STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT FORT WAYNE WEST	611 W COUNTY LINE RD SOUTH, FORT WAYNE, , 46814

(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 also included the Investigation of Intake 467289. Intake 467289 deficiencies related to the allegations are cited at R0145. Survey dates: February 3, 4 and 5, 2026 Facility number: 011804 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 6, 2026	R 0000		
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently,	R 0119	**Deficiency ID**: R 119 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance	

	each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in,		**Completion Date:** March 31,2026 **Plan of correction text:** By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March31,2026. We respectfully request paper compliance for this survey resolution. **Deficiency ID**: R 119 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance **Completion Date**: March 31,2026 **Plan of Correction Text**: property administrator will conduct audit and ensure all	

	the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to provide job-specific orientation for five of five employee files reviewed: Certified Nursing Assistant (CNA) 4, Qualified Medical Assistant (QMA) 6, QMA 7, QMA 8, and Licensed Practical Nurse (LPN) 5. Findings included: On 02/03/2026, the Administrator provided a completed state form for Residential Care Employee Records, which identified facility employees, job titles, and start dates. The form indicated CNA 4 had a start date of 05/2025, QMA 6 had a start date of 10/2025, QMA 7 had a start date of 06/2025, QMA 8 had a start date of 09/2025, and LPN 5 had a start date of 12/2025. On 02/04/2026, a review of CNA 4's employee file indicated no job-specific orientation documentation was found. On 02/04/2026, a review of QMA 6's employee file indicated no job-specific orientation		appropriate staff completes job specific orientation and ensure specific orientations are completed within the first 30 days of hire. **What corrective action (s)** - The property administrator will follow up weekly to ensure job specific orientation is completed after general orientation within the allocated time frame per job specific orientation. The property administrator will report weekly to Executive Director about progress and completion of job specific orientations. -How the facility will identify other employss having the potential to be affected by the same deficient practice and what corrective action will be taken; property administrator will conduct audit and ensure all appropriate staff completes job specific orientation and ensure specific orientations are completed within the first 30 days of hire. - The property	

	documentation was found. On 02/04/2026, a review of QMA 7's employee file indicated no job-specific orientation documentation was found. On 02/04/2026, a review of QMA 8's employee file indicated no job-specific orientation documentation was found. On 02/04/2026, a review of LPN 5's employee file indicated no job-specific orientation documentation was found. In an interview, on 02/05/2026 at 8:34 AM, the Director of Nursing (DON) indicated the facility did not have job-specific orientation for any of the employees reviewed. In an interview, on 02/05/2026 at 10:00 AM, the Executive Director (ED) indicated she was made aware that some employees did not have job-specific orientation completed. The ED indicated some employees had job-specific orientation; however, some did not. The ED further indicated the facility did not have job-specific orientation documentation for any of the employees reviewed. A current facility policy titled Training Requirements, dated 02/21/2023, was provided by the ED on 02/05/2026. The		administrator will follow up weekly to ensure job specific orientation is completed after general orientation within the allocated time frame per job specific orientation. The property administrator will report weekly to Executive Director about progress and completion of job specific orientations. -What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: - The property administrator will follow up weekly to ensure job specific orientation is completed after general orientation within the allocated time frame per job specific orientation. The property administrator will report weekly to Executive Director about progress and completion of job specific orientations. -How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.	

	policy indicated, "All staff must have orientation to their specific job skills ..." Based on interview and record review, the facility failed to provide job-specific orientation for five of five employee files reviewed: Certified Nursing Assistant (CNA) 4, Qualified Medical Assistant (QMA) 6, QMA 7, QMA 8, and Licensed Practical Nurse (LPN) 5. Findings included: On 02/03/2026, the Administrator provided a completed state form for Residential Care Employee Records, which identified facility employees, job titles, and start dates. The form indicated CNA 4 had a start date of 05/2025, QMA 6 had a start date of 10/2025, QMA 7 had a start date of 06/2025, QMA 8 had a start date of 09/2025, and LPN 5 had a start date of 12/2025. On 02/04/2026, a review of CNA 4's employee file indicated no job-specific orientation documentation was found. On 02/04/2026, a review of QMA 6's employee file indicated no job-specific orientation documentation was found. On 02/04/2026, a review of QMA 7's employee file indicated no job-specific orientation		The property administrator and Executive Director will continuously monitor employs files and ensure updates during weekly meetings going forward By what date will the systemic changes be completed: March 31,2026	

	documentation was found. On 02/04/2026, a review of QMA 8's employee file indicated no job-specific orientation documentation was found. On 02/04/2026, a review of LPN 5's employee file indicated no job-specific orientation documentation was found. In an interview, on 02/05/2026 at 8:34 AM, the Director of Nursing (DON) indicated the facility did not have job-specific orientation for any of the employees reviewed. In an interview, on 02/05/2026 at 10:00 AM, the Executive Director (ED) indicated she was made aware that some employees did not have job-specific orientation completed. The ED indicated some employees had job-specific orientation; however, some did not. The ED further indicated the facility did not have job-specific orientation documentation for any of the employees reviewed. A current facility policy titled Training Requirements, dated 02/21/2023, was provided by the ED on 02/05/2026. The policy indicated, "All staff must have orientation to their specific job skills ..."			

R 0145	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(b) (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on interview and record review the facility failed to keep an exit door in working order. This affected 1 of 3 residents reviewed. (Resident B) Findings include: A facility reported incident investigation dated 1/12/26 was reviewed on 2/4/26 at 12:10 PM. The investigation included a written statement from Certified Nursing Assistant 6 (CNA). The statement indicated Housekeeper 4 mentioned she was told not to use the door between rooms 404 and 405 (Door 12) as it was not functioning properly. The statements in the facilities investigation indicated Door 12 did not alarm to indicate it had been opened when Resident B exited the building. In an interview, on 2/4/26 at 1:00 PM, Housekeeper 4 indicated appropriately 2 weeks prior to Resident B exiting, the door did not alarm when held	R 0145	**Deficiency ID**: R 145 410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency **Completion Date**: March 31,2026 **Deficiency ID**: R 145 410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency **Completion Date**: March 31,2026 **Plan of Correction Text**: By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective October 31,2025. We respectfully request paper compliance for this survey resolution. **What corrective action (s)**	

	open. Housekeeper 4 indicated while holding the door open for a family, Door 12 did not alarm. Housekeeper 4 indicated she told the maintenance tech the door was not functioning. Housekeeper 4 indicated she was unable to let managers know as it was a holiday. In an interview, on 2/4/26 at 1:15 PM, Maintenance Director 5 indicated he was aware there was a problem with Door 12's key fob but the magnet was working fine. Maintenance Director 5 indicated there was no communication from the system of a failure of the alarm. Maintenance Director 5 indicated he did not check the alarm system when he learned of the key fob errors due to lack of communication from the system and the working magnets. There were no policy and procedure available at time of exit. A job description for maintenance lead was given in place of a policy. The Administrator provided the job description on 2/5/26 at 10:13 AM. The Administrator highlighted ...Ensures that preventative maintenance procedures are carried out on a scheduled basis and completes maintenance records for equipment ...		- The maintenance director will check and document all interior doors daily to ensure alarm are active and doors work properly. If defaults are found additional staffing will monitor door and appropriate service will be completed until door is back working properly. -**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Staff will monitor and check on all residents every 2 hours to ensure residents are non-exit seeking. Facility will do four checks on all residents to ensure safety in facility. The maintenance director will check and document all interior doors daily to ensure alarms are active and doors work properly. If defaults are found, additional staffing will monitor door and appropriate service will be completed until door is back working properly. -**What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:**	

	This citation is related to Intake 467289. Based on interview and record review the facility failed to keep an exit door in working order. This affected 1 of 3 residents reviewed. (Resident B) Findings include: A facility reported incident investigation dated 1/12/26 was reviewed on 2/4/26 at 12:10 PM. The investigation included a written statement from Certified Nursing Assistant 6 (CNA). The statement indicated Housekeeper 4 mentioned she was told not to use the door between rooms 404 and 405 (Door 12) as it was not functioning properly. The statements in the facilities investigation indicated Door 12 did not alarm to indicate it had been opened when Resident B exited the building.		The Maintenance Director will meet with the Executive Director weekly about ongoing and new maintenance issues and have ongoing daily check-ins to ensure all equipment is working properly daily.. -**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place**. The Maintenance Director and Executive Director will continuously monitor completion of work orders daily for 3 weeks and then weekly ongoing **By what date will the systemic changes be completed**: March 31,2026	

	In an interview, on 2/4/26 at 1:00 PM, Housekeeper 4 indicated appropriately 2 weeks prior to Resident B exiting, the door did not alarm when held open. Housekeeper 4 indicated while holding the door open for a family, Door 12 did not alarm. Housekeeper 4 indicated she told the maintenance tech the door was not functioning. Housekeeper 4 indicated she was unable to let managers know as it was a holiday. In an interview, on 2/4/26 at 1:15 PM, Maintenance Director 5 indicated he was aware there was a problem with Door 12's key fob but the magnet was working fine. Maintenance Director 5 indicated there was no communication from the system of a failure of the alarm. Maintenance Director 5 indicated he did not check the alarm system when he learned of the key fob errors due to lack of communication from the system and the working magnets. There were no policy and procedure available at time of exit. A job description for maintenance lead was given in place of a policy. The Administrator provided the job description on 2/5/26 at 10:13 AM. The Administrator highlighted ...Ensures that preventative maintenance			

	procedures are carried out on a scheduled basis and completes maintenance records for equipment ... This citation is related to Intake 467289.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure medications were administered as ordered by the physician for one of five residents reviewed (Resident 10). Findings included: Resident 10's record was reviewed on 02/03/2026. Diagnoses included dementia in other disease classified elsewhere, undifferentiated schizophrenia, adjustment disorder, vitamin D deficiency, and hyperlipidemia. A review of physician orders, dated 04/23/2025 at 4:32 PM, indicated Resident 10 was ordered Buspirone HCL 15 mg tablet three times daily for anxiety. The Medication	R 0240	**Deficiency ID:** R 240 410 IAC 16.2-5-4(d) Health Services-Deficiency **Completion Date**: March 31st, 2026 **Plan of correction text:** By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 31,2026. We respectfully request paper compliance for this survey resolution.	

	Administration Record (MAR) for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 04/23/2025 at 432PM, indicated Resident 10 was ordered Donepezil HCL 10 mg tablet once daily for sleep. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 09/17/2024 at 9:50PM, indicated Resident 10 was ordered Famotidine 20 mg tablet twice daily for gastroesophageal reflux disease. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed two doses. A review of physician orders, dated 09/17/2024 at 9:51PM, indicated Resident 10 was ordered Midodrine HCL 5 mg tablet twice daily for blood pressure. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 09/17/2024 at 9:52PM, indicated Resident 10 was ordered Polyethylene Glycol 3350 powder 17 grams once		**Deficiency ID:** R 240 410 IAC 16.2-5-4(d) Health Services **Completion Date:** March 31, 2026 **Plan of Correction Text**: Nurses will ensure that medications are administered per physician order **What corrective action (s)** - The nurse on duty or the Wellness Director will review medications daily. The Wellness Director will review MARS and have weekly meeting with Executive Director to discuss all findings going forward. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**; The Wellness Director will review all MARS on daily basis and ensure that the nurse on duty is following up on missed	

	daily for constipation. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed three doses. A review of physician orders, dated 09/17/2024 at 9:39 PM, indicated Resident 10 was ordered Rexulti 1 mg tablet once daily for schizophrenia. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 05/13/2025 at 4:17PM, indicated Resident 10 was ordered Vitamin D3 5,000 IU capsule once daily. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed one dose. A review of physician orders, dated 12/18/2024 at 3:16PM, indicated Resident 10 was ordered Melatonin 5 mg tablet once daily for insomnia. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 09/17/2024 at 12:47PM indicated Resident 10 was ordered Rosuvastatin Calcium 20 mg tablet once daily for hyperlipidemia. The MAR for the period of January 1, 2026		medications -**What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:** Wellness Director or nurse on duty will ensure all meds are signed out for that day, nurse, AWD, and WD will follow up on medications that have not been administered to see the cause **-How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** The Wellness Director and Executive Director will continuously the MARs to ensure that medications are passed. These will be monitored daily and then on weekly and monthly basis to ensure all medications have been followed up on **By what date will the systemic changes be completed**:	

	through February 5, 2026, indicated Resident 10 missed four doses. Resident 10's progress notes were reviewed, and no documentation explaining the missed medication administrations during the period of January 1, 2026 through February 5, 2026, was available for review. In an interview, on 02/04/2026, the Director of Nursing (DON) indicated she was unable to locate any documentation regarding the missed medication administrations during January 2026 through February 2026. The DON indicated the Regional Nurse did not allow Qualified Medical Assistants to document medication refusals and stated the missed doses were due to resident refusal. The DON was unable to provide documentation supporting the refusals. A review of the MAR indicated that during January 2026, Resident 10 refused Buspirone, Donepezil, Famotidine, Midodrine HCL, Rexulti, Melatonin, and Rosuvastatin Calcium on three separate occasions, with QMA 8 documenting the resident refused the medications. A current policy, titled		March 31, 2026	

	Medication Administration, dated 04/11/2022, provided by the DON, indicated, "Medications are administered in accordance with written orders of the attending Healthcare provider ...if a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time, the space provided in the front of the MAR for that dosage administration is initialed and circled ..." Based on interview and record review, the facility failed to ensure medications were administered as ordered by the physician for one of five residents reviewed (Resident 10). Findings included: Resident 10's record was reviewed on 02/03/2026. Diagnoses included dementia in other disease classified elsewhere, undifferentiated schizophrenia, adjustment disorder, vitamin D deficiency, and hyperlipidemia. A review of physician orders, dated 04/23/2025 at 4:32 PM, indicated Resident 10 was ordered Buspirone HCL 15 mg tablet three times daily for anxiety. The Medication Administration Record (MAR) for the period of January 1, 2026 through February 5, 2026,			

	indicated Resident 10 missed four doses. A review of physician orders, dated 04/23/2025 at 432PM, indicated Resident 10 was ordered Donepezil HCL 10 mg tablet once daily for sleep. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 09/17/2024 at 9:50PM, indicated Resident 10 was ordered Famotidine 20 mg tablet twice daily for gastroesophageal reflux disease. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed two doses. A review of physician orders, dated 09/17/2024 at 9:51PM, indicated Resident 10 was ordered Midodrine HCL 5 mg tablet twice daily for blood pressure. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 09/17/2024 at 9:52PM, indicated Resident 10 was ordered Polyethylene Glycol 3350 powder 17 grams once daily for constipation. The MAR for the period of January 1, 2026 through February 5, 2026,			

	indicated Resident 10 missed three doses. A review of physician orders, dated 09/17/2024 at 9:39 PM, indicated Resident 10 was ordered Rexulti 1 mg tablet once daily for schizophrenia. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. A review of physician orders, dated 05/13/2025 at 4:17PM, indicated Resident 10 was ordered Vitamin D3 5,000 IU capsule once daily. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed one dose. A review of physician orders, dated 12/18/2024 at 3:16PM, indicated Resident 10 was ordered Melatonin 5 mg tablet once daily for insomnia. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses.			

	A review of physician orders, dated 09/17/2024 at 12:47PM indicated Resident 10 was ordered Rosuvastatin Calcium 20 mg tablet once daily for hyperlipidemia. The MAR for the period of January 1, 2026 through February 5, 2026, indicated Resident 10 missed four doses. Resident 10's progress notes were reviewed, and no documentation explaining the missed medication administrations during the period of January 1, 2026 through February 5, 2026, was available for review. In an interview, on 02/04/2026, the Director of Nursing (DON) indicated she was unable to locate any documentation regarding the missed medication administrations during January 2026 through February 2026. The DON indicated the Regional Nurse did not allow Qualified Medical Assistants to document medication refusals and stated the missed doses were due to resident refusal. The DON was unable to provide documentation supporting the refusals. A review of the MAR indicated that during January 2026, Resident 10 refused Buspirone, Donepezil, Famotidine,			

	Midodrine HCL, Rexulti, Melatonin, and Rosuvastatin Calcium on three separate occasions, with QMA 8 documenting the resident refused the medications. A current policy, titled Medication Administration, dated 04/11/2022, provided by the DON, indicated, "Medications are administered in accordance with written orders of the attending Healthcare provider ...if a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time, the space provided in the front of the MAR for that dosage administration is initialed and circled ..."			
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 and interview, the facility failed to store food under sanitary conditions 110 of 110 residents who resided in the facility ate food prepared in the kitchen.	R 0273	***Deficiency ID**: R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services **Completion Date:** March 31,2026 **Plan of correction text:** By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the	

	Findings include: During an initial tour in the kitchen on 2/3/26 at 9:05 AM with the Executive Chief, the following was observed: Inside the walk-in cooler a tub of tuna salad (prepped 1/31) and a tub of yellow rice (prepped 1/30) were found past their use by dates of 2/2 and 2/1. A tub of coleslaw prepped on 1/29 had a used by date of 1/31. A pie was observed unlabeled and undated. The lid was not completely sealed. Two heads of Romaine lettuce were partially exposed to the air with no labeling. A tub of basil pesto, a bag of sliced ham, delete and bags of shredded mozzarella and grated parmesan cheese, improperly sealed, all lacked required "open" dates. At 9:12 AM, a observation in delete the walk-in freezer had an opened box of California vegetable blend and a box of beef hamburgers both contained inner plastic bags that were left open, leaving the food unprotected. At 9:15 AM, the side cooler had a bottle of poppy seed dressing with an expiration date of 1/31. Bottles of salad dressing and mayonnaise, as well as opened bags of cubed Colby cheese, cubed cheddar cheese, and baby carrots, were all stored		right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March31,2026. We respectfully request paper compliance for this survey resolution. **Deficiency ID:** R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services **Completion Date**: March 31,2026 **Plan of Correction Text** **What corrective action (s)** - Executive Chef will implement procedures to maintain the quality and safety of all products stored within the refrigerator, freezer and all storage areas in the kitchen. The Executive Chef will utilize a daily checklist to ensure	

	without any open dates. The baby carrots were add uncovered and exposed to the air. At 9:19 AM, the dry storage room had a bag of rainbow pasta and an opened bag of white cake mix, both improperly sealed and exposed to the air without open dates. An opened bottle of Irish cream syrup was undated. In an interview, on 2/3/26 at 9:14 AM, the Executive Chief indicated all opened items should have dates, items inside of the boxes should be sealed properly to not expose the food and the opened bags should be closed properly with ties. A current facility policy, titled, Proper food storage, dated 6/22, was provided by the Executive Chief on 2/3/26 at 9:50 AM. The policy indicated..."Store food in airtight containers to keep moisture out...label all open containers with open date and expiration date...keep foods properly wrapped or covered and dated with date opened and date expires...." Based on observation and interview, the facility failed to store food under sanitary conditions 110 of 110 residents who resided in the facility ate food prepared in the kitchen. Findings include:		consistency on the ongoing bases. Additionally, the Sous Chef will be trained on this checklist to ensure procedures are followed diligently without exception. -**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**; The Executive Chef will utilize a daily checklist to ensure consistency on the ongoing bases. Additionally, the Sous Chef will be trained on this checklist to ensure procedures are followed diligently without exception. The Executive Director and Executive Chef will meet weekly to monitor progress. This will be ongoing. -**What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:** - The Executive Chef will utilize a	

	During an initial tour in the kitchen on 2/3/26 at 9:05 AM with the Executive Chief, the following was observed: Inside the walk-in cooler a tub of tuna salad (prepped 1/31) and a tub of yellow rice (prepped 1/30) were found past their use by dates of 2/2 and 2/1. A tub of coleslaw prepped on 1/29 had a used by date of 1/31. A pie was observed unlabeled and undated. The lid was not completely sealed. Two heads of Romaine lettuce were partially exposed to the air with no labeling. A tub of basil pesto, a bag of sliced ham, delete and bags of shredded mozzarella and grated parmesan cheese, improperly sealed, all lacked required "open" dates. At 9:12 AM, a observation in delete the walk-in freezer had an opened box of California vegetable blend and a box of beef hamburgers both contained inner plastic bags that were left open, leaving the food unprotected. At 9:15 AM, the side cooler had a bottle of poppy seed dressing with an expiration date of 1/31. Bottles of salad dressing and mayonnaise, as well as opened bags of cubed Colby cheese, cubed cheddar cheese, and baby carrots, were all stored without any open dates. The		daily checklist to ensure consistency on the ongoing bases. Additionally, the Sous Chef will be trained on this checklist to ensure procedures are followed diligently without exception. The Executive Director and Executive Chef will meet weekly to monitor progress. This will be ongoing. **-How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** Executive Chef will implement procedures to maintain the quality and safety of all products stored within the refrigerator, freezer and all storage areas in the kitchen by utilizing a daily checklist. The Executive Director and Executive Chef will meet weekly to monitor progress. This will be ongoing. **By what date will the systemic**	

	baby carrots were add uncovered and exposed to the air. At 9:19 AM, the dry storage room had a bag of rainbow pasta and an opened bag of white cake mix, both improperly sealed and exposed to the air without open dates. An opened bottle of Irish cream syrup was undated. In an interview, on 2/3/26 at 9:14 AM, the Executive Chief indicated all opened items should have dates, items inside of the boxes should be sealed properly to not expose the food and the opened bags should be closed properly with ties. A current facility policy, titled, Proper food storage, dated 6/22, was provided by the Executive Chief on 2/3/26 at 9:50 AM. The policy indicated..."Store food in airtight containers to keep moisture out...label all open containers with open date and expiration date...keep foods properly wrapped or covered and dated with date opened and date expires...."		**changes be completed**: March 31,2026	
R 0382	Mental Health Screening - Noncompliance 410 IAC 16.2-5-11.1(f) (f) Each resident with a major mental illness must have a comprehensive care plan that is	R 0382	**Deficiency ID:** R 382 410 IAC 16.2-5-11.1(f) Mental Health Screening -	

	developed within thirty (30) days after admission to the residential care facility. Based on interview and record review the facility failed to ensure a comprehensive care plan was developed related to Major Mental Illness diagonsis for 3 of 7 residents reviewed. (Resident 8, Resident 9, and Resident 10) Findlings include: 1) Resident 8's record was reviewed on 2/3/26 at 11:33 AM. Diagnoses included Bipolar disease. A review of Resident 8's current care plan dated 11/15/25, did not include the diagnosis of Bipolar disease. 2) Resident 9's record was reviewed on 2/3/26 at 11:44 AM. Diagnoses included Bipolar disease. A review of Resident 9's current care plan dated 12/9/25, did not include the diagnosis of Bipolar disease. 3) Resident 10's record was reviewed on 2/3/26 at 1:30 PM. Diagnoses included undifferentiated Schizophrenia. A review of Resident 9's current care plan dated 5/5/25, did not include the diagnosis of		**Completion Date:** March 31,2026 **Plan of correction text**: By submitting the enclosed materials, we are not admitting the truth of accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of proceedings and submit these responses pursuant to regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 31,2026. We respectfully request paper compliance for this survey resolution. **Deficiency ID:** R 382 410 IAC 16.2-5-11.1(f) Mental Health Screening - **Completion Date:** March 31,2026 **Plan of Correction Text**: Wellness director will ensure residents with major mental illness have a comprehensive care plan.	

	undifferentiated Schizophrenia. In an interview, on 2/3/26 at 10:58AM, the Executive Director indicated they did not have any resident with a major mental illness. In an interview, on 2/4/26 at 9:39 AM, the Director of Nursing indicated she did not realize individuals with major mental illness required a care plan to address specific needs related to the mental illness. A current facility policy, titled, Resident Evaluation and service plan, dated 2/23, was provided by the Director of Nursing on 2/4/26 at 11:59 AM. The policy indicated..."the purpose of the resident evaluation and service plan is to establish a process to evaluate and plan for the resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on his or her individual needs and preferences...." Based on interview and record review the facility failed to ensure a comprehensive care plan was developed related to Major Mental Illness diagonsis for 3 of 7 residents reviewed. (Resident 8, Resident 9, and Resident 10) Findlings include:		**What corrective action (s**) - The Wellness Director will follow up daily to ensure care plans are followed. The Wellness Director will review MARS and have weekly meeting with Executive Director to discuss all findings going forward. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**; The Wellness Director will review all resident care plans to identify if any opportunities with care and update care plans as needed. Care plans will be reviewed semiannually or upon any substantial change in resident or facility’s request -**What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:**	

	1) Resident 8's record was reviewed on 2/3/26 at 11:33 AM. Diagnoses included Bipolar disease. A review of Resident 8's current care plan dated 11/15/25, did not include the diagnosis of Bipolar disease. 2) Resident 9's record was reviewed on 2/3/26 at 11:44 AM. Diagnoses included Bipolar disease. A review of Resident 9's current care plan dated 12/9/25, did not include the diagnosis of Bipolar disease. 3) Resident 10's record was reviewed on 2/3/26 at 1:30 PM. Diagnoses included undifferentiated Schizophrenia. A review of Resident 9's current care plan dated 5/5/25, did not include the diagnosis of undifferentiated Schizophrenia. In an interview, on 2/3/26 at 10:58AM, the Executive Director indicated they did not have any resident with a major mental illness.		Wellness Director will ensure all care plans are updated within 1 business day to reflect any updates with care. **-How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** The Wellness Director and Executive Director will continuously monitor care plans and ensure updates during weekly meetings going forward **By what date will the systemic changes be completed**: March 31,2026	

	In an interview, on 2/4/26 at 9:39 AM, the Director of Nursing indicated she did not realize individuals with major mental illness required a care plan to address specific needs related to the mental illness. A current facility policy, titled, Resident Evaluation and service plan, dated 2/23, was provided by the Director of Nursing on 2/4/26 at 11:59 AM. The policy indicated..."the purpose of the resident evaluation and service plan is to establish a process to evaluate and plan for the resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on his or her individual needs and preferences...."			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing	R 0410	**Deficiency ID**: R 410 410 IAC 16.2-5-12(e)(f)(g) Infection Control **Completion Date:** March 31, 2026 **Plan of correction text:** By submitting the enclosed materials, we are not admitting the truth of accuracy of any	

should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on interview and record review, the facility failed to ensure tuberculosis (TB) testing was completed for one of five residents reviewed (Resident 5).

Findings included:

Resident 5's record was reviewed on 02/03/2026 at 12:53 PM. A TB test was completed on 12/24/2025 upon Resident 5's admission to the facility. The result was negative with a value of 0 mm. The second-step TB test could not be located, and no additional TB testing documentation was found.

A progress note, dated 01/26/2026 at 12:01 PM, indicated Resident 5 had refused the second TB administration. No progress notes indicating Resident 5 was reapproached were located.

specific findings or allegations. We reserve the
right to contest the findings or allegations as part of proceedings and submit
these responses pursuant to regulatory obligations. The facility requests that
the plan of correction be considered our allegation of compliance effective
March 31, 2026. We respectfully request paper compliance for this survey
resolution.

Deficiency ID: R 410 410 IAC 16.2-5-12(e)(f)(g)
Infection Control

Completion Date: March 31, 2026

Plan of Correction Text:
Wellness director will ensure all resident’s have proper tuberculin testing completed.

What corrective action (s)

	In an interview, on 02/04/2026 at 10:24 AM, the DON indicated a chest x-ray was not completed when Resident 5 refused the second-step TB test. The DON indicated the second-step TB test was not completed and no additional TB testing was completed beyond the test dated 12/24/2025. In an interview, on 02/05/2026 at 10:00 AM, the DON indicated she was unable to locate any progress notes documenting Resident 5 being reapproached regarding TB testing. A current policy titled Tuberculosis Infection Control Plan, dated 01/08/2026, was provided by the Executive Director. The policy indicated, " ...New residents shall be screened within 3 months prior to move in or upon move in as follows: A flow chart indicated if a resident does not have a past history of positive TB test, disease, or latent TB infection (LTBI) and has no symptoms or risk factors and a tuberculin skin test (TST) has not been completed within 12 months, the facility will perform TB testing via 2-Step TST or blood test ..." Based on interview and record review, the facility failed to ensure tuberculosis (TB) testing was completed for one of five residents reviewed (Resident 5).		- The Wellness Director will audit all residents to ensure proper tuberculin testing was completed. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**. The Wellness Director will review all residents' immunizations regarding tuberculin testing. Any resident found not to be in compliance will re-start the 2-step TB series. -**What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:** Wellness Director will monitor the immunizations tab in PPC daily. Nurse on duty will be assigned to administer TBS. **-How the corrective action will be monitored to ensure the deficient practice will not**	

	Findings included: Resident 5's record was reviewed on 02/03/2026 at 12:53 PM. A TB test was completed on 12/24/2025 upon Resident 5's admission to the facility. The result was negative with a value of 0 mm. The second-step TB test could not be located, and no additional TB testing documentation was found. A progress note, dated 01/26/2026 at 12:01 PM, indicated Resident 5 had refused the second TB administration. No progress notes indicating Resident 5 was reapproached were located. In an interview, on 02/04/2026 at 10:24 AM, the DON indicated a chest x-ray was not completed when Resident 5 refused the second-step TB test. The DON indicated the second-step TB test was not completed and no additional TB testing was completed beyond the test dated 12/24/2025. In an interview, on 02/05/2026 at 10:00 AM, the DON indicated she was unable to locate any progress notes documenting Resident 5 being reapproached regarding TB testing. A current policy titled Tuberculosis Infection Control Plan, dated 01/08/2026, was		**recur, i.e., what quality assurance program will be put in place.** The Wellness director will audit immunizations weekly for 4 weeks, then twice a month for 2 months and then monthly there after. The Wellness Director and Executive Director will continuously monitor immunizations going forward. **By what date will the systemic changes be completed**: March 31, 2026	

	provided by the Executive Director. The policy indicated, " ...New residents shall be screened within 3 months prior to move in or upon move in as follows: A flow chart indicated if a resident does not have a past history of positive TB test, disease, or latent TB infection (LTBI) and has no symptoms or risk factors and a tuberculin skin test (TST) has not been completed within 12 months, the facility will perform TB testing via 2-Step TST or blood test ..."			

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 SIGNATURELaura Lovell	TITLEExecutive Director	(X6) DATE02/22/2026