism (underactive thyroid). A physician's order, dated 8/20/24, indicated Resident C could receive acetaminophen (over the counter pain medication) 325 milligrams (mg) one to two tablets as needed every four to six hours.			

	A physician's order, dated 3/20/25, indicated Resident C was to receive acetaminophen 500 mg three times daily. A service plan, dated 7/1/25, indicated Resident C required standby assistance of staff with transfers and standby assistance with being escorted to meals and activities using a walker. A progress note, dated 8/4/25 at 3:40 p.m., indicated Resident C was moaning and screaming in pain regarding the right groin. Resident C had no recent falls noted. The physician was notified, and a new order was received for an x-ray of the pelvis and sacrum. A progress note, dated 8/5/25 at 10:30 a.m., indicated Resident C complained of right groin pain, unable to stand or bear weight on the right leg. A new order was received for an x-ray of pelvis and sacrum (triangular bone at base of spine). Resident C was unable to determine the nature of how or where the pain originated from. A progress note, dated 8/5/25 at 11:15 a.m., indicated Resident C was up in a wheelchair for breakfast and received his morning medications. Resident C complained of right groin pain. An x-ray technician arrived to do the ordered x-ray. The Nurse			

	Practitioner (NP) was notified and a new order for a right hip x-ray STAT (right away) was received. The x-ray results concluded that Resident C had an acute right femoral basicervical neck fracture (fractured right hip). The NP was notified, and a new order was received to send Resident C to the hospital for evaluation and treatment. Resident C's son was notified and emergency services transferred him to an acute care hospital. During an interview on 8/25/25 at 2:43 p.m., Family Member (FM) 20 indicated his family had been informed, on 8/5/25, that Resident C had a fractured hip. The family had not been informed of any problems with Resident C until the phone call about the hip fracture. Resident C had been complaining about pain for couple of days and nothing was done for him. Resident C had to have been in pain due to the fractured hip, and the family was informed of nothing prior to the call, on 8/5/25, informing them that Resident C was being sent to the hospital for the hip fracture.			

	On 8/25/25 at 3:18 p.m., the Executive Director (ED) provided the Incident Report filed with the Indiana Department of Health on 8/5/25, and the investigation file related to Resident C's hip fracture. The investigation file contained the Incident Report that indicated Resident C had complained of right groin pain. The type of injury was a fractured right hip. The immediate action taken was that x-rays were done, and Resident C was sent to an acute care hospital. The Power of Attorney (POA), physician, Executive Director (ED), and Director of Nursing (DON) were notified. A written statement from Certified Nurse Aide (CNA) 15 was included in the investigation file. The written statement indicated on the evening shift of Saturday, 8/2/25, Resident C was "okay" and had no complaints of pain anywhere. He was able to walk and get into his chair. On Sunday, 8/3/25, CNA 15 received a report that Resident C was complaining of pain and needed more assistance. CNA 15 had provided assistance for Resident C, and he was barely able to put weight on his right leg and was "screaming" in pain. A written statement from CNA			

	16 indicated that on Saturday, 8/2/25, Resident C had requested to use his walker to move about the facility. He had no complaints of pain or discomfort. On Sunday, 8/3/25, Resident C was "crying" in pain and could not stand on his leg. A typed statement from Licensed Practical Nurse (LPN) 17, dated 8/5/25, indicated on Saturday, 8/2/25, Resident C had used his walker and had no issues or complaints of pain. LPN 17 had left the facility, on 8/2/25 at around 8:30 p.m., and no concerns had been reported to her about Resident C. On Sunday 8/3/25, LPN 17 had pushed Resident C closer to the television in the sitting area on the second floor. LPN 17 noticed Resident C "cried out in pain". LPN 17 had done an assessment of Resident C, having him stand and had asked which leg hurt. Resident C had indicated his right leg hurt. Resident C's right leg was not inverted, swollen, red, or warm to touch. Resident C did not recall falling. LPN 17 was concerned and had notified the Wellness Director (DON). During an interview on 8/26/25 at 11:06 a.m., LPN 17 indicated she had personally walked with Resident C using his walker on Saturday, 8/2/25, and there had been no concerns with pain or abnormal gait. Upon returning to			

work on 8/3/25, the CNA had informed her that Resident C was complaining his leg was hurting. LPN 17 had assisted the CNA with taking Resident C to the bathroom. Resident C had complained of pain but was able to bear weight and pivot onto the toilet. LPN 17 examined Resident C and found no bruising and the leg was not inverted. LPN 17 had reported to the DON that Resident C was complaining of a lot of pain. LPN 17 had not been made aware that Resident C had been screaming in pain. If she had known he was screaming in pain, she would have notified the physician. LPN had administered scheduled acetaminophen to Resident C.

During an interview on 8/26/25 at 11:21 a.m., CNA 16 indicated on Sunday morning, 8/3/25, Resident C was having pain in his leg and trouble moving. CNA 16 had touched Resident C's leg, and he could not move it and screamed that his leg hurt. CNA 16 had told the nurse on duty, who assessed Resident C. CNA 16 had told the nurse that Resident C was crying and in pain. Once Resident C had finished eating his lunch, he had been put in his recliner to hopefully help him be more comfortable.

During an interview on 8/26/25 at 11:27 a.m., CNA 15 indicated

	Resident C had "moaned and groaned" about pain during her shift on 8/3/25. She had informed the Qualified Medication Aide who was working with her that evening. She had also informed the DON. The August 2025 Medication Administration Record indicated that Resident C did not receive any as needed acetaminophen pain medication on 8/2/25, 8/3/25, 8/4/25, or 8/5/25. During an interview on 8/26/25 at 12:04 p.m., the DON indicated she had been made aware of Resident C's pain on Sunday morning, 8/3/25. He was having issues standing and bearing weight. He had an issue in the past with his legs and dementia. He had an order for scheduled acetaminophen. The nurse on duty had done an assessment and there were no signs of a fracture. The physician should have been notified if Resident C was screaming out in pain. During an interview on 8/26/25 at 1:48 p.m., Nurse Practitioner 18 indicated she had been told about Resident C being in pain on Monday, 8/4/25, and had ordered x-rays. If Resident C was screaming in pain, the nurses should have informed the provider on call.			

	This citation relates to Intake IN00464032.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to timely report an allegation of abuse for 1 of 3 reportable incidents reviewed. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/25/25 at 1:00 p.m. The diagnoses included, but were not limited to, dementia. The resident resided in the memory care unit. A reportable incident to the Indiana Department of Health,	R 0091	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B was immediately assessed on 8/21/25 when the allegation was reported. No signs of injury or distress were noted. Resident B's responsible party and physician were notified. The involved staff (CNA 1, HHA 4, LPN 2) were immediately suspended pending investigation. An abuse investigation was initiated and submitted to IDOH within the required timeframes. 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 residing in the Memory Care unit were assessed by nursing staff on 8/21/25 for signs of abuse or neglect; no concerns were identified. All residents in the community are considered to be at risk for abuse or neglect; therefore, immediate re-education was provided to staff on mandatory reporting requirements.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff were re-educated on 8/26/25 by the Executive Director and Director of Nursing regarding	09/25/2025

	dated 8/21/25, indicated an alleged abuse of Resident B involving Certified Nurse Aide (CNA) 1, Home Health Aide (HHA) 4, and Licensed Practical Nurse (LPN) 2. The brief description of the incident indicated "Dietary Aide [5] and Memory Care Director [MCD] came to ED [Executive Director] office on Thursday at 5:00 p.m. Dietary Aide said that she suspected verbal abuse against resident [B]. Dietary Aide stated that she saw one CNA [1] with her hands on resident chin and yelling at her to hush. Dietary Aide [5] also stated that LPN [2] and HHA [4] both have been yelling at residents to sit down and be quiet..." The reportable incident investigation of Resident B was provided by the ED on 8/25/25 at 12:38 p.m. It included, but was not limited to the following, a typed statement by the ED indicating Dietary Aide (DA) 5 had reported, on 8/21/25, an allegation of abuse of Resident B involving CNA 1, HHA 4, and LPN 2 was observed, on 8/19/25, at approximately 5:30 p.m. DA 5 indicated she delayed reporting due to concerns with upsetting peers. An interview was conducted with MCD on 8/26/25 at 9:54 a.m. She indicated DA 5 had reported to her on Thursday, 8/21/25, an allegation of abuse		the Abuse Prevention Policy, including the requirement to immediately report any allegation of abuse to the ED or supervisor on duty. Staff were reminded of the abuse reporting chain of command and after-hours contact process. The ED phone number posting at the time clock was reviewed and enlarged for visibility. Alternate reporting routes (Nurse Supervisor, DON, Dietary Manager, corporate compliance hotline) were emphasized. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place; The Executive Director or designee will conduct random staff interviews (minimum of 5 staff weekly × 4 weeks, then monthly × 3 months) to ensure staff can verbalize the process for immediate reporting of abuse allegations. Results will be reviewed in the Clinical Meeting. Any staff unable to verbalize correct procedure will receive immediate re-education.	

	of Resident B. She instructed DA 5 to report the allegation to the ED immediately. An interview was conducted DA 5 on 8/26/25 at 10:45 a.m. She indicated she had observed an incident, on the evening of 8/19/25, on the memory care unit. She had not reported the abuse allegation to the ED nor any other management staff that night, because she did not have the ED's phone number. There were no other management staff in the building at the time. She had forgotten to report the incident on Wednesday, 8/20/25, but did recall the incident that occurred on 8/19/25. She then reported it to the ED on 8/21/25. An interview was conducted with the ED on 8/26/25 at 11:31 a.m. She indicated an allegation of abuse was reported to her, on 8/21/25, that had occurred on the evening of 8/19/25. DA 5 had stated she delayed reporting due to concerns about upsetting the staff. She was not told it was due to not having her phone number to reach her. The ED's phone number was posted at the time clock to notify her after hours. DA 5 could also have notified the Dietary Manager who then would have notified her of the incident. DA 5 should have reported the allegation immediately.			

An abuse policy was provided by the ED on 8/25/25 at 12:38 p.m. It indicated, "...Any associate who witnesses or becomes aware of alleged abuse, neglect, or exploitation, should report such incident to the Executive Director, or designee, or supervisor on duty immediately..."

This citation relates to Intake IN00464245.

Based on interview and record review, the facility failed to timely report an allegation of abuse for 1 of 3 reportable incidents reviewed. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 8/25/25 at 1:00 p.m. The diagnoses included, but were not limited to, dementia. The resident resided in the memory care unit.

A reportable incident to the Indiana Department of Health, dated 8/21/25, indicated an alleged abuse of Resident B involving Certified Nurse Aide (CNA) 1, Home Health Aide (HHA) 4, and Licensed Practical Nurse (LPN) 2. The brief description of the incident indicated "Dietary Aide [5] and Memory Care Director [MCD] came to ED [Executive Director] office on Thursday at 5:00 p.m. Dietary Aide said that she suspected verbal abuse against

	resident [B]. Dietary Aide stated that she saw one CNA [1] with her hands on resident chin and yelling at her to hush. Dietary Aide [5] also stated that LPN [2] and HHA [4] both have been yelling at residents to sit down and be quiet..." The reportable incident investigation of Resident B was provided by the ED on 8/25/25 at 12:38 p.m. It included, but was not limited to the following, a typed statement by the ED indicating Dietary Aide (DA) 5 had reported, on 8/21/25, an allegation of abuse of Resident B involving CNA 1, HHA 4, and LPN 2 was observed, on 8/19/25, at approximately 5:30 p.m. DA 5 indicated she delayed reporting due to concerns with upsetting peers. An interview was conducted with MCD on 8/26/25 at 9:54 a.m. She indicated DA 5 had reported to her on Thursday, 8/21/25, an allegation of abuse of Resident B. She instructed DA 5 to report the allegation to the ED immediately. An interview was conducted DA 5 on 8/26/25 at 10:45 a.m. She indicated she had observed an incident, on the evening of 8/19/25, on the memory care unit. She had not reported the abuse allegation to the ED nor any other management staff that night, because she did not			

	have the ED's phone number. There were no other management staff in the building at the time. She had forgotten to report the incident on Wednesday, 8/20/25, but did recall the incident that occurred on 8/19/25. She then reported it to the ED on 8/21/25. An interview was conducted with the ED on 8/26/25 at 11:31 a.m. She indicated an allegation of abuse was reported to her, on 8/21/25, that had occurred on the evening of 8/19/25. DA 5 had stated she delayed reporting due to concerns about upsetting the staff. She was not told it was due to not having her phone number to reach her. The ED's phone number was posted at the time clock to notify her after hours. DA 5 could also have notified the Dietary Manager who then would have notified her of the incident. DA 5 should have reported the allegation immediately. An abuse policy was provided by the ED on 8/25/25 at 12:38 p.m. It indicated, "...Any associate who witnesses or becomes aware of alleged abuse, neglect, or exploitation, should report such incident to the Executive Director, or designee, or supervisor on duty immediately..."			

	This citation relates to Intake IN00464245.			
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 interview and record review, the facility failed to ensure a staff member with	R 0117	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents were not found to have suffered actual harm. Immediate corrective action was taken to ensure a staff member with current CPR and First Aid certification was present on all subsequent shifts following the identified dates. 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 residing in the facility had the potential to be affected by the lack of certified staff. The Executive Director (ED) and Director of Nursing (DON) reviewed current staff schedules and certifications to confirm that all shifts are staffed with at least one CPR/First Aid certified employee. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A master list of staff with current CPR/First Aid certifications was created and placed with the scheduling binder. All non-certified staff were enrolled in CPR/First Aid training and was completed on 9/8/25. Schedulingwas updated to require documented verification that one certified staff member is scheduled per shift. The ED/DON will not approve final staffing	09/15/2025

	current first aid and cardiopulmonary resuscitation (CPR) training/certification was scheduled for all shifts for 9 days of schedules reviewed. This had the potential to affect 50 of 50 residents that reside in the facility. Findings include: A binder that contained first aid and CPR certifications was provided by the Executive Director (ED) on 8/26/25 at 9:30 a.m. The daily staffing sheets were provided by the ED on 8/25/25 at 12:35 p.m. The following date(s) and shift(s) were noted without a staff member having current CPR and/or first aid certification: 8/17/25 on night shift and 8/22/25 on night shift. An interview was conducted with the ED on 8/26/25 at 11:51 a.m. She indicated they were not able to find any further CPR and first aid certifications for current employees. Based on interview and record review, the facility failed to ensure a staff member with current first aid and cardiopulmonary resuscitation (CPR) training/certification was scheduled for all shifts for 9 days of schedules reviewed. This had the potential to affect 50 of 50 residents that reside in		schedules unless CPR/First Aid coverage is verified.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place; The DON or designee will audit weekly staff schedules for 90 days to verify that each shift is covered by a certified staff member. Certification records will be reviewed monthly to ensure all staff remain current. Results of audits will be reported and reviewed during meetings for six months and quarterly thereafter. Any identified concerns will be addressed immediately through staff re-education and scheduling adjustments.	

	the facility. Findings include: A binder that contained first aid and CPR certifications was provided by the Executive Director (ED) on 8/26/25 at 9:30 a.m. The daily staffing sheets were provided by the ED on 8/25/25 at 12:35 p.m. The following date(s) and shift(s) were noted without a staff member having current CPR and/or first aid certification: 8/17/25 on night shift and 8/22/25 on night shift. An interview was conducted with the ED on 8/26/25 at 11:51 a.m. She indicated they were not able to find any further CPR and first aid certifications for current employees.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to maintain the first-floor	R 0154	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 8/27/25, maintenance staff repaired the hole in the drywall in the first-floor kitchenette. An outlet cover was installed on the empty electrical outlet in the service area. The first-floor kitchenette and service area were inspected by the Executive Director and Dietary Service Director to ensure the areas	09/05/2025

	kitchenette in good repair with the potential to affect 24 of 50 residents residing in the facility. Findings include: On 8/25/25 at 12:04 p.m., the first-floor kitchenette was observed to have a hole in the drywall, just above the cove base on the back wall of the kitchenette. The hole appeared to be cut in the drywall approximately five inches in length and three inches in width. The serve area adjacent to the kitchenette had a hole which appeared to be an empty electrical outlet. On 8/26/25 at 8:57 a.m., the first-floor kitchenette and service area were observed with the Dietary Service Director (DSD). The DSD indicated she was unaware of the hole in the drywall in the kitchenette and the empty outlet in the service area. During an interview on 8/26/25 at 9:10 a.m., the Executive Director indicated the hole in the kitchenette drywall needed to be fixed and the electrical outlet in the service area needed a cover.		were restored to good repair and safe for resident use. 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. A facility-wide environmental inspection was conducted on 8/27/25 by the Executive Director and Maintenance Director to identify any similar repair needs. Any holes in walls, damaged finishes, or uncovered outlets were immediately repaired or scheduled for repair within 48 hours. All common areas and service areas were checked to ensure compliance with sanitation and safety standards.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 Maintenance Director will conduct monthly environmental rounds with the Executive Director and Dietary Service Director to assess all kitchenettes, dining areas, and service areas for needed repairs. Any findings will be documented on an Environmental Rounds Checklist and corrected within 48 hours. The Environmental Rounds Checklist will be submitted to the Executive Director monthly for review and follow-up. Staff will be re-educated by 9/5/25 on the responsibility of reporting any maintenance concerns such as holes in walls, exposed outlets, or damaged surfaces immediately to the Maintenance Department.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what	

	Based on observation and interview, the facility failed to maintain the first-floor kitchenette in good repair with the potential to affect 24 of 50 residents residing in the facility. Findings include: On 8/25/25 at 12:04 p.m., the first-floor kitchenette was observed to have a hole in the drywall, just above the cove base on the back wall of the kitchenette. The hole appeared to be cut in the drywall approximately five inches in length and three inches in width. The serve area adjacent to the kitchenette had a hole which appeared to be an empty electrical outlet. On 8/26/25 at 8:57 a.m., the first-floor kitchenette and service area were observed with the Dietary Service Director (DSD). The DSD indicated she was unaware of the hole in the drywall in the kitchenette and the empty outlet in the service area. During an interview on 8/26/25 at 9:10 a.m., the Executive Director indicated the hole in the kitchenette drywall needed to be fixed and the electrical outlet in the service area needed a cover.		quality assurance program will be put into place; The Executive Director or designee will review the Environmental Rounds Checklist monthly for six months to ensure identified issues are corrected timely. Results of environmental rounds will be reviewed during the meeting for six months. If no further issues are identified after six months, monitoring will continue on a quarterly basis. The Executive Director is responsible for overall compliance.	
R 0240	Health Services - Deficiency	R 0240	What corrective action(s) will be	09/15/2025

	410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to timely address pharmacy recommendations for 2 of 5 residents reviewed for pharmacy reviews and administer medications as ordered for 1 of 5 residents records reviewed. (Residents' 18, D, and E) Findings include: 1. The clinical record for Resident 18 was reviewed on 8/25/25 at 3:40 p.m. The diagnoses included, but were not limited to, pulmonary embolism (blood clot in lung) and depression. A physician's order, dated 12/19/24, indicated he was to receive Eliquis (blood thinner) 5 milligrams (mg) twice daily. On 8/26/25 at 9:59 a.m., the Executive Director (ED) provided "A Note to Attending Physician/Prescriber", with a print date of 7/11/25, that indicated Resident 18 had received Eliquis 5 mg twice daily for greater than 6 months. The only listed indication for the Eliquis was pulmonary		accomplished for those residents found to have been affected by the deficient practice; Resident 18's Eliquis order was updated per physician signature on 8/26/25 to reflect the pharmacy's recommendation of Eliquis 2.5 mg twice daily. Resident D's pharmacy regimen review was requested and completed on 8/26/25. Resident E's medications, divalproex DR and Namenda, were verified against the hard chart and reconciled to the Medication Administration Record (MAR). Missed doses due to pharmacy delay were communicated to the prescribing physician, and orders were confirmed as continued. Documentation of medication administration has been corrected to ensure accuracy moving forward. 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 receiving pharmacy services have the potential to be affected. A facility-wide audit of July and August 2025 pharmacy regimen reviews was initiated on 8/26/25 to verify all recommendations were received, addressed, and implemented. A 100 percent audit of current MARs was conducted to verify medications are administered as ordered and accurately documented. Any discrepancies were immediately corrected in consultation with the	

	embolism. After six months of stable therapy, current guidelines indicated that the dose can either be reduced or stopped, depending on if resident has a history of past VTE (venous thrombosis). Please consider evaluating. It indicated the Eliquis was to be decreased to Eliquis 2.5 mg twice a day and was signed by the physician on 8/26/25. During an interview on 8/26/25 at 10:20 a.m., The Director of Nursing (DON) indicated the pharmacy had just sent Resident 18's pharmacy recommendation. She had not received any pharmacy recommendations from July. She was unsure why the July pharmacy recommendations had not been sent until 8/26/25. 2. The clinical record for Resident D was reviewed on 8/25/25 at 1:30 p.m. The diagnoses included, but were not limited to, atrial fibrillation. On 8/26/25 at 10:41 a.m., the DON provided pharmacy drug regimen reviews that had been completed for residents during the month of May, but not July of 2025. During an interview on 8/26/25 at 12:00 p.m., the DON indicated the pharmacy drug regimen reviews had not been completed for the month of July		prescribing physician and pharmacy.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 Director of Nursing (DON) or designee will obtain pharmacy drug regimen reviews by the 10th of each month and review them within 48 hours to ensure timely follow-up. DON will maintain a tracking log to confirm all pharmacy recommendations are received, reviewed, and implemented with physician approval. Licensed nursing staff received re-education on 8/28/25 regarding the importance of timely review of new orders, ensuring medications are administered as prescribed, and documenting accurately on the MAR. The pharmacy has been engaged to provide confirmation of delivery of monthly recommendations and new order fills, and any delay will be escalated to the DON immediately.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place; The DON or designee will audit 10 percent of resident MARs weekly for four weeks, then monthly for three months, to verify medications are administered as ordered and documentation is accurate. The DON will review pharmacy drug regimen recommendations monthly for six months to ensure timely receipt, follow-up, and physician sign-off. Audit results will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee for review and follow-up. Continued	

	and had to request them that day (8/26/25). 3. The clinical record for Resident E was reviewed on 8/25/25 at 3:45 p.m. The diagnoses included, but were not limited to, Alzheimer's dementia. A Resident Assessment, dated 8/20/25, indicated Resident E required max assistance due to cognitive impairment. A physician's order, dated 8/7/25, was placed for divalproex DR (delayed release) 125 mg to be taken two times a day at 8:00 a.m. and 3:00 p.m. A physician's order, dated 8/14/25, was placed for Namenda (memantine HCL [Hydrochloric Acid]) 10 mg to be taken daily for seven days. The Medication Administration Record (MAR) was reviewed on 8/26/25 at 10:00 a.m. It indicated Resident E did not receive her morning and afternoon doses of divalproex DR 125 mg from 8/7/25 to 8/11/25. The MAR indicated the resident did not receive her daily dose of memantine HCL 10 mg from 8/16/25 to 8/19/25. An interview was conducted with the DON on 8/26/25 at 10:40 a.m. She indicated the facility had been running into issues with delays with the		monitoring will occur until three consecutive months of compliance are achieved, at which time the QAPI Committee will determine the need for ongoing review.	

	pharmacy when a new order had been submitted. The DON indicated she had been working with a supervisor at the pharmacy to try to resolve the issues. During an interview on 8/26/25 at 11:30 a.m., Licensed Practical Nurse (LPN) 2 indicated she was working, on 8/18/25 and 8/19/25, and had administered the medication memantine to Resident E, but did not know why it was not included on the MAR. LPN 2 confirmed in Resident E's hard chart that the medication divalproex was ordered, on 8/7/25, and indicated the doses not administered must have been an instance where there was a delay from the pharmacy. Based on interview and record review, the facility failed to timely address pharmacy recommendations for 2 of 5 residents reviewed for pharmacy reviews and administer medications as ordered for 1 of 5 residents records reviewed. (Residents' 18, D, and E) Findings include: 1. The clinical record for Resident 18 was reviewed on 8/25/25 at 3:40 p.m. The diagnoses included, but were not limited to, pulmonary embolism (blood clot in lung)			

and depression.

A physician's order, dated 12/19/24, indicated he was to receive Eliquis (blood thinner) 5 milligrams (mg) twice daily.

On 8/26/25 at 9:59 a.m., the Executive Director (ED) provided "A Note to Attending Physician/Prescriber", with a print date of 7/11/25, that indicated Resident 18 had received Eliquis 5 mg twice daily for greater than 6 months. The only listed indication for the Eliquis was pulmonary embolism. After six months of stable therapy, current guidelines indicated that the dose can either be reduced or stopped, depending on if resident has a history of past VTE (venous thrombosis). Please consider evaluating. It indicated the Eliquis was to be decreased to Eliquis 2.5 mg twice a day and was signed by the physician on 8/26/25.

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2. The clinical record for

Resident D was reviewed on 8/25/25 at 1:30 p.m. The diagnoses included, but were not limited to, atrial fibrillation.

On 8/26/25 at 10:41 a.m., the DON provided pharmacy drug regimen reviews that had been completed for residents during the month of May, but not July of 2025.

During an interview on 8/26/25 at 12:00 p.m., the DON indicated the pharmacy drug regimen reviews had not been completed for the month of July and had to request them that day (8/26/25).

3. The clinical record for Resident E was reviewed on 8/25/25 at 3:45 p.m. The diagnoses included, but were not limited to, Alzheimer's dementia.

A Resident Assessment, dated 8/20/25, indicated Resident E required max assistance due to cognitive impairment.

A physician's order, dated 8/7/25, was placed for divalproex DR (delayed release) 125 mg to be taken two times a day at 8:00 a.m. and 3:00 p.m.

A physician's order, dated 8/14/25, was placed for Namenda (memantine HCL [Hydrochloric Acid]) 10 mg to be taken daily for seven days.

	The Medication Administration Record (MAR) was reviewed on 8/26/25 at 10:00 a.m. It indicated Resident E did not receive her morning and afternoon doses of divalproex DR 125 mg from 8/7/25 to 8/11/25. The MAR indicated the resident did not receive her daily dose of memantine HCL 10 mg from 8/16/25 to 8/19/25. An interview was conducted with the DON on 8/26/25 at 10:40 a.m. She indicated the facility had been running into issues with delays with the pharmacy when a new order had been submitted. The DON indicated she had been working with a supervisor at the pharmacy to try to resolve the issues. During an interview on 8/26/25 at 11:30 a.m., Licensed Practical Nurse (LPN) 2 indicated she was working, on 8/18/25 and 8/19/25, and had administered the medication memantine to Resident E, but did not know why it was not included on the MAR. LPN 2 confirmed in Resident E's hard chart that the medication divalproex was ordered, on 8/7/25, and indicated the doses not administered must have been an instance where there was a delay from the pharmacy. Based on interview and record review, the facility failed to			

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During an interview on 8/26/25 at 12:00 p.m., the DON indicated the pharmacy drug regimen reviews had not been completed for the month of July and had to request them that day (8/26/25).

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A physician's order, dated 8/14/25, was placed for Namenda (memantine HCL [Hydrochloric Acid]) 10 mg to be taken daily for seven days.

The Medication Administration Record (MAR) was reviewed on 8/26/25 at 10:00 a.m. It indicated Resident E did not receive her morning and

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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	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents who received meals during the lunch	08/27/2025

	' 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 use an ice scoop to remove ice from the ice machine and to ensure food was served under sanitary conditions with the potential to affect 24 of 50 residents residing at the facility. Findings include: On 8/25/25 at 12:10 p.m., lunch service was observed in the first-floor kitchenette. Cook 10 was observed with a resident's personal insulated tumbler. Cook 10 took the insulated tumbler and dipped it into the ice inside of the ice machine, filling the cup with ice, and sat it on the counter to be taken to the resident. Cook 10 indicated the ice scoop was being used in the dining room to serve residents, so he had used the tumbler to obtain the ice instead of using his gloved hands to grab the ice from the machine. Cook 10 was then observed, using the same glove on his hands, removing food containers from the insulated cart and placing them onto the steam table for service. He unwrapped the serving utensils and placed the utensils on the		service on 8/25/25 were assessed, and no negative outcomes were identified because of the observed practices. The resident whose personal insulated tumbler was dipped directly into the ice machine had the tumbler replaced with a clean one, and the ice in the machine was discarded and replaced with fresh ice. The ice machine was sanitized immediately following the incident. 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 who utilize the first-floor kitchenette and are served food or ice from this location have the potential to be affected. To address this, all dietary staff were immediately re-educated on proper ice handling, glove use, and safe food handling practices. Ice machines throughout the facility were checked to ensure signage was posted requiring the use of a scoop only. Ice scoops were sanitized and properly stored outside of the ice machines in compliance with policy.What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur; The Dietary Service Manager has re-educated all dietary staff on the Hand Washing Policy and the Ice Handling Policy. Staff were trained in proper glove use, hand hygiene, and serving procedures, with emphasis on not touching the eating surfaces of plates or food	

	serving containers in the steam table. He obtained temperatures of the food on the steam table and then picked up 5 plates from the stack of plates by the steam table. He placed the plates on the counter at the front of the steam table. His gloved hands touched the eating service of each plate. He then obtained 5 bowls from the rack underneath the steam table and placed the bowls on top of the plates. Cook 10 then began serving the meal. He served cornbread onto each plate using a spatula and touching the corn bread with his gloved finger to assist with transferring it from the pan to the plate. Cook 10 then removed his gloves and performed hand hygiene. He donned a new pair of gloves and assisted in cleansing a service cart of ice and water using a paper towel. Cook 10 then assisted in putting the plated food on the service cart and began serving food again without changing his gloves. During an interview on 8/26/25 at 8:57 a.m., the Dietary Service Manager indicated residents' personal cups should not be placed inside the ice machine to obtain ice. Gloves should be changed after touching high contact surfaces prior to serving or touching food. On 8/25/25 at 11:56 a.m., the Executive Director (ED)		items with gloved hands. Signage has been posted at each ice machine stating that only the provided ice scoop is to be used for dispensing ice. Ice scoops will be sanitized daily and stored properly. Ongoing staff training will be incorporated into monthly in-service training. Any staff observed failing to comply with sanitation standards will receive immediate corrective counseling. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place; The Dietary Service Manager or designee will conduct random observations of meal service and ice handling three times per week for four weeks, then weekly for two months, and then monthly thereafter. Any noncompliance will be immediately corrected and re-education provided. Results of these audits will be documented and reviewed with the Executive Director (ED) during -up meeting and will determine if additional interventions are needed and ensure ongoing compliance.	

	provided the Hand Washing Policy, dated September 2011, that indicated "...Hand washing is regarded as the single most important means of preventing the spread of infections...Appropriate fifteen [15] to twenty [20] second hand washing should be performed in situations including but not limited to...before touching, preparing, or serving food..." On 8/25/25 at 2:45 p.m., the ED provided the Infection Control-Ice Handling Policy, dated September 2011, that indicated "...When an ice scoop is used, it will be stored outside the machine. The scoop will be sanitized daily. A notice will be posted identifying that ice will be served by using a scoop only. In selecting/ gathering ice, the will [sic] no use of hands or glasses by customers..." Based on observation, interview, and record review, the facility failed to use an ice scoop to remove ice from the ice machine and to ensure food was served under sanitary conditions with the potential to affect 24 of 50 residents residing at the facility. Findings include: On 8/25/25 at 12:10 p.m., lunch service was observed in the first-floor kitchenette. Cook 10 was observed with a resident's			

	personal insulated tumbler. Cook 10 took the insulated tumbler and dipped it into the ice inside of the ice machine, filling the cup with ice, and sat it on the counter to be taken to the resident. Cook 10 indicated the ice scoop was being used in the dining room to serve residents, so he had used the tumbler to obtain the ice instead of using his gloved hands to grab the ice from the machine. Cook 10 was then observed, using the same glove on his hands, removing food containers from the insulated cart and placing them onto the steam table for service. He unwrapped the serving utensils and placed the utensils on the serving containers in the steam table. He obtained temperatures of the food on the steam table and then picked up 5 plates from the stack of plates by the steam table. He placed the plates on the counter at the front of the steam table. His gloved hands touched the eating service of each plate. He then obtained 5 bowls from the rack underneath the steam table and placed the bowls on top of the plates. Cook 10 then began serving the meal. He served cornbread onto each plate using a spatula and touching the corn bread with his gloved finger to assist with transferring it from the pan to the plate. Cook 10 then removed his gloves and			

	performed hand hygiene. He donned a new pair of gloves and assisted in cleansing a service cart of ice and water using a paper towel. Cook 10 then assisted in putting the plated food on the service cart and began serving food again without changing his gloves. During an interview on 8/26/25 at 8:57 a.m., the Dietary Service Manager indicated residents' personal cups should not be placed inside the ice machine to obtain ice. Gloves should be changed after touching high contact surfaces prior to serving or touching food. On 8/25/25 at 11:56 a.m., the Executive Director (ED) provided the Hand Washing Policy, dated September 2011, that indicated "...Hand washing is regarded as the single most important means of preventing the spread of infections...Appropriate fifteen [15] to twenty [20] second hand washing should be performed in situations including but not limited to...before touching, preparing, or serving food..." On 8/25/25 at 2:45 p.m., the ED provided the Infection Control-Ice Handling Policy, dated September 2011, that indicated "...When an ice scoop is used, it will be stored outside the machine. The scoop will be sanitized daily. A notice will be			

	posted identifying that ice will be served by using a scoop only. In selecting/ gathering ice, the will [sic] no use of hands or glasses by customers..."			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure infection control was maintained with hand hygiene during medication administration for 5 of 5 residents observed during medication administration. (Residents' 6, 8, 9, 10, and 12) Findings include: 1. An observation was conducted of a medication administration for Resident 6 with Licensed Practical Nurse (LPN) 3 on 8/26/25 at 8:18 a.m. LPN 3 was observed at the medication cart pulling the resident's medications. During that time, LPN 3 dropped a medication cup on to the floor. She then picked it up and discarded it in the trash. After, she continued to prepare the medications by popping the	R 0414	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 6, 8, 9, 10, and 12 were assessed by the Director of Nursing (DON) for any negative outcomes related to the deficient infection control practice. No adverse effects were identified. All medications administered during the observed med pass were verified as correct. 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 improper hand hygiene during medication administration. Immediately following the observation, Licensed Practical Nurse (LPN) 3 was re-educated on hand hygiene expectations, including the use of hand sanitizer before and after each medication administration, after glove removal, and after any contact with environmental surfaces. All licensed nursing staff were re-educated by the DON on proper hand hygiene during medication administration.What measures will be put into place or what systemic changes the facility will make to ensure that the	09/15/2025

	medications from the bubble cards into the medication cup. LPN 3 then administered the medications to the resident. There was no hand hygiene before the preparation of the medications, after picking up the medication cup off the floor, nor after administration of medications to the resident. 2. An observation was conducted of a medication administration for Resident 9 with LPN 3 on 8/26/25 at 8:29 a.m. LPN 3 was observed preparing the medications at the medication cart. During that time, she was observed touching the computer, medication bubble cards, medication cart. After, she administered the medications to the resident. There was no hand hygiene observed prior or after the administration of medications. 3. An observation was conducted of a medication administration for Resident 12 with LPN 3 on 8/26/25 at 8:34 a.m. LPN 3 was observed preparing the resident's medications by popping pill medications in a medication cup. During that time, she had dropped a pill on the medication cart. She picked the pill up with her band hands and dropped it in the medication cup of pills. After, she administered the cup of pill medications to the		deficient practice does not recur; The facility revised its infection control policy to include specific hand hygiene steps during medication administration. Mandatory in-service training was provided to all licensed nursing staff regarding hand hygiene and glove use. Return demonstrations were conducted to ensure competency. The DON and/or designee will monitor hand hygiene compliance during medication passes at least three times weekly for four weeks, then weekly for eight weeks, and monthly thereafter. Results will be reviewed in the facility's Clinical meetings. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place; The DON or designee will complete random direct observation audits of medication administration focusing on hand hygiene practices. Any noncompliance will be addressed immediately with re-education. Audit results will be reported to the Executive Director (ED) monthly for a minimum of six months. Continued monitoring and re-education will occur as necessary to ensure sustained compliance with 410 IAC 16.2-5-12(k).	

resident. There was no observation of hand hygiene utilized before or after the medication administration.

4. An observation was conducted of medication administration for Resident 10 on 8/26/25 at 8:40 a.m. LPN 3 was observed at the medication cart preparing the resident's medications. During that time, LPN 3 had donned on gloves and broke two tablets in half. She then doffed the gloves and administered the medications. There was no hand hygiene observed prior to preparing the medications, prior or after donning and doffing gloves nor after the medication administration.

5. An observation was conducted of a medication administration for Resident 8 with LPN 3 on 8/26/25 at 8:45 a.m. LPN 3 was observed preparing by popping the pill medications in a medication cup. She then walked to the resident's room. She knocked on the resident's door, and handed the resident the cup of pill medications. After, she went to the resident's refrigerator and grabbed the resident a pop to drink with this pill medications. There was no hand hygiene observed prior or after the administration.

An interview was conducted

with LPN 3 on 8/26/25 at 8:53 a.m. She indicated she does have hand sanitizer in her medication cart. She believed hand sanitizer was to be utilized after the 5th resident's medication administration was completed.

During an interview with the Director of Nursing and Executive Director on 8/26/25 at 12:09 p.m., they indicated hand sanitizer was to be utilized after each resident's medication administration.

Based on observation, interview, and record review, the facility failed to ensure infection control was maintained with hand hygiene during medication administration for 5 of 5 residents observed during medication administration. (Residents' 6, 8, 9, 10, and 12)

Findings include:

1. An observation was conducted of a medication administration for Resident 6 with Licensed Practical Nurse (LPN) 3 on 8/26/25 at 8:18 a.m. LPN 3 was observed at the medication cart pulling the resident's medications. During that time, LPN 3 dropped a medication cup on to the floor. She then picked it up and discarded it in the trash. After, she continued to prepare the medications by popping the

medications from the bubble cards into the medication cup. LPN 3 then administered the medications to the resident. There was no hand hygiene before the preparation of the medications, after picking up the medication cup off the floor, nor after administration of medications to the resident.

2. An observation was conducted of a medication administration for Resident 9 with LPN 3 on 8/26/25 at 8:29 a.m. LPN 3 was observed preparing the medications at the medication cart. During that time, she was observed touching the computer, medication bubble cards, medication cart. After, she administered the medications to the resident. There was no hand hygiene observed prior or after the administration of medications.

3. An observation was conducted of a medication administration for Resident 12 with LPN 3 on 8/26/25 at 8:34 a.m. LPN 3 was observed preparing the resident's medications by popping pill medications in a medication cup. During that time, she had dropped a pill on the medication cart. She picked the pill up with her band hands and dropped it in the medication cup of pills. After, she administered the cup of pill medications to the

resident. There was no observation of hand hygiene utilized before or after the medication administration.

4. An observation was conducted of medication administration for Resident 10 on 8/26/25 at 8:40 a.m. LPN 3 was observed at the medication cart preparing the resident's medications. During that time, LPN 3 had donned on gloves and broke two tablets in half. She then doffed the gloves and administered the medications. There was no hand hygiene observed prior to preparing the medications, prior or after donning and doffing gloves nor after the medication administration.

5. An observation was conducted of a medication administration for Resident 8 with LPN 3 on 8/26/25 at 8:45 a.m. LPN 3 was observed preparing by popping the pill medications in a medication cup. She then walked to the resident's room. She knocked on the resident's door, and handed the resident the cup of pill medications. After, she went to the resident's refrigerator and grabbed the resident a pop to drink with this pill medications. There was no hand hygiene observed prior or after the administration.

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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 SIGNATURE	TITLE	(X6) DATE