

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM		STREET ADDRESS, CITY, STATE, ZIP CODE 3177 MERIDIAN PARKE DR, GREENWOOD, , 46142					
(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 Intake 471430. Intake 471430 - No deficiencies related to the allegations are cited. Survey dates: August 20 and 21, 2026 Facility number: 011478 Residential Census: 80 These State Residential Finding are cited in accordance with 410 IAC 16.2-5. Quality review completed August 31, 2026.	R 0000					
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute				

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(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to protect the residents right to be free from neglect for 1 of 3 residents reviewed for smoking. A resident was observed smoking unsafely without additional interventions. (Resident 91) Finding included: On 8/20/26 at 11:00 a.m., the clinical record for Resident 91 was reviewed. The diagnosis included, but was not limited to, chronic obstructive pulmonary disease. A Smoking Safety Evaluation, dated 8/6/26, indicated Resident 91 displayed safe smoking but since admission "Resident 91 has been witnessed smoking and utilizing oxygen via nasal cannula." A Nurses Note, dated 8/6/26, indicated a late entry for 8/3/26, the entry indicated Resident 91's hospice service and the		an admission on the part of Country Charm as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remediat measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • How will the facility identify other residents having the potential to be affected by the same	
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facility social worker had a care plan meeting regarding resident smoking with oxygen in place and turned on. Resident denies smoking at that time. Hospice reminded Resident 91 this was an issue at the previous facility that the resident had resided in. A Nurses Note, dated 8/6/26, late entry for 8/4/26 at 11:41 a.m., indicated Resident 91 was observed on her back porch smoking with her oxygen on via nasal cannula. The resident was reminded to remove the oxygen prior to smoking. A Nurses Note, dated 8/5/26 at 11:45 a.m., indicated Resident 91 was observed on her back porch smoking with oxygen being administered via nasal cannula at that time. A Nurses Note, dated 8/7/26 at 11:45 a.m., indicated Resident 91 was observed outside smoking with oxygen being administered via nasal cannula. A Nurses Note, dated 8/12/26, indicated Resident 91 was witnessed at 12:30 p.m., smoking cigarettes outside on her back porch with oxygen running via nasal cannula. Resident was aware not to wear the oxygen cannula while smoking. During an interview on 8/20/26 at 11:33 a.m., the Executive		deficient practice and what corrective action will be taken? • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? • 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? • By the date the systemic changes will be completed. R 052 A review identified that all residents could be affected by the deficient practice. The resident in question has initiated immediate discharge. The discharge is dated for 9/30/2026. The resident will be discharging to the Waters of Indianapolis. Systematic changes: 9/30/2026	
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	Director indicated Resident 91 had been witnessed smoking with her oxygen on several times. On 8/3/26 a sign was made for her back porch door to remind her to take off her oxygen prior to smoking. She had been witnessed multiple times smoking with her oxygen still on and running via nasal cannula after the sign was posted on her back porch door. On 8/21/26 at 8:40 a.m., the Executive Director provided policy titled Resident Smoking, dated 8/2/23, and indicated it was the current policy being used by the facility. A review of the policy indicated "This facility shall establish and maintain safe resident smoking practices. Procedure: ...8. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 9. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training	R 0117	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute	

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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 at least one staff member per shift were CPR (Cardiopulmonary Resuscitation) and First Aid certified for 4 of 21 shifts reviewed. (LPN 6, QMA 7, QMA 8) Finding includes: On 8/21/26 at 9:00 a.m., the	an admission on the part of Country Charm as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remediat measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • How will the facility identify other residents having the potential to be affected by the same	
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Executive Director provided a copy of the "staff work schedule" from 8/16/26 through 8/22/26. A review of the document indicated the following: - The work schedule identified 3 shifts per day. The "first shift" hours were from 6:00 a.m. to 2:00 p.m.; "second shift" were from 2:00 p.m. to 10:00 p.m.; and "third shift" hours were from 10:00 p.m. to 6:00 a.m. - The schedule identified the designated staff member who served as the certified CPR and First Aid staff member for that shift. The designated staff member's CPR and First Aid certifications were reviewed. The facility was unable to provide verification that LPN 6, QMA 7 or QMA 8 were CPR and/or First Aid certified. The following shifts lacked staff members who were CPR and/or First Aid certified: - 8/19/26 - second shift; LPN 6 was designated as the CPR and First Aid certified staff member. No certification verification was provided. No other CPR or First Aid certified staff member was on duty at that time. - 8/20/26 - third shift; QMA 7 was designated as the First Aid	deficient practice and what corrective action will be taken? • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? • 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? • By the date the systemic changes will be completed. A review identified that all residents could be affected by the deficient practice. A complete audit on all clinical staff to determine CPR/First Aid will be conducted by 9/18/2026. All clinical staff including new hires, will be CPR/First Aid certified. The executive director or designee will conduct random employee file audits weekly x 4 weeks, then quarterly thereafter to ensure compliance with CPR/First Certification. Systematic changes 9/18/2026	
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certified staff member. No certification verification was provided. No other First Aid certified staff member was on duty at that time.

- 8/22/26 - first shift; QMA 8 was the designated First Aid certified staff member. No certification verification was provided. No other First Aid certified staff member was scheduled for duty at that time.

- 8/22/26 - second shift; LPN 6 was the designated CPR and First Aid certified staff member. No certification verification was provided. No other CPR or First Aide certified staff member was scheduled for duty at that time.

During an interview on 8/21/26 at 11:30 a.m., the Regional Clinical Nurse indicated the facility followed the State regulations regarding the certified CPR and First Aid staffing requirements. Each shift was to have at least one working staff member who was CPR and First Aid certified.

During an interview on 8/21/26 at 1:45 p.m., the Executive Director indicated the facility was unable to provide verification of the staff's CPR and First Aid certification for the identified shifts.

On 8/21/26 at 1:30 p.m., the Executive Director provided a

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	copy of the Life Safety Operations Manual, dated August 2023, and indicated it was the current policy in use by the facility. A review of the document indicated, "...all Community members should be CPR certified if required by state licensing regulations...First Aid...reference state licensing regulations requirements as indicated..."			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure physician orders for medication administration were being followed for 1 of 3 residents reviewed. (Resident 81) Finding includes: On 8/21/26 at 11:30 a.m., Resident 81's clinical record	R 0241	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Country Charm as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remediat measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction	

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was reviewed. Resident 81's diagnoses included, but were not limited to, angina pectoris, atherosclerosis, and hypothyroidism. The Physician Orders included, but were not limited to, "Levothyroxine [a medication used to replace thyroid hormone] 50 mcg [micrograms] tabs, take one tablet once daily on empty stomach, start date of 8/14/26 [no end date]." A SLUMS (Saint Louis University Mental Status) assessment, dated 3/10/26, indicated Resident 81 was mildly cognitively impaired. During a medication administration observation on 8/21/26 at 7:53 a.m., LPN 5 administer oral tablets to Resident 81 while Resident 81 was eating the morning meal, which included Levothyroxine 50 mcg. During an interview on 8/21/26 at 11:18 a.m., LPN 5 indicated that the Levothyroxine should not have been administered with the morning meal. During an interview on 8/21/26 at 11:41 a.m., the Executive Director (ED) indicated that nurses should not administer any medication that did not follow physician orders.	with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? • 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? • By the date the systemic changes will be completed. R 241 A review identified that all residents could be affected by	
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	On 8/21/26 at 12:15 p.m., the DNS (Director of Nursing Services) provided a copy of the Community team members procedures for medication assistance policy, dated January 8/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...When assisting a resident with routine medication administration, read the Resident's MAR sheet or EMAR system if used: Checking the resident's name, medication name, and date, route of administration, frequency, reason being taken, time of administration, strength and number of tablets/capsules..."		the deficient practice. An all-nursing staff in-service will be completed including medication administration, The Executive Director or designee will conduct random medication pass audits 2 x weekly x 4 weeks, then monthly thereafter, Systematic changes 9/18/2026	
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number.	R 0306	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Country Charm as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remediat measures as the	

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(4) The reason for disposal.

(5) The amount disposed of.

(6) The method of disposition.

(7) The date of the disposal.

(8) The signature of the person conducting the disposal of the drug.

(9) The signature of a witness, if any, to the disposal of the drug.

Based on record review and interview, the facility failed to ensure a drug disposition record was completed for residents who had discharged from the facility for 2 of 2 residents reviewed for discharge.
(Resident 142, Resident 143)

Findings include:

1. On 8/21/26 at 10:33 a.m., the closed clinical record for Resident 142 was reviewed.

Physicians Orders, included but were not limited to:

- allopurinol (a medication used to treat high levels of uric acid in the blood and urine) 100 mg (milligrams)

- atorvastatin (a medication used to treat high cholesterol levels) 10 mg

- levothyroxine (a medication used to replace thyroid

concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
- How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will

hormone) 50 mcg (micrograms)

- verapamil (a medication used to treat high blood pressure)
240 mg

The clinical record lacked a drug disposition for Resident 142's medications.

2. On 8/21/26 at 10:45 a.m., the closed clinical record for Resident 143 was reviewed. The diagnosis included, but was not limited to, anxiety.

Physician's Orders included, but was not limited to:

- acetaminophen suppository (a medication used to treat pain)
650 mg

- fentanyl patch (a controlled opiod pain medication) 50 mcg per hour

- hyoscyamine (a medication used to calm muscle spasms)
0.125 mg

- lorazepam (a medication used to treat anxiety) 2 mg/mL (milliliter)

- morphine solution (a controlled opiod pain medication) 100 mg/5 mL

The clinical record lacked a drug disposition for Resident 143's medication.

be put into place?

- By the date the systemic changes will be completed.

R 306

A review identified that all residents could be affected by the deficient practice.

A nursing in-service will be completed on medication destruction.

The Executive Director or designee will conduct random medication destruction logs weekly x 4 weeks then monthly thereafter.

Systematic changes 9/18/2026

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During an interview on 8/22/26 at 10:25 a.m., the Executive Director (ED) indicated the facility was unable to provide a copy of the drug disposition for the two discharged residents.

On 8/21/26 at 11:19 a.m., the ED provided a policy titled Drug Disposal, dated August, 2017, and indicated it was the current policy being used by the facility. A review of the policy indicated "1. All unused medications must be returned to the pharmacy or disposed of and a record kept in the Resident's Service Record of such disposal or return..."

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 SIGNATUREAngela Sortore	TITLEExecutive Director	(X6) DATE09/11/2026
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