| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COUNTRY CHARM | 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 |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey.<br><br>Survey dates: July 14, 15, and 16, 2025<br><br>Facility number: 011478<br><br>Residential Census: 77<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed July 18, 2025. | R 0000 | | |
| R 0246 | Health Services - Deficiency<br><br>410 IAC 16.2-5-4(e)(6)<br><br>(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 | R 0246 | This Plan of Correction is submitted as required under State<br>law. The submission of this Plan of<br>Correction does not constitute admission on the part of Country Charm as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of | 08/15/2025 |

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| | premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.<br><br>Based on observation, interview, and record review, the facility failed to ensure a Qualified Medication Aide obtained authorization from a licensed nurse prior to the administration of an as needed (PRN) medication for 1 of 5 medication administration observations. (Resident 56, QMA 4)<br><br>Finding includes:<br><br>During medication administration observation on 7/15/25 at 8:15 a.m., observed Qualified Medication Aide 4 (QMA) exit the room of Resident 56. QMA 4 indicated Resident 56 requested a pain pill, the resident had complained of back pain. QMA 4 obtained one oxycodone (narcotic pain medication) 5 mg (milligrams) for Resident 56. QMA 4 was observed to administer the oxycodone to Resident 56.<br><br>During an interview at on 7/15/25 at 8:22 a.m., QMA 4 indicated she would notify the nurse after the pain medication was administered.<br><br>During an interview at 9:33 a.m., the Director of Nursing indicated | | Correction 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 remedial measures, as that 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 judicial and/or administrative proceeding on that basis. The Community also 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.<br><br>What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice? | |

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| | a licensed nurse should have been notified prior to the administration of the oxycodone to Resident 56.<br><br>On 7/15/25 at 10:00 a.m., the clinical record of Resident 56 was reviewed. The diagnosis included, but was not limited to, low back pain.<br><br>A Physicians Order, initiated 5/21/25, indicated oxycodone 5 mg, take one tablet by mouth every 6 hours as needed for pain.<br><br>The residents clinical record lacked documentation of a licensed nurse being notified or authorizing the administration of an as needed oxycodone on 7/15/25 at 8:15 a.m.<br><br>On 7/15/25 at 11:33 a.m., the Director of Nursing indicated the facility followed the State regulations for a QMA's Job Description.<br><br>On 7/16/25 at 8:22 a.m., the Executive Director provided a document titled Job Description and Profile, dated 3/1/22. The document indicated "Job Position Title: QMA...Objective: ...act within the State Regulations..."<br><br>On 7/16/25 at 9:31 a.m., the facility was unable to provide a policy specific to QMA's administering PRN medication. | | How will the facility identify other residents having the<br>potential to be affected by the same deficient practice and what corrective<br>action will be taken?<br><br>What<br>measures will be put into place or what systemic changes the facility will make<br>to ensure that the deficient practice does not recur?<br><br>How<br>the corrective action(s) will be monitored to ensure the deficient practice<br>will not recur, i.e. what quality assurance program will be put into place?<br><br>By<br>the date the systemic changes will be completed.<br><br>**R 246**<br><br>1 Resident 5 is receiving PRN | |

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| R 0273 | Food and Nutritional Services - Deficiency<br><br>410 IAC 16.2-5-5.1(f)<br><br>(f) All food preparation and serving | R 0273 | **This plan of correction is submitted as required under State and Federal law.**<br>**The submission of this Plan** | 08/15/2025 |

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 foods were served in a sanitary and safe manner for 1 of 4 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Dining Services Chef)

Finding includes:

During the initial kitchen observation with the Dining Services Supervisor (DSS), on 7/14/25 from 9:00 a.m. to 9:15 a.m., the Dining Services Chef was observed walking throughout the kitchen area and near the steamtable where the breakfast foods were being held. The Dining Services Chef was observed to have facial hair, approximately one-half inch in length, located above the lip area and at the chin area. The facial hair was observed to not be covered.

During an interview on 7/14/25 at 12:35 p.m., the Dining Services Chef indicated facial hair was supposed to be kept covered while in the kitchen area.

**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 remedial measures as that 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

During an interview on 7/14/25 at 12:45 p.m., the DSS indicated all facial hair was to be kept covered while in the kitchen area.

On 7/14/25 at 1:18 p.m., the Executive Director provided an undated copy of the Hair Restraint Policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all dietary staff shall wear hair restraints...including beard restraints...while in the kitchen..."

On 7/14/25 at 1:18 p.m., the Executive Director provided an undated copy of the "Hair Nets and Beards Guards" document and indicated it was the current process in use by the facility. A review of the document indicated, "...beard guards must be worn in the kitchen..."

On 7/15/25 at 11:00 a.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as nets...beard restraints...that are designed and worn to effectively keep their hair from contacting...exposed food..."

Based on observation,

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.

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**R 273**

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

An all staff in-service will be conducted on hairnet use by 8/12/2025.

All new hires will be educated on the
hair net policy.

The executive director or designee will
conduct random dietary audits weekly x 4 weeks, then monthly x 3 months, then
quarterly thereafter to ensure compliance with hairnet usage.

Systematic changes 8/15/2025

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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