STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE, MUNSTER, , 46321

(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: October 15 and 16, 2025 Facility number: 010937 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/17/25.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be	R 0217	Assisted Living at Hartsfield Village 10002 Columbia Avenue Munster, Indiana 46321	11/28/2025

	appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 3. The record for Resident 2 was reviewed on 10/15/25 at 1:25 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, type 2 diabetes, and an infected		**This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.** **R 217** The facility shall update the residents' service plan regarding home health services, wound care, antibiotics and palliative care at least semi-annually and as needed. The facility failed to ensure the residents' service plan was	

	wound. The Service Plan, signed and dated on 9/19/25, had no documentation or information regarding the resident's infected wound, home health services, and that he had been receiving skilled physical and occupational therapies. Home Health Notes, dated 9/22, 9/26, 9/29, 10/3, 10/6, 10/10, and 10/13/25, indicated the resident had received either wound care or therapy services on the above mentioned dates. During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the resident's wound care and therapies were not addressed on the current service plan. 4. The record for Resident 5 was reviewed on 10/16/25 at 10:50 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, type 2 diabetes, repeated falls and osteoporosis. The Service Plan, signed and dated on 10/11/25, had no documentation or information regarding home health care and or skilled physical and occupational therapies.		updated for 5 of 7 residents reviewed. (Residents 10, 3, 2, 5, and 7) **Corrective action taken for residents found to have been affected by the deficient practice:** The facility reviewed all residents with home health services, antibiotics, wound care and palliative care and updated their service plans as warranted. **Identification of other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. **To ensure that proper practices continue:** Director of Nursing/Designee will re-educate the nursing staff regarding	

	A Home Health Note, dated 10/10/25, indicated the resident had received physical and occupational therapy. During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the skilled therapy and home health services were not addressed on the current service plan. Based on record review and interview, the facility failed to ensure Service Plans were revised and updated for 5 of 7 residents reviewed for Service Plans. (Residents 10, 3, 2, 5, and 7) Findings include:op 1. The record for Resident 10 was reviewed on 10/15/25 at 1:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peripheral neuropathy (nerve damage). The resident's Service Plan was reviewed on 6/23/25. A Nursing Progress Note, dated 9/22/25 at 8:54 p.m., indicated the resident had a small open area to the left buttock. A physician's order was received for a home health referral for wound care. Home Health Services were initiated on 9/25/25.		the requirement for the facility to add home health, antibiotics, wound care and palliative care to the residents' service plan. The DON/Designee will initiate and complete a monitoring tool and conduct patient chart audits weekly for residents with orders specifying home health, antibiotics, wound care and palliative care. Each week, a minimum of 4 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four-week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 100% compliance. The systemic plan will be randomly initiating this audit tool again monthly throughout the next 3 months, to ensure that this deficient	

	The Service Plan was not updated to reflect the wound to the resident's buttock and home health services. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's open area recently healed but the service plan did not address the resident's open area and home health services while he was being treated. 2. The closed record for Resident 3 was reviewed on 10/16/25 at 11:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and stroke. The resident's Service Plan was reviewed on 9/2/25. A Physician's Order, dated 9/19/25, indicated the resident was to receive Amoxicillin (an antibiotic) 500 milligrams (mg) three times a day for a urinary tract infection (UTI). The Service Plan was not updated to reflect the antibiotic use. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's service plan did not address the antibiotic use. 5. The closed record for Resident 7 was reviewed on		practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 3 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** November 28, 2025	

	10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia. The resident's face sheet in the EMR (Electronic Medical Record) indicated the resident was receiving palliative care services. A Nurse's Note, dated 8/8/25 at 12:49 p.m., indicated a palliative care nurse visited the resident. The Service Plan, last reviewed on 9/8/25, lacked documentation of the palliative care services. During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident received palliative care services for about 30 days before she transferred to another facility. Palliative care was not on the service plan because the family did not tell them about it. 3. The record for Resident 2 was reviewed on 10/15/25 at 1:25 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, type 2 diabetes, and an infected wound. The Service Plan, signed and dated on 9/19/25, had no documentation or information regarding the resident's infected wound, home health services, and that he had been receiving			

skilled physical and occupational therapies.

Home Health Notes, dated 9/22, 9/26, 9/29, 10/3, 10/6, 10/10, and 10/13/25, indicated the resident had received either wound care or therapy services on the above mentioned dates.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the resident's wound care and therapies were not addressed on the current service plan.

4. The record for Resident 5 was reviewed on 10/16/25 at 10:50 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, type 2 diabetes, repeated falls and osteoporosis.

The Service Plan, signed and dated on 10/11/25, had no documentation or information regarding home health care and or skilled physical and occupational therapies.

A Home Health Note, dated 10/10/25, indicated the resident had received physical and occupational therapy.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the skilled therapy and home health services were not addressed on the current service plan.

	Based on record review and interview, the facility failed to ensure Service Plans were revised and updated for 5 of 7 residents reviewed for Service Plans. (Residents 10, 3, 2, 5, and 7) Findings include:op 1. The record for Resident 10 was reviewed on 10/15/25 at 1:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peripheral neuropathy (nerve damage). The resident's Service Plan was reviewed on 6/23/25. A Nursing Progress Note, dated 9/22/25 at 8:54 p.m., indicated the resident had a small open area to the left buttock. A physician's order was received for a home health referral for wound care. Home Health Services were initiated on 9/25/25. The Service Plan was not updated to reflect the wound to the resident's buttock and home health services. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's open area recently healed but the service plan did not address the resident's open area and home health services while he			

	was being treated. 2. The closed record for Resident 3 was reviewed on 10/16/25 at 11:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and stroke. The resident's Service Plan was reviewed on 9/2/25. A Physician's Order, dated 9/19/25, indicated the resident was to receive Amoxicillin (an antibiotic) 500 milligrams (mg) three times a day for a urinary tract infection (UTI). The Service Plan was not updated to reflect the antibiotic use. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's service plan did not address the antibiotic use. 5. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia. The resident's face sheet in the EMR (Electronic Medical Record) indicated the resident was receiving palliative care services. A Nurse's Note, dated 8/8/25 at			

	12:49 p.m., indicated a palliative care nurse visited the resident. The Service Plan, last reviewed on 9/8/25, lacked documentation of the palliative care services. During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident received palliative care services for about 30 days before she transferred to another facility. Palliative care was not on the service plan because the family did not tell them about it. 3. The record for Resident 2 was reviewed on 10/15/25 at 1:25 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, type 2 diabetes, and an infected wound. The Service Plan, signed and dated on 9/19/25, had no documentation or information regarding the resident's infected wound, home health services, and that he had been receiving skilled physical and occupational therapies. Home Health Notes, dated 9/22, 9/26, 9/29, 10/3, 10/6, 10/10, and 10/13/25, indicated the resident had received either wound care or therapy services on the above mentioned dates. During an interview on 10/16/25 at 1:05 p.m., the Director of			

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	1:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peripheral neuropathy (nerve damage). The resident's Service Plan was reviewed on 6/23/25. A Nursing Progress Note, dated 9/22/25 at 8:54 p.m., indicated the resident had a small open area to the left buttock. A physician's order was received for a home health referral for wound care. Home Health Services were initiated on 9/25/25. The Service Plan was not updated to reflect the wound to the resident's buttock and home health services. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's open area recently healed but the service plan did not address the resident's open area and home health services while he was being treated. 2. The closed record for Resident 3 was reviewed on 10/16/25 at 11:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and stroke.			

	The resident's Service Plan was reviewed on 9/2/25. A Physician's Order, dated 9/19/25, indicated the resident was to receive Amoxicillin (an antibiotic) 500 milligrams (mg) three times a day for a urinary tract infection (UTI). The Service Plan was not updated to reflect the antibiotic use. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's service plan did not address the antibiotic use. 5. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia. The resident's face sheet in the EMR (Electronic Medical Record) indicated the resident was receiving palliative care services. A Nurse's Note, dated 8/8/25 at 12:49 p.m., indicated a palliative care nurse visited the resident. The Service Plan, last reviewed on 9/8/25, lacked documentation of the palliative care services. During an interview on 10/16/25 at 1:15 p.m., the Director of			

Nursing indicated the resident received palliative care services for about 30 days before she transferred to another facility. Palliative care was not on the service plan because the family did not tell them about it.

3. The record for Resident 2 was reviewed on 10/15/25 at 1:25 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, type 2 diabetes, and an infected wound.

The Service Plan, signed and dated on 9/19/25, had no documentation or information regarding the resident's infected wound, home health services, and that he had been receiving skilled physical and occupational therapies.

Home Health Notes, dated 9/22, 9/26, 9/29, 10/3, 10/6, 10/10, and 10/13/25, indicated the resident had received either wound care or therapy services on the above mentioned dates.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the resident's wound care and therapies were not addressed on the current service plan.

4. The record for Resident 5 was reviewed on 10/16/25 at 10:50 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure,

type 2 diabetes, repeated falls and osteoporosis.

The Service Plan, signed and dated on 10/11/25, had no documentation or information regarding home health care and or skilled physical and occupational therapies.

A Home Health Note, dated 10/10/25, indicated the resident had received physical and occupational therapy.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the skilled therapy and home health services were not addressed on the current service plan.

Based on record review and interview, the facility failed to ensure Service Plans were revised and updated for 5 of 7 residents reviewed for Service Plans. (Residents 10, 3, 2, 5, and 7)

Findings include:op

1. The record for Resident 10 was reviewed on 10/15/25 at 1:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peripheral neuropathy (nerve damage).

The resident's Service Plan was reviewed on 6/23/25.

A Nursing Progress Note, dated

	9/22/25 at 8:54 p.m., indicated the resident had a small open area to the left buttock. A physician's order was received for a home health referral for wound care. Home Health Services were initiated on 9/25/25. The Service Plan was not updated to reflect the wound to the resident's buttock and home health services. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's open area recently healed but the service plan did not address the resident's open area and home health services while he was being treated. 2. The closed record for Resident 3 was reviewed on 10/16/25 at 11:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and stroke. The resident's Service Plan was reviewed on 9/2/25. A Physician's Order, dated 9/19/25, indicated the resident was to receive Amoxicillin (an antibiotic) 500 milligrams (mg) three times a day for a urinary tract infection (UTI). The Service Plan was not updated to reflect the antibiotic			

use.

During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's service plan did not address the antibiotic use.

5. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia.

The resident's face sheet in the EMR (Electronic Medical Record) indicated the resident was receiving palliative care services.

A Nurse's Note, dated 8/8/25 at 12:49 p.m., indicated a palliative care nurse visited the resident.

The Service Plan, last reviewed on 9/8/25, lacked documentation of the palliative care services.

During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident received palliative care services for about 30 days before she transferred to another facility. Palliative care was not on the service plan because the family did not tell them about it.

3. The record for Resident 2 was reviewed on 10/15/25 at 1:25 p.m. Diagnoses included, but were not limited to, heart

	disease, high blood pressure, type 2 diabetes, and an infected wound. The Service Plan, signed and dated on 9/19/25, had no documentation or information regarding the resident's infected wound, home health services, and that he had been receiving skilled physical and occupational therapies. Home Health Notes, dated 9/22, 9/26, 9/29, 10/3, 10/6, 10/10, and 10/13/25, indicated the resident had received either wound care or therapy services on the above mentioned dates. During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the resident's wound care and therapies were not addressed on the current service plan. 4. The record for Resident 5 was reviewed on 10/16/25 at 10:50 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, type 2 diabetes, repeated falls and osteoporosis. The Service Plan, signed and dated on 10/11/25, had no documentation or information regarding home health care and or skilled physical and occupational therapies. A Home Health Note, dated 10/10/25, indicated the resident			

had received physical and occupational therapy.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the skilled therapy and home health services were not addressed on the current service plan.

Based on record review and interview, the facility failed to ensure Service Plans were revised and updated for 5 of 7 residents reviewed for Service Plans. (Residents 10, 3, 2, 5, and 7)

Findings include:op

1. The record for Resident 10 was reviewed on 10/15/25 at 1:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peripheral neuropathy (nerve damage).

The resident's Service Plan was reviewed on 6/23/25.

A Nursing Progress Note, dated 9/22/25 at 8:54 p.m., indicated the resident had a small open area to the left buttock. A physician's order was received for a home health referral for wound care.

Home Health Services were initiated on 9/25/25.

The Service Plan was not updated to reflect the wound to

	the resident's buttock and home health services. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's open area recently healed but the service plan did not address the resident's open area and home health services while he was being treated. 2. The closed record for Resident 3 was reviewed on 10/16/25 at 11:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and stroke. The resident's Service Plan was reviewed on 9/2/25. A Physician's Order, dated 9/19/25, indicated the resident was to receive Amoxicillin (an antibiotic) 500 milligrams (mg) three times a day for a urinary tract infection (UTI). The Service Plan was not updated to reflect the antibiotic use. During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's service plan did not address the antibiotic use. 5. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were			

	not limited to, arthritis, osteoporosis, and dementia. The resident's face sheet in the EMR (Electronic Medical Record) indicated the resident was receiving palliative care services. A Nurse's Note, dated 8/8/25 at 12:49 p.m., indicated a palliative care nurse visited the resident. The Service Plan, last reviewed on 9/8/25, lacked documentation of the palliative care services. During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident received palliative care services for about 30 days before she transferred to another facility. Palliative care was not on the service plan because the family did not tell them about it. 3. The record for Resident 2 was reviewed on 10/15/25 at 1:25 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, type 2 diabetes, and an infected wound.			

	The Service Plan, signed and dated on 9/19/25, had no documentation or information regarding the resident's infected wound, home health services, and that he had been receiving skilled physical and occupational therapies. Home Health Notes, dated 9/22, 9/26, 9/29, 10/3, 10/6, 10/10, and 10/13/25, indicated the resident had received either wound care or therapy services on the above mentioned dates. During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the resident's wound care and therapies were not addressed on the current service plan. 4. The record for Resident 5 was reviewed on 10/16/25 at 10:50 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, type 2 diabetes, repeated falls and osteoporosis. The Service Plan, signed and dated on 10/11/25, had no documentation or information regarding home health care and or skilled physical and occupational therapies. A Home Health Note, dated 10/10/25, indicated the resident had received physical and occupational therapy. During an interview on 10/16/25			

at 1:05 p.m., the Director of Nursing indicated the skilled therapy and home health services were not addressed on the current service plan.

Based on record review and interview, the facility failed to ensure Service Plans were revised and updated for 5 of 7 residents reviewed for Service Plans. (Residents 10, 3, 2, 5, and 7)

Findings include:op

1. The record for Resident 10 was reviewed on 10/15/25 at 1:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and peripheral neuropathy (nerve damage).

The resident's Service Plan was reviewed on 6/23/25.

A Nursing Progress Note, dated 9/22/25 at 8:54 p.m., indicated the resident had a small open area to the left buttock. A physician's order was received for a home health referral for wound care.

Home Health Services were initiated on 9/25/25.

The Service Plan was not updated to reflect the wound to the resident's buttock and home health services.

During an interview on 10/16/25

at 1:30 p.m., the Director of Nursing indicated the resident's open area recently healed but the service plan did not address the resident's open area and home health services while he was being treated.

2. The closed record for Resident 3 was reviewed on 10/16/25 at 11:15 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and stroke.

The resident's Service Plan was reviewed on 9/2/25.

A Physician's Order, dated 9/19/25, indicated the resident was to receive Amoxicillin (an antibiotic) 500 milligrams (mg) three times a day for a urinary tract infection (UTI).

The Service Plan was not updated to reflect the antibiotic use.

During an interview on 10/16/25 at 1:30 p.m., the Director of Nursing indicated the resident's service plan did not address the antibiotic use.

5. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia.

The resident's face sheet in the

	EMR (Electronic Medical Record) indicated the resident was receiving palliative care services. A Nurse's Note, dated 8/8/25 at 12:49 p.m., indicated a palliative care nurse visited the resident. The Service Plan, last reviewed on 9/8/25, lacked documentation of the palliative care services. During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident received palliative care services for about 30 days before she transferred to another facility. Palliative care was not on the service plan because the family did not tell them about it.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.	R 0349	Assisted Living at Hartsfield Village 10002 Columbia Avenue Munster, Indiana 46321 **This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance**	11/28/2025

Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to self-administration of medication assessments, indwelling Foley (urniary) catheter orders, and transfer/discharge documentation for 3 of 9 sampled residents (Residents 6, 8, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 10/15/25 at 2:25 p.m., Diagnoses included, but were not limited to, urinary retention. The resident was admitted to the facility with an indwelling Foley catheter on 10/3/25.

There were no physician orders for the catheter at the time of admission.

A Physician's Order, dated 10/15/25, indicated Foley catheter, 16 French with a 30 cubic centimeters (cc) balloon.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing was unaware there was no physician's order for the Foley catheter until 10/15/25.

2. During a medication pass observation on 10/15/25 at 11:40 a.m., LPN 1 poured and prepared medications for Resident 8. She then entered

is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

R 349

The facility shall ensure the residents' clinical records are complete and accurately documented related to self-administration of medication assessments, indwelling Foley catheter orders, and transfer/discharge documentation. The facility failed to ensure the residents' clinical records were complete and accurately documented for 3 of 9 sampled residents. (Residents 6, 8, and 7)

the resident's room with the medication, however, the resident was in the bathroom, but told her to wait a minute. At that time, there was a bottle of over the counter Tylenol on the kitchen counter as well an old unlabeled brown pharmacy bottle with numerous white oval pills inside.

During an interview at that time, LPN 1 indicated the resident did not self-administer her own medications.

The record for Resident 8 was reviewed on 10/16/25 at 10:20 a.m. Diagnoses included, but were not limited to, osteoporosis.

A Self-Administration of Medication Assessment, dated 8/23/25, indicated the resident was able to self-administer her own medications, however, there were no medications listed which she could administer herself.

A Physician's Order, dated 8/23/25, indicated Acetaminophen 325 milligrams (mg) every six hour as needed for pain.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the LPN who worked on 10/15/25 did not normally work in the assisted living and was from the rehab center. The self-administration

Corrective action taken for residents found to have been affected by the deficient practice:

The facility reviewed all self-administration of medication assessments,
indwelling Foley catheter orders, and transfer/discharge documentation to
ensure clinical records are complete, accurate and updated as warranted.

**Identification of other residents
having the potential to be affected by the same deficient practice:**

All residents have the potential to be affected.

**To ensure that proper practices
continue:**

Director of Nursing/Designee will re-educate the nursing staff regarding
the requirement for the facility to have complete and accurately

	of medication assessment should have indicated the resident could self-administer the Tylenol herself. 3. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia. A Transfer/Discharge Form, dated 9/16/25, indicated the resident was transferred to another assisted living facility. The resident's record lacked documentation of a reason for the transfer. During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident was transferred due to family preference, and they usually did not put that information in the record. Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to self-administration of medication assessments, indwelling Foley (urniary) catheter orders, and transfer/discharge documentation for 3 of 9 sampled residents (Residents 6, 8, and 7) Findings include:		documented self-administration of medication assessments, indwelling Foley catheter orders, and transfer/discharge documentation. The DON/Designee will initiate and complete a monitoring tool and conduct patient chart audits weekly for residents with self-administration of medication assessments, indwelling Foley catheter orders, and transfer/discharge documentation. Each week, a minimum of 4 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four-week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 100% compliance. The systemic plan will be randomly initiating this	

	1. The record for Resident 6 was reviewed on 10/15/25 at 2:25 p.m., Diagnoses included, but were not limited to, urinary retention. The resident was admitted to the facility with an indwelling Foley catheter on 10/3/25. There were no physician orders for the catheter at the time of admission. A Physician's Order, dated 10/15/25, indicated Foley catheter, 16 French with a 30 cubic centimeters (cc) balloon. During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing was unaware there was no physician's order for the Foley catheter until 10/15/25. 2. During a medication pass observation on 10/15/25 at 11:40 a.m., LPN 1 poured and prepared medications for Resident 8. She then entered the resident's room with the medication, however, the resident was in the bathroom, but told her to wait a minute. At that time, there was a bottle of over the counter Tylenol on the kitchen counter as well an old unlabeled brown pharmacy bottle with numerous white oval pills inside.		audit tool again monthly throughout the next 3 months, to ensure that this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility’s QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 3 months. Recommendations for further corrective action will be discussed and implemented as needed. **Completion Date:** November 28, 2025	

During an interview at that time, LPN 1 indicated the resident did not self-administer her own medications.

The record for Resident 8 was reviewed on 10/16/25 at 10:20 a.m. Diagnoses included, but were not limited to, osteoporosis.

A Self-Administration of Medication Assessment, dated 8/23/25, indicated the resident was able to self-administer her own medications, however, there were no medications listed which she could administer herself.

A Physician's Order, dated 8/23/25, indicated Acetaminophen 325 milligrams (mg) every six hour as needed for pain.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the LPN who worked on 10/15/25 did not normally work in the assisted living and was from the rehab center. The self-administration of medication assessment should have indicated the resident could self-administer the Tylenol herself.

3. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia.

A Transfer/Discharge Form, dated 9/16/25, indicated the resident was transferred to another assisted living facility.

The resident's record lacked documentation of a reason for the transfer.

During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident was transferred due to family preference, and they usually did not put that information in the record.

Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to self-administration of medication assessments, indwelling Foley (urniary) catheter orders, and transfer/discharge documentation for 3 of 9 sampled residents (Residents 6, 8, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 10/15/25 at 2:25 p.m., Diagnoses included, but were not limited to, urinary retention. The resident was

admitted to the facility with an indwelling Foley catheter on 10/3/25.

There were no physician orders for the catheter at the time of admission.

A Physician's Order, dated 10/15/25, indicated Foley catheter, 16 French with a 30 cubic centimeters (cc) balloon.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing was unaware there was no physician's order for the Foley catheter until 10/15/25.

2. During a medication pass observation on 10/15/25 at 11:40 a.m., LPN 1 poured and prepared medications for Resident 8. She then entered the resident's room with the medication, however, the resident was in the bathroom, but told her to wait a minute. At that time, there was a bottle of over the counter Tylenol on the kitchen counter as well an old unlabeled brown pharmacy bottle with numerous white oval pills inside.

During an interview at that time, LPN 1 indicated the resident did not self-administer her own medications.

The record for Resident 8 was reviewed on 10/16/25 at 10:20 a.m. Diagnoses included, but were not limited to,

osteoporosis.

A Self-Administration of Medication Assessment, dated 8/23/25, indicated the resident was able to self-administer her own medications, however, there were no medications listed which she could administer herself.

A Physician's Order, dated 8/23/25, indicated Acetaminophen 325 milligrams (mg) every six hour as needed for pain.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the LPN who worked on 10/15/25 did not normally work in the assisted living and was from the rehab center. The self-administration of medication assessment should have indicated the resident could self-administer the Tylenol herself.

3. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia.

A Transfer/Discharge Form, dated 9/16/25, indicated the resident was transferred to another assisted living facility.

The resident's record lacked documentation of a reason for the transfer.

During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident was transferred due to family preference, and they usually did not put that information in the record.

Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to self-administration of medication assessments, indwelling Foley (urniary) catheter orders, and transfer/discharge documentation for 3 of 9 sampled residents (Residents 6, 8, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 10/15/25 at 2:25 p.m., Diagnoses included, but were not limited to, urinary retention. The resident was admitted to the facility with an indwelling Foley catheter on 10/3/25.

There were no physician orders for the catheter at the time of admission.

A Physician's Order, dated 10/15/25, indicated Foley catheter, 16 French with a 30 cubic centimeters (cc) balloon.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing was unaware there was no physician's order for the Foley catheter until 10/15/25.

2. During a medication pass observation on 10/15/25 at 11:40 a.m., LPN 1 poured and prepared medications for Resident 8. She then entered the resident's room with the medication, however, the resident was in the bathroom, but told her to wait a minute. At that time, there was a bottle of over the counter Tylenol on the kitchen counter as well an old unlabeled brown pharmacy bottle with numerous white oval pills inside.

During an interview at that time, LPN 1 indicated the resident did not self-administer her own medications.

The record for Resident 8 was reviewed on 10/16/25 at 10:20 a.m. Diagnoses included, but were not limited to, osteoporosis.

A Self-Administration of Medication Assessment, dated 8/23/25, indicated the resident was able to self-administer her own medications, however, there were no medications listed

which she could administer herself.

A Physician's Order, dated 8/23/25, indicated Acetaminophen 325 milligrams (mg) every six hour as needed for pain.

During an interview on 10/16/25 at 1:05 p.m., the Director of Nursing indicated the LPN who worked on 10/15/25 did not normally work in the assisted living and was from the rehab center. The self-administration of medication assessment should have indicated the resident could self-administer the Tylenol herself.

3. The closed record for Resident 7 was reviewed on 10/16/25 at 9:57 a.m. Diagnoses included, but were not limited to, arthritis, osteoporosis, and dementia.

A Transfer/Discharge Form, dated 9/16/25, indicated the resident was transferred to another assisted living facility.

The resident's record lacked documentation of a reason for the transfer.

	During an interview on 10/16/25 at 1:15 p.m., the Director of Nursing indicated the resident was transferred due to family preference, and they usually did not put that information in the record.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAlyssa Fusco	TITLEAdministrator	(X6) DATE10/28/2025