STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF EVANSVILLE LLC	6521 GREENDALE DR, EVANSVILLE, , 47711

(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 3, 4, 5, 6, 2026 Facility number: 010681 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 11, 2026.	R 0000		
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references	R 0116	This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of February 25,2026 and requests paper	02/25/2026

	and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to screen and inquire about a prospective employee's Registered Nurse (RN) license for 1 of 6 employee records reviewed. The facility was unaware of RN's probation terms before hire date on 10/16/25. (RN 20) Finding includes: On 2/5/26 at 10:30 AM, while doing a clinical record review on a resident, RN 20 gave as needed (PRN) medications. At that time, the RN license was found on the pla.in.gov website and indicated a status of active but on probation. The last two weeks of nursing schedules provided by the Administrator at the entrance conference were reviewed and indicated the last shift RN 20 worked at the facility was 1/31/26. On 2/5/26 at 11:30 A.M., the Administrator provided a court document from the Office of the Indiana Attorney General, filed 12/17/20, that indicated RN 20 was involved with an incident on 5/12/19 at another facility and was terminated from her position because of that		compliance for this survey. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The facility contacted PLA and obtained RNs probation terms. Facility in compliance as of 2/24/2026 with terms. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected No other staff members identified at facility to currently be on probation. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Policy on hiring updated to include that if a license is identified as being on probation, then the facility will obtain probation terms from PLA before	

	incident. At that time, the Administrator indicated RN 20 was a current employee at the facility and she was aware RN 20's license was on probation, but she was not aware of any terms of her probation and did not receive any additional documentation other then the letter from the Attorney General that was provided. On 2/5/26 at 12:18 P.M., court documents titled "Proposed Settlement Agreement", dated 10/19/23, and "Final Order Accepting Proposed Final Agreement", filed 1/31/24, were provided by a Litigation Coordinator from the Indiana Professional Licensing Agency and indicated RN 20 was in violation and placed license on indefinite probation subject to following the terms of her probation. During an interview on 2/6/26 at 9:25 A.M., the Administrator indicated she hired new employees. The screening process included interviewing the perspective employee, background and reference checks, and she did look up the licenses to make sure they have an active status. The RN had not disclosed any information other then the letter from the Attorney General. RN 20 worked Wednesday through Saturday nights for eight hour		hire. 4. Describe 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. Staff licenses/certifications will be monitored monthly for any findings. This monitoring plan to ensure compliance has no end date and is implemented as our new standard monthly.	

	shifts. She did not have any restrictions with nurse duties and responsibilities at the facility. On 2/6/26 at 9:57 A.M., a current Hiring Process, dated 5/1/19, was provided by the Administrator and indicated, "For any employee that is applying for a position within the company the following steps will be completed. An interview of the employee will be conducted. A background check will be completed through Indiana State Police. References provided by the employee will be called. If the position requires a license/certification, this will be checked to make sure the license/certification is active. Once completed and verified, the employee will undergo a new hire orientation process at the community."			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and	R 0243	This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of February 27,2026 and requests paper compliance for this survey.	02/27/2026

	(D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure over the counter (OTC) medications were labeled according to regulation and facility policy for 3 of 5 residents reviewed for medication administration. Resident OTC medications did not include all identifying components. (Resident 124, Resident 50, Resident 70) Findings include: During medication administration on 2/4/26 from 8:40 A.M. through 9:57 A.M., Qualified Medication Aide (QMA) 2 was observed to administer medications. The following medications were observed in the medication cart without all identifying information: A Calcium Citrate bottle with Resident 124's name, but no physician name. A multivitamin gummy bottle with no resident name or physician name, administered to Resident 124.		1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The facility corrected all OTC medication labels for each client cited in the deficiency. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected Medication carts audited to ensure all OTC medications were labeled properly. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Monthly in-services will be provided to staff responsible for labeling of OTC medication to ensure facility stays in compliance. 4. Describe how the corrective action(s) will	

	A B12 bottle with no resident name or physician name, administered to Resident 50. A Centrum Silver bottle with Resident 50's first name only. No last name and no physician name. A Centrum Silver bottle with no resident name or physician name, administered to Resident 70. On 2/5/26 at 9:20 A.M., the same was observed in the medication cart. At that time, QMA 4 indicated medication bottles should be labeled with the resident's name and the physician's name, as well as the expiration date and the name of the medication. He indicated all staff that received medications had access to labels and it would be the staff on duty for the resident at the time that the medication was received that would be responsible for putting the label on the medication bottle. On 2/5/26 at 2:43 P.M., the Administrator provided a current Physician/Healthcare Provider's Order Summary policy, last revised 5/2025, that indicated "Over-the-counter Medications must be labeled with a. Resident name b. Physician name c. Expiration date d. Name of drug e. Strength"		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. OTC medications will be audited weekly for 30 days, every other week for 60 days, monthly for 90 days and PRN thereafter.	

R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure that as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were documented as preauthorized by a licensed nurse for 4 of 7 resident records reviewed. (Resident 125, Resident 368, Resident 124, Resident 133) Findings include: 1. On 2/4/26 at 12:50 PM., Resident 125's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder, fracture of left femur, and diabetes mellitus type II. Current physician orders	R 0246	***R -0246 410 IAC16.2-5-4(e)(6) Health Services– offense*** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** **The community disputes the finding of a Health Services – Offense R -0246 410 IAC16.2-5-4(e)(6) which stated, "the facility failed to ensure that as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were documented as preauthorized by a licensed nurse."** • The facility requests an IDR for this deficiency. • Facility has nursing notes documented throughout the resident's chart in PointClickCare that disputes the series of events that are listed in R 0246 Health Services- Offense. • Tylenol Sinus Severe Oral Tablet was given to 124 on 12/4/2025 by Tina Francis, QMA. In her documentation on	02/24/2026

	included, but were not limited to: Norco tablet (pain medication) 7.5-325 milligrams (mg), give one tablet by mouth every six hours as needed for pain, dated 12/16/25 Zofran tablet (antiemetic) 4 MG, give one tablet by mouth every eight hours as needed for nausea, dated 12/6/25 Resident 125's Medication Administration Record (MAR) from 2/1/26 through 2/4/26 included the following dates that Zofran was administered by a QMA without authorization from a licensed nurse: 2/1/26 at 6:02 P.M. (given by QMA 9) 2/3/26 at 8:01 A.M. (given by QMA 5) Resident 125's MAR from 2/1/26 through 2/4/26 included the following dates that Norco was administered by a QMA without authorization from a licensed nurse: 2/1/26 at 7:39 P.M. (given by QMA 9) 2/2/26 at 3:05 P.M. (given by QMA 9) 2/3/26 at 8:02 A.M. (given by QMA 5)		the MAR, she noted that, “the nurse advised to give”. Randa Rigdon, RN also followed up on the PRN administration and noted the effectiveness of the medication given. • Tylenol Sinus Severe Oral Tablet was given to 124 on 1/17/2025 by Tiffany Hill, QMA. In her documentation on the MAR, she noted that she, “administered per nurse”. Michelle Dorrough, LPN followed up on the PRN administration and noted the effectiveness of the medication given. • Tylenol Extra Strength Oral Tablet was given to 124 on 11/4/2025 by Kelly Lenning, QMA. In her documentation on the MAR, she noted that it was, “given per nurse”. Melanie Kluemper, RN followed up on the PRN	

	2/3/26 at 4:57 P.M. (given by QMA 9) 2/4/26 at 8:10 A.M. (given by QMA 2) The clinical record lacked documentation from a licensed nurse about approval of the medication to be given. 2. On 2/4/26 at 1:04 PM., Resident 368's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and cerebral infarction (stroke). Current physician orders included, but were not limited to: Norco tablet 325-5 MG, give one tablet by mouth every 12 hours as needed for pain, dated 8/3/25 Resident 368's MAR from 10/1/25 through 10/14/25 included the following dates that Norco was administered by a QMA without authorization from a licensed nurse: 10/11/25 at 10:39 A.M. (given by QMA 9) The clinical record lacked documentation from a licensed nurse about approval of the medication to be given. 3. On 2/3/26 at 12:49 P.M., Resident 124's clinical record		administration and noted the effectiveness of the medication given. • It is cited that a Tylenol Extra Strength was given to 124 on 1/19/2025. Resident 124 was not admitted to our facility until 6/25/2025. • Norco Oral Tablet was given on 1/5/2025 to 133 by Norma Jourdan, LPN and followed up by Norma Jourdan, LPN on the effectiveness of the medication given. This does not require documentation of a nurse's permission as the administrator of the medication is a licensed nurse. • Zofran Oral Tablet was given to 125 on 2/1/2026 by Donna Robinson, QMA. In her documentation on the MAR, she noted, "ok per nurse". Nancy Mahrenholz, LPN followed up on the administration and	

	was reviewed. Diagnosis included, but was not limited to, hypertension (high blood pressure). Current Physician Orders included, but were not limited to: Tylenol Severe Sinus Oral Tablet 5-325-200 mg, give two tablets by mouth every four hours prn for congestion, start date 6/30/25. Tylenol Extra Strength Oral Tablet (pain medication) 500 mg, give one tablet by mouth every six hours prn for pain, start date 6/30/25. Resident 124's MAR from 11/1/25 through current indicated Tylenol Severe Sinus was administered by a QMA without documentation of who the nurse that authorized the medication was on the following dates: 12/4/25 (given by QMA 2) 1/17/26 (given by QMA 5) Resident 124's MAR from 11/1/25 through current indicated Tylenol Extra Strength was administered by a QMA without documentation of who the nurse that authorized the medication was on the following dates:		noted the effectiveness of the medication given. • Zofran Oral Tablet was given to 125 on 2/3/2026 by Tiffany Hill, QMA. In her documentation on the MAR, she noted, “administered per nurse”. Stephanie Houghton, LPN followed up on the administration and noted the effectiveness of the medication given. • Norco Tablet was given to 125 on 2/1/2026 by Donna Robinson, QMA. In her documentation on the MAR, she noted, “ok by nurse”. Melanie Kluemper, RN followed up on the administration and noted the effectiveness of the medication given. • Norco Tablet was given on 2/2/2026 was Amos Grogan, QMA. In his documentation on the MAR, he	

	11/4/25 (given by QMA 7) 1/19/25 (given by QMA 4) The clinical record lacked documentation from a licensed nurse about approval of the medication to be given. 4. On 2/4/26 at 10:40 A.M., Resident 133's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II and hypertension. Current Physician's Orders included, but were not limited to: Norco Tablet 5-325 mg, give one tablet by mouth every eight hours prn for pain, start date 7/26/25. Resident 133's MAR from 11/1/25 through current indicated Norco was administered by a QMA without documentation of who the nurse that authorized the medication was on the following dates: 1/5/25 (given by QMA 8) The clinical record lacked documentation from a licensed nurse about approval of the medication to be given. During an interview on 2/5/26 at 1:34 P.M., QMA 2 indicated when a QMA gave as needed medications, they should get		noted, “consulted nurse”. Stephanie Houghton, LPN followed up on the administration and noted the effectiveness of the medication given. • Norco Tablet was given on 2/3/2026 by Tiffany Hill, QMA. In her documentation on the MAR, she noted, “administered per nurse”. Stephanie Houghton, LPN followed up on the administration and noted the effectiveness of the medication given. • Norco Tablet was given on 2/4/2026 by Tina Francis, QMA. In her documentation on the MAR, she noted, “nurse advised to give”. Michelle Dorrough, LPN followed up on the administration and noted the effectiveness of the medication given. **How will the facility identify**	

	approval from a licensed nurse and make a comment in the MAR when giving the medication. During an interview on 2/5/26 at 2:07 P.M., Licensed Practical Nurse (LPN) 3 indicated she preferred to go talk to the resident before a QMA administered an as needed medication. The QMA documented in the progress note that they administered it. On 2/5/26 at 1:12 P.M., the Administrator provided a current Medication Administration Record policy, revised 3/29/2020 that indicated, "...7. Documentation for PRN medications shall include a. Symptoms for which medication was given b. Exact dosage given c. Response of the resident to the prn medication."		**other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** • The community completed audits of other resident charts, to ensure they were not affected by the same alleged deficient practice. No concerns noted. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** • Facility will continue to ensure that QMA's administering PRN medication will obtain permission from a licensed nurse prior to administrator. • The facility will continue to have a licensed nurse follow up on the effectiveness of the PRN administration. • Staff Education completed frequently on QMA administering PRN medication will continue to be ongoing.	

			How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance programs will be put into place? • The facility will continue to complete audits on resident charts related to the administration of PRN medication by a QMA. These audits will occur weekly for 30days, biweekly for 60 days, monthly for 90 days, and PRN thereafter. • A Medication Administration Audit Tool will be completed routinely to ensure community remains in compliance. • The Executive Director will receive reports regarding the results of such audits and will direct further action if required. **By what date will the systemic changes be implemented?** • 2/24/2026	
R 0247	Health Services - Deficiency	R 0247	This Plan of Correction is	02/27/2026

	410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview, and record review, the facility failed to ensure medications were administered without error and appropriate documentation of errors was in the resident's record for 5 of 5 residents reviewed for medication administration. Medications were not given within the allowed time frame, over the counter (OTC) medication was not administered as ordered by the physician, medication was administered when vital signs were out of parameters to give, and the physician was not notified when indicated. (Resident 124, Resident 30, Resident 40, Resident 50, Resident 70) Findings include: 1. On 2/4/26 from 8:40 A.M. through 9:57 A.M., Qualified Medication Aide (QMA) 2 was observed to administer morning medications. At that time, she indicated the medications were being administered		neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of February 27,2026 and requests paper compliance for this survey. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The facility reviewed medication times to ensure they were appropriate for each resident and their situation. Facility preformed an in-service with nursing staff members and educated staff members of the medication administer policy and the timeframes surrounding giving medication. Staff members also in serviced on the parameters of medications and ensuring they are being followed. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the	

	late. The following medications were administered to Resident 40 at 9:26 A.M.: amlodipine 5 milligrams (mg) Arimedex 1 mg tenormin 25 mg Calcium 600 mg + 400 Vitamin D Lasix 20 mg ipratropium bromide nasal spray, 2 sprays each nostril losartan 100 mg Crestor 5 mg The following medications were administered to Resident 50 at 9:43 A.M.: Vitamin C tablet (2 tablets) Vitamin B12 2500 micrograms (mcg) Centrum Silver multivitamin allopurinol 300 mg ferrous gluconate 324 mg Gemtesa 75 mg apresoline 25 mg		facility took to correct the deficient practice for any client the facility identified as being affected 100% of clients were reviewed and no one was identified as being affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Monthly educationgiven to educate staff members of the appropriate timeframes for giving medication and the parameters surrounding giving medication. Some medication times adjusted in compliance with physician and resident wishes. 4. Describe 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. Medication administration times and parameters will be audited by DON or designee weekly for 30 days, biweekly for 60 days, and monthly for 90	

	paroxetine 20 mg senna 8.6 mg Vitamin D3 50 mcg Lyrica 75 mg The following medications were administered to Resident 70 at 9:57 A.M.: Centrum Silver multivitamin (2 tablets) allopurinol 100 mg amlodipine 10 mg aspirin 81 mg wellbutrin 300 mg clopidogrel 75 mg escitalopram 10 mg (1 ½ tablets) Zetia 10 mg famotidine 20 mg Farxiga 10 mg metformin 500 mg Potassium Chloride ER (extended release) 10 milliequivalents (meq) Lasix 40 mg carvedilol 12.5 mg		days, and PRN thereafter.	

	Norco 5 mg On 2/4/26 at 1:12 P.M., Resident 40's clinical record was reviewed. All medications given by QMA 2 at 9:26 A.M. were scheduled to be given at 8:00 A.M. On 2/4/26 at 1:25 P.M., Resident 50's clinical record was reviewed. All medications given by QMA 2 at 9:43 A.M. were scheduled to be given at 8:00 A.M. On 2/4/26 at 1:47 P.M., Resident 70's clinical record was reviewed. All medications given by QMA 2 at 9:57 A.M. were scheduled to be given at 8:00 A.M. On 2/5/26 at 1:00 P.M., Licensed Practical Nurse (LPN) 3 indicated staff had a one hour window prior to the scheduled time and one hour after the scheduled time to administer medications. 2. On 2/4/26 at 8:40 A.M., Qualified Medication Aide (QMA) 2 was observed to administer the following medications to Resident 124: Calcium Citrate 600 mg Vitamin D Gummy On 2/4/26 at 12:40 P.M., Resident 124's clinical record			

	was reviewed. Current physician orders included, but were not limited to: Calcium 600- vitamin D oral tablet 600-10 mg-mcg once a day, dated 1/21/26. Vitamin D3 oral tablet 25 mcg once a day, dated 6/25/25. On 2/4/26 at 1:34 P.M., QMA 2 indicated the Calcium Citrate and Vitamin D that were administered to Resident 124 were different than what was ordered. She indicated that happened a lot when family brought in medications for the resident. 3. On 2/4/26 at 1:00 P.M., Resident 30's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension (high blood pressure). Current physician orders included, but were not limited to, the following: Propranolol HCl oral tablet 80 mg, give 1 tablet by mouth two times a day for hypertension. Hold for SBP (systolic blood pressure) <110 or HR (heart rate) <60, notify physician HR is 55, dated 6/3/25. Resident 30's Medication Administration Record (MAR) indicated the following dates in			

	January 2026 and February 2026 that propranolol was administered outside of the ordered parameters: 1/7/26 8:00 A.M. HR 58 1/8/26 8:00 A.M. HR 56 1/9/26 8:00 A.M. HR 58 1/11/26 8:00 A.M. HR 58 1/15/26 8:00 A.M. HR 59 1/16/26 8:00 A.M. HR 52 (MAR did not indicate notification to physician) 1/16/26 4:00 P.M. HR 52 (MAR did not indicate notification to physician) 1/17/26 8:00 A.M. HR 56 1/18/26 8:00 A.M. HR 55 (MAR did not indicate notification to physician) 1/19/26 8:00 A.M. HR 58 1/20/26 8:00 A.M. HR 50 (MAR did not indicate notification to physician) 1/23/26 8:00 A.M. HR 55 (MAR did not indicate notification to physician) 1/26/26 4:00 P.M. HR 59 1/27/26 8:00 A.M. HR 59			

	1/27/26 4:00 P.M. HR 57 1/30/26 8:00 A.M. HR 56 2/1/26 8:00 A.M. HR 57 2/2/26 4:00 P.M. HR 58 Resident 30's clinical record lacked progress notes related to notification to the physician when the HR was 55 or less in January 2026 or February 2026. On 2/5/26 at 12:43 P.M., QMA 2 indicated when a vital sign was out of parameters to be administered, staff should enter that code into the resident's MAR then enter a progress note as to why the medication was not administered. She indicated if a physician needed to be notified, the QMA would ask a nurse to notify the physician. On 2/5/26 at 1:00 P.M., Licensed Practical Nurse (LPN) 3 indicated when contacting a physician, the nurse should document into the resident's progress notes indicating they were notified. On 2/5/26 at 2:43 P.M., the Administrator provided a current Medication Administration Record policy, last revised 3/29/20, that indicated "After the medication is received and consumed by the resident, the associate will document the "Administered" chart code that			

	reflects that the medication was taken. If the medication is refused or not given/taken, the associate will document the appropriate chart code in the administration on details that reflects the refusal or reason the medication was not given/taken On 2/5/26 at 2:43 P.M., the Administrator provided a current Physician/Healthcare Provider's Order Summary policy, last revised 5/2025, that indicated "It is the policy of [facility name] to provide associates with appropriate directives regarding Physician/Healthcare Provider's orders in accordance with state regulations ... The nurse is responsible for maintaining the Physician/Healthcare Provider's orders, the orders should be filed in the resident record" On 2/5/26 at 2:43 P.M., the Administrator provided a current Medication Administration policy, last revised 3/29/21, that indicated "Medication Administration/Assistance and/or Treatment shall be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider ... Medication assistance and administration should be accordance with the prescriber's orders ... Medications are to be given within the parameter of 1 hour before or after the			

	scheduled medication time"			
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 items were properly labeled and dated. Food was not dated, dishwasher, refrigerator, and freezer temperatures were not logged, and the same soiled gloves were used to touch multiple items during 2 of 2 kitchen observations. Findings include: On 2/3/26 at 8:40 A.M., the following was observed: Dishwasher: lacked a current log of the daily dishwasher temperature top of the dishwasher was caked with debris The same was observed on 2/5/26 at 9:28 A.M.	R 0273	This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of February 27,2026 and requests paper compliance for this survey. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Executive chef obtained his servsafe to be able to have the knowledge to properly lead the kitchen. Kitchen staff members in-serviced on proper food handling, temperature logs, storage, and cleanliness of areas used to serve food. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified	02/27/2026

	On 2/3/26 at 8:40 A.M., the following was observed: Walk in refrigerator: the posted temperature log was September 2025 and there was nothing else documented a clear bag of sausage links, undated 6 clear bowls of cottage cheese, unlabeled and undated 4 stacks of cheese slices wrapped in clear wrap, unlabeled and undated The same was observed on 2/5/26 at 9:28 A.M. On 2/3/26 at 8:40 A.M., the following was observed: Walk in freezer: the posted temperature log was September 2025 and there was nothing else documented On 2/3/26 at 8:40 A.M., the following was observed: Refrigerator: lacked a current log of daily temperature checks tea pitcher had a use by date of 1/30		as being affected 100% of clients were reviewed and none identified as being affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Temperature logs were added to the kitchen in each of the identified locations. Executive chef will ensure that temperature logs and cleaning schedules are filled our accurately and in a timely manner. Will continue to in-service and educate on proper food handling and storage. 4. Describe 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. Weekly audits will be performed by Executive Director or designee of the kitchen, looking for cleanliness, proper storage and food handling, and temperatures log	

	fruit punch pitcher had a use by date of 1/28 2 pitchers of lemonade had a use by date of 1/29 During an observation on 2/3/26 at 12:00 P.M., the Executive Chef obtained gloves, and used a different scoop for each of the 3 items in the steam table. Then he used the same soiled gloves and picked up bread and placed it on a plate. The Executive Chef was observed to touch the above items throughout the entire meal preparation and never changed gloves. During an observation on 2/4/26 at 12:15 P.M., Cook 10 obtained gloves, and used a different scoop for each of the items, wiped his pant leg, and then used the same soiled gloves and picked up bread and placed it on a plate throughout the meal preparation. During an interview on 2/5/26 at 9:28 A.M., the Executive Chef indicated that the dishwasher, walk in refrigerator, walk in freezer, and stand alone refrigerator should all have a daily log. All food items should be labeled with the food item and expiration date. The debree on top of the dishwasher should be cleaned when it is visibly dirty. He further indicated that food should not be touched by soiled gloves, and the bread		appropriately filled out for 60 days. Monthly for 60 days and PRN thereafter.	

	should have been picked up by a utensil. On 2/5/26 at 1:12 P.M., a Labeling and Dating for Safe Storage of Food policy, revised 3/31/2020 was provided by the Administrator and indicated, "...When food is taken out of an original container write the name of the food being stored on the container and the use by date..." On 2/5/26 at 1:12 P.M., an undated Kitchen Cleanliness policy was provided by the administrator and indicated, "GOAL: The kitchen appears neat, clean...The dishwasher is operable and temperature logs...are updated and maintained..." On 2/5/26 at 1:12 P.M., an undated Assisted Living Kitchen Cleanliness Policy was provided by the administrator and indicated, "Refrigerators, freezers, and dry storage areas shall be kept clean, organized, and maintained at safe temperatures. Expired or spoiled food shall be discarded immediately...Food shall be served in a sanitary manner that protects against contamination..."			
R 0274	Food and Nutritional Services - Noncompliance	R 0274	This Plan of Correction is neither an agreement with nor	02/17/2026

	410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide		an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of February 17,2026 and requests paper compliance for this survey. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Executive Chef went to ServSafe Food Manager class and obtained a certificate on 2/17/2025. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected Reviewed all clients and no clients were identified as being affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you	

	consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on interview and record review, the facility failed to follow job description requirements for kitchen staff certification for 1 of 1 kitchen staff reviewed. (Executive Chef) Finding includes: On 2/3/26 at 8:40 A.M., the Executive Chef indicated he did not have any current valid certifications. He indicated his SERVsafe certification expired years ago. On 2/5/26 at 10:30 A.M., employee files were reviewed. The Executive Chef began employment with the facility on 10/29/25. On 2/5/26 at 1:12 P.M., the Administrator provided the Executive Chef/ Food Service Manager policy, dated 5/2019, indicated, "...EDUCATION & QUALIFICATIONS To perform this position successfully, an individual must be able to perform each essential due satisfactorily...Minimum of one (1) year experience as Certified		made. Servsafe certificate will be added to license book to make sure it stays in good standing and active. 4. Describe 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. Certificate will be audited monthly to ensure it is active. This practice has no end date and is the new standard review time to ensure compliance.	

	Food and Beverage Services Manager, Registered Dietetic Technician; or Executive Chef. Must have successfully completed an approved sanitation course..."			

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 SIGNATUREJessie Moore	TITLEExecutive Director	(X6) DATE03/05/2026