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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VICTORIAN OF ZIONSVILLE	11755 N MICHIGAN RD, ZIONSVILLE, , 46077

(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 Complaints IN00459009, IN00459210, IN00461309, IN00461395, and IN00461703. Complaint IN00459009 - State deficiencies related to the allegations are cited at R148, R154, R247. Complaint IN00459210 - State deficiencies related to the allegations are cited at R217, R407, R410. Complaint IN00461309 - State deficiencies related to the allegations are cited at R117. Complaint IN00461395 - State deficiencies related to the allegations are cited at R217. Complaint IN00461703 - State deficiencies related to the allegations are cited at R117.	R 0000		

	Survey dates: July 14, 15, and 16, 2025 Facility number: 012263 Residential Census: 61 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 28, 2025.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training 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	R 0117	R117 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a No residents experienced adverse effects from the alleged deficient practice. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice**	09/01/2025

	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 record review, the facility failed to ensure the minimum staffing requirements to meet the regulation to have at least one awake person who was First Aide and CPR certified available at all times. This deficient practice had the potential to effect 61 of 61 residents who resided in the facility. Findings include: During the survey entrance conference on 7/14/25 at 9:50 a.m., the actual worked nursing schedule for 7/8/25 - 7/14/25 was requested and provided by the Executive Director (ED). The schedule was reviewed to ensure appropriate and adequate coverage for staff available who were First Aid certified, and Cardiopulmonary Resuscitation (CPR) certified. The schedule lacked coverage as follows: No First Aid or CPR coverage on 7/8/25 from 2:30 p.m. until 6:00 p.m. No First Aid coverage on 7/9/25 from 2:30 p.m. until 6:00 a.m., and no CPR coverage from 6:30		**and what corrective will be taken** a **3 What measures will be put into place** **or what systemic changes the facility will make to ensure that the deficient** **practice does not recur:** a **4 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:** a **5 By what date will the systematic changes be completed: 9/1/25**	

	p.m. until 10:00 p.m. No First Aid coverage on 7/10/25 from 2:30 p.m. until 6:00 a.m. No First Aid or CPR coverage on 7/11/25 from 4:00 p.m. until 6:00 p.m. No First Aid or CPR coverage on 7/12/25 from 6:30 a.m. until 2:00 p.m. No First Aid or CPR coverage on 7/13/25 from 2:30 p.m. until 6:00 p.m. No First Aide coverage on 7/14/25 from 2:30 p.m. until 6:00 p.m. On 7/15/25 at 2:00 p.m., the First Aide and CPR certification binder was returned to the ED. Several certifications were expired. An updated binder with any additional certified staff certificates was requested. On7/16/25 at 10:00 a.m., the ED indicated what had been provided was all there was. No additional staff certifications were provided before the time of exit. On 7/16/25 at 12:00 p.m., the ED provided a copy of current facility policy titled, "CPR & First Aid Certifications," revised 9/2021. The policy indicated, " ...It is the responsibility of the Director of Nursing or designee			

	to ensure at least one on-duty employee has current CPR & First Aide Certifications at all times ...." This citation relates to Complaints IN00461309 and IN00461703. Based on record review, the facility failed to ensure the minimum staffing requirements to meet the regulation to have at least one awake person who was First Aide and CPR certified available at all times. This deficient practice had the potential to effect 61 of 61 residents who resided in the facility. Findings include: During the survey entrance conference on 7/14/25 at 9:50 a.m., the actual worked nursing schedule for 7/8/25 - 7/14/25 was requested and provided by the Executive Director (ED). The schedule was reviewed to ensure appropriate and adequate coverage for staff available who were First Aid certified, and Cardiopulmonary Resuscitation (CPR) certified. The schedule lacked coverage as follows: No First Aid or CPR coverage on 7/8/25 from 2:30 p.m. until 6:00 p.m. No First Aid coverage on 7/9/25			

	from 2:30 p.m. until 6:00 a.m., and no CPR coverage from 6:30 p.m. until 10:00 p.m. No First Aid coverage on 7/10/25 from 2:30 p.m. until 6:00 a.m. No First Aid or CPR coverage on 7/11/25 from 4:00 p.m. until 6:00 p.m. No First Aid or CPR coverage on 7/12/25 from 6:30 a.m. until 2:00 p.m. No First Aid or CPR coverage on 7/13/25 from 2:30 p.m. until 6:00 p.m. No First Aide coverage on 7/14/25 from 2:30 p.m. until 6:00 p.m. On 7/15/25 at 2:00 p.m., the First Aide and CPR certification binder was returned to the ED. Several certifications were expired. An updated binder with any additional certified staff certificates was requested. On7/16/25 at 10:00 a.m., the ED indicated what had been provided was all there was. No additional staff certifications were provided before the time of exit. On 7/16/25 at 12:00 p.m., the ED provided a copy of current facility policy titled, "CPR & First Aid Certifications," revised 9/2021. The policy indicated, "			

	...It is the responsibility of the Director of Nursing or designee to ensure at least one on-duty employee has current CPR & First Aide Certifications at all times ...." This citation relates to Complaints IN00461309 and IN00461703.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six	R 0120	**R120** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 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:** a No residents had the potential	09/01/2025

	(6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff received at least the minimum required amount of dementia-specific training for 4 of 5 employee records reviewed. Findings include: Activity Aid 10 was hired on 7/10/17 and his record lacked documentation of 3 hours of annual dementia-specific training.		to be affected by the alleged deficient practice. ED and/or designee will ensure that staff that have contact with residents will have a minimum of 6 hours of dementia training within 6 months of hire and 3 hours annually thereafter. **3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a ED and/or designee will ensure that staff have sufficient dementia training completed. Any staff member out of compliance with facility policies and protocols will receive progressive corrective action. The ED/designee will educate all newly hired staff on policies and protocols during employee orientation moving forward. **4 How the corrective action(s)**	

	Housekeeper 11 was hired on 3/31/25 and had no records of dementia-specific training. Qualified Medication Aide was hired on 4/20/23 and her record lacked documentation of 3 hours of annual dementia-specific training. Certified Nursing Assistant 9 was hired on 7/5/22 and her record lacked documentation of 3 hours of annual dementia-specific training. On 7/16/25 at 12:00 p.m., the ED indicated, the facility did not have a policy to address dementia-specific upon hire and on-going training requirements, but they followed the Residential Regulations. Based on record review and interview, the facility failed to ensure staff received at least the minimum required amount of dementia-specific training for 4 of 5 employee records reviewed. Findings include: Activity Aid 10 was hired on 7/10/17 and his record lacked documentation of 3 hours of annual dementia-specific training. Housekeeper 11 was hired on 3/31/25 and had no records of dementia-specific training.		**will be** **monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed:** **9/1/25**	

	Qualified Medication Aide was hired on 4/20/23 and her record lacked documentation of 3 hours of annual dementia-specific training. Certified Nursing Assistant 9 was hired on 7/5/22 and her record lacked documentation of 3 hours of annual dementia-specific training. On 7/16/25 at 12:00 p.m., the ED indicated, the facility did not have a policy to address dementia-specific upon hire and on-going training requirements, but they followed the Residential Regulations.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first	R 0121	**R121** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice**	09/01/2025

	tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure a Tuberculosis (TB) skin test was completed for 1 of 1 new hired employees reviewed. Findings include: Housekeeper 11 was hired on 3/31/25. A first step TB was		**and what corrective action will be taken:** a No residents had the potential to be affected by the alleged deficient practice. ED and/or designee will ensure that all new employees have a 1st and 2nd step TB test. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a ED and/or designee will ensure that staff have a completed 1st and 2nd step TB test on file. Any staff member out of compliance with facility policies and protocols will receive progressive corrective action.	

	placed on 3/28/25 and read on 3/30/25, the results were negative. The record lacked documentation of the second step. During an interview on 7/15/25 at 9:00 a.m. the ED indicated all the employee records available had been provided. A second step TB test was not provided before the survey exit. On 7/16/25 at 12:00 p.m., the ED provided a copy of current facility policy titled, "Tuberculosis Skin Testing and Follo Up (Resident s& Employees)," revised 5/2025. The policy indicated, " ...A two-step mantotux PPD tuberculosis skin test will be administered to: 1. New employees within 90 days prior to the date of hire or commenced no more that seven days after the date of hire ... if the first stepis negative, a second test should be performed one (1) to three (3) weeks after the first step ...." Based on record review and interview, the facility failed to ensure a Tuberculosis (TB) skin test was completed for 1 of 1 new hired employees reviewed. Findings include: Housekeeper 11 was hired on		**4 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:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed: 9/1/25**	

	3/31/25. A first step TB was placed on 3/28/25 and read on 3/30/25, the results were negative. The record lacked documentation of the second step. During an interview on 7/15/25 at 9:00 a.m. the ED indicated all the employee records available had been provided. A second step TB test was not provided before the survey exit. On 7/16/25 at 12:00 p.m., the ED provided a copy of current facility policy titled, "Tuberculosis Skin Testing and Follo Up (Resident s& Employees)," revised 5/2025. The policy indicated, " ...A two-step mantotux PPD tuberculosis skin test will be administered to: 1. New employees within 90 days prior to the date of hire or commenced no more that seven days after the date of hire ... if the first stepis negative, a second test should be performed one (1) to three (3) weeks after the first step ...."			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment	R 0148	**R148** **1 What corrective action(s) will be**	09/01/2025

	in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observations, interviews, and record reviews, the facility failed to ensure the environment was free from the potential for accidents when a bio-hazard closet and a cabinet of heavy chemicals were left unlocked on the secured memory care unit for 2 of 3 days of observation. Findings include:		**accomplished for those residents found to have been affected by the deficient practice:** a **2** **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:** a All residents had the potential to be affected by the alleged deficient practice. ED and/or designee will ensure that the environment is free from the potential for accidents and biohazard closet and cabinets with chemicals are locked. **3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	

	On 7/14/25 at 11:00 a.m., during a general tour through the secured memory care (MC) unit, a bio-hazard closet was observed to be unlocked. On 7/16/25 at 10:50 a.m., during a follow up tour through the secured MC unit, the bio-hazard closet remained unlocked. On 7/16/25 at 10:55 a.m., a cabinet underneath a generally accessible sink in the secured MC unit was observed unlocked. In the cabinet, the following hard chemicals were observed: Germicidal bleach Neutral PH Floor Cleaner Open and uncovered can of Comet dust Spray bleach bottle Coil Doctor Coil Cleaner & Disinfectant Open and uncovered bottle of Crew Heavy Duty Toilet Bowl Cleanser. On 7/16/25 at 12:00 p.m., the ED indicated the facility did not have a policy to address environmental safety hazards, but they followed the Residential Regulations. This citation relates to		**practice does not recur:** a ED and/or designee will ensure that biohazard closets and cabinets containing chemicals are locked. **4 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:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until	

	Complaint IN00459009. Based on observations, interviews, and record reviews, the facility failed to ensure the environment was free from the potential for accidents when a bio-hazard closet and a cabinet of heavy chemicals were left unlocked on the secured memory care unit for 2 of 3 days of observation. Findings include: On 7/14/25 at 11:00 a.m., during a general tour through the secured memory care (MC) unit, a bio-hazard closet was observed to be unlocked. On 7/16/25 at 10:50 a.m., during a follow up tour through the secured MC unit, the bio-hazard closet remained unlocked. On 7/16/25 at 10:55 a.m., a cabinet underneath a generally accessible sink in the secured MC unit was observed unlocked. In the cabinet, the following hard chemicals were observed: Germicidal bleach Neutral PH Floor Cleaner Open and uncovered can of Comet dust Spray bleach bottle		resolved. **5** **By** **what date the systemic changes will be completed:** **9/1/25**	

	Coil Doctor Coil Cleaner & Disinfectant Open and uncovered bottle of Crew Heavy Duty Toilet Bowl Cleanser. On 7/16/25 at 12:00 p.m., the ED indicated the facility did not have a policy to address environmental safety hazards, but they followed the Residential Regulations. This citation relates to Complaint IN00459009.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to the ensure the refrigerator was in good repair to prevent the potential for contamination as there was a leak that left standing water in the unit for 1 of 1 kitchen observation. Findings include: On 7/14/25 at 9:50 a.m., a	R 0154	**R154** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 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:**	09/01/2025

	general kitchen tour was conducted with the Dietary Manager (DM). The refrigerator was observed. There was a puddle of standing water on the bottom shelf that covered the whole shelf. The Dietary Manger (DM) indicated the cooler was broken, but since there was no Maintenance Director, it had not been repaired. The DM indicated that she thought the water was dripping from the ceiling of the machine and she tried to wipe out the water as often as possible. The DM indicated she had not thought about moving the items from the fridge to a safer storage area until the unit could be repaired. Water was observed trickling down the refrigerator wall on the left panel and dripped from the plastic drainpipe at the top of the unit. A metal, circular vent on the ceiling of the refrigerator was observed to be rusted and covered with debris that blew in the moving air. Items in the refrigerator at this time include but were not limited to, various pitches of beverages, containers of milk, and condiment bottles, some with the tops left open. On 7/14/25 at 11:50 a.m., the DM provided a copy of current, but undated, facility policy titled, "Equipment Use, Storage, Warranty and Repairs Policy and Procedures." The policy indicated, " ...ensure that would		a No residents had the potential to be affected by the alleged deficient practice. Maintenance Director and/or designee will ensure that refrigerator is in good repair to prevent the potential for contamination. **3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a ED and/or designee will ensure that refrigerator is in good repair to prevent the **4 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:**	

	read the directions on all of the equipment within the kitchen. Know how to use the equipment, how to clean the equipment, and lastly how to maintain the equipment ..." This citation relates to Complaint IN00459009. Based on observation, interview, and record review, the facility failed to the ensure the refrigerator was in good repair to prevent the potential for contamination as there was a leak that left standing water in the unit for 1 of 1 kitchen observation. Findings include: On 7/14/25 at 9:50 a.m., a general kitchen tour was conducted with the Dietary Manager (DM). The refrigerator was observed. There was a puddle of standing water on the bottom shelf that covered the whole shelf. The Dietary Manger (DM) indicated the cooler was broken, but since there was no Maintenance Director, it had not been repaired. The DM indicated that she thought the water was dripping from the ceiling of the machine and she tried to wipe out the water as often as possible. The DM indicated she had not thought about moving the items from the fridge to a safer storage area until the unit could be repaired.		a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed:** **9/1/25**	

	Water was observed trickling down the refrigerator wall on the left panel and dripped from the plastic drainpipe at the top of the unit. A metal, circular vent on the ceiling of the refrigerator was observed to be rusted and covered with debris that blew in the moving air. Items in the refrigerator at this time include but were not limited to, various pitches of beverages, containers of milk, and condiment bottles, some with the tops left open. On 7/14/25 at 11:50 a.m., the DM provided a copy of current, but undated, facility policy titled, "Equipment Use, Storage, Warranty and Repairs Policy and Procedures." The policy indicated, " ...ensure that would read the directions on all of the equipment within the kitchen. Know how to use the equipment, how to clean the equipment, and lastly how to maintain the equipment ..." This citation relates to Complaint IN00459009.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the	R 0214	R214	09/01/2025

	resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. 3. On 7/14/25 at 1:30 p.m., Resident L's record was reviewed. He has a diagnosis of Alzheimer's dementia and resided on the secured memory care unit. He was at risk for falls and had a history of falls. A nursing progress note, dated 2/18/25 at 8:33 p.m., indicated the resident was sitting in the tv room and took off his pants. He tried to get up by himself and fell on the right side. The resident hit his right forehead and had a little skin tear. The record lacked documentation of physician/Licensed Nurse notification. The record lacked documentation of first aide provided. The record lacked documentation of fall follow up to ensure no residual issues or injuries arose. The record lacked documentation of any post-fall interventions. A nursing progress note, dated 3/4/2025 at 6:21 p.m., indicated, "Resident was trying to transfer himself and fell. Sitting on his buttocks. Triage and DON		**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 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:** a All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure that admission assessments and quarterly Level of Care assessments are completed by a licensed nurse reviewed and signed by the resident, in a timely manner. Employees found to be out of compliance with medication documentation will receive additional education and corrective action.	

	notified." The record lacked documentation of an evaluation or assessment post fall to ensure no residual issues or injuries arose. The record lacked documentation of any post-fall interventions. On 7/15/25 at 9:00 a.m. the ED provided a copy of current facility policy titled, "Fall Prevention and Management Policy," revised 2/2022. The policy indicated, " ...Upon a resident fall event, an immediate evaluation ... of the resident will be completed to determine any possible injury. The licensed nurse at the community shall be promptly notified and consulted as appropriate. Any injuries noted shall be communicated to the community licensed nurse for consideration of further direction. Any post fall interventions determined shall be implemented and documented in the medical record, if applicable ... The resident's primary care provider shell be notified of any fall event. Any communication with the primary care provider along with any orders received shall be documented in the resident's medical record ...." Based on interviews and record reviews, the facility failed to		**3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a DON and/or designee will ensure that admission assessments and quarterly Level of Care assessments are completed by a licensed nurse reviewed and signed by the resident, in a timely manner. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing/designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be** **monitored to ensure the**	

	ensure a resident who was admitted to the facility in December of 2024 had an admission and a semi-annual assessment in her medical record for 1 of 9 residents reviewed for admission and semiannual assessments (Resident K). Based on interviews and record reviews, the facility failed to ensure new assessments with changes of condition for a resident who required supervision while outside resulting in a fracture (Resident J) and for a resident post fall documentation (Resident L) for 2 of 9 residents reviewed for the potential for accidents. Findings include: 1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living resident whose diagnoses included, but were not limited to, insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's medical record, it was found that the Resident had no admission or semiannual assessment in the medical record. On 7/14/25 at 2:45 p.m. an		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed:** **9/1/25**	

admission or semiannual assessment for Resident K was requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included an admission or semiannual assessment for Resident K.

On 7/15/25 at 10:45 a.m. an admission or semiannual assessment for Resident K was requested from the ED for a second time.

On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K.

On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to admission or semiannual assessments. They only followed the state regulations.

At the time of exit on 7/16/25 at 12:30 p.m. an admission or semiannual assessment was not provided for Resident K.

2. On 7/14/25 at 11:35 a.m. Resident J indicated she had a fall about a month ago that resulted in her breaking her hip and a rehab stay for physical therapy. She indicated she just got back to the facility about a week ago. She could not remember anymore details of

this fall.

On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced amount of hemoglobin). Resident J was a Medicaid recipient with a major mental health diagnosis.

A current Level of Care (LOC) assessment, dated 4/22/25, under the section titled, "Mobility," indicated, " ...2. Can get around inside without assistance but needs assistance of another person outside. Endurance limited to immediate vicinity of facility. Requires constant presence of staff for safety outside ...."

A progress note, dated 5/5/25 at 11:59 a.m., indicated Resident J had an unwitnessed fall outside, was found by her daughter and taken to the local hospital.

A hospital record, dated 5/6/25, indicated Resident J was walking around some construction outside of the facility with her rollator (a rolling walker) and attempted to go

underneath the yellow construction tape but ended up falling on to her right side. The record indicated imaging done in the Emergency Room (ER) showed a right hip fracture.

3. On 7/14/25 at 1:30 p.m., Resident L's record was reviewed. He has a diagnosis of Alzheimer's dementia and resided on the secured memory care unit. He was at risk for falls and had a history of falls.

A nursing progress note, dated 2/18/25 at 8:33 p.m., indicated the resident was sitting in the tv room and took off his pants. He tried to get up by himself and fell on the right side. The resident hit his right forehead and had a little skin tear.

The record lacked documentation of physician/Licensed Nurse notification.

The record lacked documentation of first aide provided.

The record lacked documentation of fall follow up to ensure no residual issues or injuries arose.

The record lacked documentation of any post-fall interventions.

A nursing progress note, dated 3/4/2025 at 6:21 p.m., indicated,

	"Resident was trying to transfer himself and fell. Sitting on his buttocks. Triage and DON notified." The record lacked documentation of an evaluation or assessment post fall to ensure no residual issues or injuries arose. The record lacked documentation of any post-fall interventions.			

	On 7/15/25 at 9:00 a.m. the ED provided a copy of current facility policy titled, "Fall Prevention and Management Policy," revised 2/2022. The policy indicated, " ...Upon a resident fall event, an immediate evaluation ... of the resident will be completed to determine any possible injury. The licensed nurse at the community shall be promptly notified and consulted as appropriate. Any injuries noted shall be communicated to the community licensed nurse for consideration of further direction. Any post fall interventions determined shall be implemented and documented in the medical record, if applicable ... The resident's primary care provider shell be notified of any fall event. Any communication with the primary care provider along with any orders received shall be documented in the resident's medical record ...." Based on interviews and record reviews, the facility failed to ensure a resident who was admitted to the facility in December of 2024 had an admission and a semi-annual assessment in her medical record for 1 of 9 residents reviewed for admission and semiannual assessments (Resident K). Based on interviews and record reviews, the facility failed to ensure new assessments with changes of			

condition for a resident who required supervision while outside resulting in a fracture (Resident J) and for a resident post fall documentation (Resident L) for 2 of 9 residents reviewed for the potential for accidents.

Findings include:

1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living resident whose diagnoses included, but were not limited to, insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's medical record, it was found that the Resident had no admission or semiannual assessment in the medical record.

On 7/14/25 at 2:45 p.m. an admission or semiannual assessment for Resident K was requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included an admission or semiannual assessment for Resident K.

On 7/15/25 at 10:45 a.m. an

admission or semiannual assessment for Resident K was requested from the ED for a second time.

On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K.

On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to admission or semiannual assessments. They only followed the state regulations.

At the time of exit on 7/16/25 at 12:30 p.m. an admission or semiannual assessment was not provided for Resident K.

2. On 7/14/25 at 11:35 a.m. Resident J indicated she had a fall about a month ago that resulted in her breaking her hip and a rehab stay for physical therapy. She indicated she just got back to the facility about a week ago. She could not remember anymore details of this fall.

On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of

	red blood cells or a reduced amount of hemoglobin). Resident J was a Medicaid recipient with a major mental health diagnosis. A current Level of Care (LOC) assessment, dated 4/22/25, under the section titled, "Mobility," indicated, " ...2. Can get around inside without assistance but needs assistance of another person outside. Endurance limited to immediate vicinity of facility. Requires constant presence of staff for safety outside ...." A progress note, dated 5/5/25 at 11:59 a.m., indicated Resident J had an unwitnessed fall outside, was found by her daughter and taken to the local hospital. A hospital record, dated 5/6/25, indicated Resident J was walking around some construction outside of the facility with her rollator (a rolling walker) and attempted to go underneath the yellow construction tape but ended up falling on to her right side. The record indicated imaging done in the Emergency Room (ER) showed a right hip fracture. 3. On 7/14/25 at 1:30 p.m., Resident L's record was reviewed. He has a diagnosis of Alzheimer's dementia and resided on the secured memory care unit. He was at risk for falls			

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	the facility failed to ensure new assessments with changes of condition for a resident who required supervision while outside resulting in a fracture (Resident J) and for a resident post fall documentation (Resident L) for 2 of 9 residents reviewed for the potential for accidents. Findings include: 1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living resident whose diagnoses included, but were not limited to, insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's medical record, it was found that the Resident had no admission or semiannual assessment in the medical record. On 7/14/25 at 2:45 p.m. an admission or semiannual assessment for Resident K was requested from the Executive Director (ED).			

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showed a right hip fracture.

3. On 7/14/25 at 1:30 p.m., Resident L's record was reviewed. He has a diagnosis of Alzheimer's dementia and resided on the secured memory care unit. He was at risk for falls and had a history of falls.

A nursing progress note, dated 2/18/25 at 8:33 p.m., indicated the resident was sitting in the tv room and took off his pants. He tried to get up by himself and fell on the right side. The resident hit his right forehead and had a little skin tear.

The record lacked documentation of physician/Licensed Nurse notification.

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A nursing progress note, dated 3/4/2025 at 6:21 p.m., indicated, "Resident was trying to transfer himself and fell. Sitting on his buttocks. Triage and DON notified."

	The record lacked documentation of an evaluation or assessment post fall to ensure no residual issues or injuries arose. The record lacked documentation of any post-fall interventions. On 7/15/25 at 9:00 a.m. the ED provided a copy of current facility policy titled, "Fall Prevention and Management Policy," revised 2/2022. The policy indicated, " ...Upon a resident fall event, an immediate evaluation ... of the resident will be completed to determine any possible injury. The licensed nurse at the community shall be promptly notified and consulted as appropriate. Any injuries noted shall be communicated to the community licensed nurse for consideration of further direction. Any post fall interventions determined shall be implemented and documented in the medical record, if applicable ... The resident's primary care provider shell be notified of any fall event. Any communication with the primary care provider along with any orders received shall be documented in the resident's medical record ...." Based on interviews and record reviews, the facility failed to ensure a resident who was admitted to the facility in			

	December of 2024 had an admission and a semi-annual assessment in her medical record for 1 of 9 residents reviewed for admission and semiannual assessments (Resident K). Based on interviews and record reviews, the facility failed to ensure new assessments with changes of condition for a resident who required supervision while outside resulting in a fracture (Resident J) and for a resident post fall documentation (Resident L) for 2 of 9 residents reviewed for the potential for accidents. Findings include: 1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living resident whose diagnoses included, but were not limited to, insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's medical record, it was found that the Resident had no admission or semiannual assessment in the medical record. On 7/14/25 at 2:45 p.m. an admission or semiannual assessment for Resident K was			

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	falling on to her right side. The record indicated imaging done in the Emergency Room (ER) showed a right hip fracture.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.	R 0216	R216 **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 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:** a All residents that self-administer their medications had the potential to be affected by the alleged deficient practice. DON and/or designee will audit	09/01/2025

	Based on interviews and record reviews, the facility failed to ensure a resident (Resident K) who managed her own medications had a medication self-administration assessment in her medical record for 1 of 3 residents reviewed for medication self-administration assessments. Findings include: On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's medical record, it was found that the resident had no medication self-administration assessment in the medical record. On 7/14/25 at 2:45 p.m. a medication self-administration assessment for Resident K was requested from the Executive Director (ED).		all residents who are independent with their medications to ensure a self-medication assessment is scheduled every 6 months and completed in a timely manner. Employees found to be out of compliance with completing scheduled assessments will receive additional education and corrective action. **3** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a DON and/or designee will audit all residents who are independent with their medications to ensure a self-medication assessment is scheduled every 6 months and completed in a timely manner. The Director of Nursing/designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific	

	On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a medication self-administration assessment for Resident K. On 7/15/25 at 10:45 a.m. a medication self-administration assessment for Resident K was requested from the ED for a second time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to medication self-administration assessments. They only followed the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. a medication self-administration assessment was not provided for Resident K. Based on interviews and record reviews, the facility failed to ensure a resident (Resident K) who managed her own medications had a medication self-administration assessment in her medical record for 1 of 3 residents reviewed for medication self-administration assessments. Findings include:		orientation moving forward. **4 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:** a This process will be reviewed by DON/designee on each independent resident, then upon each new admission and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed: 9/1/25**	

	On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's medical record, it was found that the resident had no medication self-administration assessment in the medical record. On 7/14/25 at 2:45 p.m. a medication self-administration assessment for Resident K was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a medication self-administration assessment for Resident K. On 7/15/25 at 10:45 a.m. a medication self-administration assessment for Resident K was requested from the ED for a second time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K. On 7/16/25 at 12:00 p.m. the			

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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 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.	R 0217	R217 **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 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:**	09/01/2025

	(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. Based on record reviews and interview, the facility failed to have service plans signed by the resident and/or resident representative for 4 of 5 residents reviewed (Residents B, D, E, F). Findings include: 1.On 7/15/25 at 8:20 a.m., a record review was completed for Resident B. She had the following diagnoses which included but were not limited to hypothyroidism (abnormally low activity of the thyroid gland, resulting in slowing of growth and mental development in children and metabolic changes in adults), hyperlipidemia (high cholesterol), and diarrhea. Her service plan was reviewed.		a All residents had the potential to be affected by the alleged deficient practice. DON and/or designee will ensure the resident service plans are reviewed and signed by the resident, in a timely manner. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a DON and/or designee will ensure the resident service plans are reviewed and signed by the resident, in a timely manner. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of	

	It was dated 2/19/25 and signed only by a Registered Nurse (RN). 2. On 7/15/25 at 9:00 a.m., a record review was completed for Resident D. She had the following diagnoses which included but were not limited to dementia, hypothyoidism, hyperlipidemia, and major depression. Her service plan was reviewed. It was dated 5/14/25 and signed only by a RN. 3. On 7/15/25 at 8:40 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, anemia, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease. Her service was reviewed. It was dated 5/7/25 and signed only by a RN. 4. On 7/15/25 at 9:05 a.m., a record review was completed for Resident E. She had the following diagnoses which included but were not limited to hyperlipidemia, chronic kidney disease, and hypertension. Her service plan was reviewed. It was dated 4/23/25 and signed only by a RN.		Nursing/designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 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:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.	

	During an interview on 7/16/25 at 10:30 a.m., the Executive Director provided the current policy and indicated it was the current policy. A policy titlted, "Service Plans," was provided by the on 7/16/25 at 10:30 a.m. It indicated, " ...Each resident will have a written plan of care that is developed on initial evaluation/assessment, semiannaul assessments, and with any changes in the resident needs. This plan will be available for staff to review to assist in the daily care/services provided to the resident ...." This citation relates to Complaints IN00459210 and IN00461395. Based on record reviews and interview, the facility failed to have service plans signed by the resident and/or resident representative for 4 of 5 residents reviewed (Residents B, D, E, F). Findings include: 1.On 7/15/25 at 8:20 a.m., a record review was completed for Resident B. She had the following diagnoses which included but were not limited to hypothyroidism (abnormally low activity of the thyroid gland, resulting in slowing of growth and mental development in children and metabolic changes in adults), hyperlipidemia (high		**5** **By** **what date the systemic changes will be completed:** **9/1/25**	

cholesterol), and diarrhea.

Her service plan was reviewed. It was dated 2/19/25 and signed only by a Registered Nurse (RN).

2. On 7/15/25 at 9:00 a.m., a record review was completed for Resident D. She had the following diagnoses which included but were not limited to dementia, hypothyoidism, hyperlipidemia, and major depression.

Her service plan was reviewed. It was dated 5/14/25 and signed only by a RN.

3. On 7/15/25 at 8:40 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, anemia, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease.

Her service was reviewed. It was dated 5/7/25 and signed only by a RN.

4. On 7/15/25 at 9:05 a.m., a record review was completed for Resident E. She had the following diagnoses which included but were not limited to hyperlipidemia, chronic kidney disease, and hypertension.

Her service plan was reviewed.

	It was dated 4/23/25 and signed only by a RN. During an interview on 7/16/25 at 10:30 a.m., the Executive Director provided the current policy and indicated it was the current policy. A policy titlted, "Service Plans," was provided by the on 7/16/25 at 10:30 a.m. It indicated, " ...Each resident will have a written plan of care that is developed on initial evaluation/assessment, semiannaul assessments, and with any changes in the resident needs. This plan will be available for staff to review to assist in the daily care/services provided to the resident ...." This citation relates to Complaints IN00459210 and IN00461395.			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled	R 0274	**R274** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2**	09/01/2025

	in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview and record review, the facility failed to ensure the Dietary Manager (DM) had knowledge and understanding of the		**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:** a No residents had the potential to be affected by the alleged deficient practice. Dietary Manager and/or designee will ensure staff have adequate knowledge and understanding of sanitization requirements for dish washing machines. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a Dietary Manager and/or designee will ensure staff have adequate knowledge and understanding of sanitization	

	sanitization requirements for the dish washing machine. This deficiency had the potential to affect 61 of 61 residents residing at the facility. Findings include: On 7/14/25 at 9:50 a.m., a general kitchen tour was conducted with the DM. When the dish washing machine was observed, the instruction label was badly faded and illegible. It was unable to be determined if the machine utilized a high temperature sanitization and/or chemical sanitization. The DM indicated, at first, the machine utilized chemical sanitization and pointed to the attached chemical bottles. When asked if the DM would check the parts per million (PPM) for chemical verification, they indicated they had never done that for the dish machine. The DM provided a copy of the dish washer log and indicated they only recorded temperatures (temp), so the dish washer must be a high temp sanitization machine. The DM indicated she would contact the retail provider for more information and guidance. A was cycle was observed. There was a sticker label on the was cycle temperature gauge that indicated 180 degrees		requirements for dish washing machines. **4 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:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.	

	Fahrenheit (F). The was cycle only reached 145 degrees F and the final rinse only reached 168 degrees F. The dish machine log for July was reviewed and revealed the dish machine failed to reach 180 degrees F for the final rinse on the following days: 7/1/25 was 174 F 7/2/25 was 170 F. 7/8/25 was 160 F. 7/9/25 was 170 F. 7/10/25 was 160 F. 7/11/25 was 176 F. 7/12/25 was 178 F. 7/13/25 was 170 F. During an interview on 7/16/25 at 12:20 p.m., the DM indicated the dish machine retail provider came out to check the dish machine and confirmed for her that the machine had dual modes and could sanitize either with high temperature or chemicals. The machine was currently set in high temperature mode and required was cycles to reach 150 F and final rinse cycle to reach 180 F. On 7/14/25 at 11:50 a.m., the DM provided a copy of current, but undated, facility policy titled,		**5** **By** **what date the systemic changes will be completed:** **9/1/25**	

	"Mechanical Cleaning and Sanitize Policy and Procedure." The policy indicated, " ...High temperature sanitization will be at 180 degrees F or higher." This citation relates to Complaint IN00459009. Based on observation, interview and record review, the facility failed to ensure the Dietary Manager (DM) had knowledge and understanding of the sanitization requirements for the dish washing machine. This deficiency had the potential to affect 61 of 61 residents residing at the facility. Findings include: On 7/14/25 at 9:50 a.m., a general kitchen tour was conducted with the DM. When the dish washing machine was observed, the instruction label was badly faded and illegible. It was unable to be determined if the machine utilized a high temperature sanitization and/or chemical sanitization. The DM indicated, at first, the machine utilized chemical sanitization and pointed to the attached chemical bottles. When asked if the DM would check the parts per million (PPM) for chemical verification, they indicated they had never done that for the dish machine.			

	The DM provided a copy of the dish washer log and indicated they only recorded temperatures (temp), so the dish washer must be a high temp sanitization machine. The DM indicated she would contact the retail provider for more information and guidance. A was cycle was observed. There was a sticker label on the was cycle temperature gauge that indicated 180 degrees Fahrenheit (F). The was cycle only reached 145 degrees F and the final rinse only reached 168 degrees F. The dish machine log for July was reviewed and revealed the dish machine failed to reach 180 degrees F for the final rinse on the following days: 7/1/25 was 174 F 7/2/25 was 170 F. 7/8/25 was 160 F. 7/9/25 was 170 F. 7/10/25 was 160 F. 7/11/25 was 176 F. 7/12/25 was 178 F. 7/13/25 was 170 F. During an interview on 7/16/25 at 12:20 p.m., the DM indicated the dish machine retail provider			

	came out to check the dish machine and confirmed for her that the machine had dual modes and could sanitize either with high temperature or chemicals. The machine was currently set in high temperature mode and required was cycles to reach 150 F and final rinse cycle to reach 180 F. On 7/14/25 at 11:50 a.m., the DM provided a copy of current, but undated, facility policy titled, "Mechanical Cleaning and Sanitize Policy and Procedure." The policy indicated, " ...High temperature sanitization will be at 180 degrees F or higher." This citation relates to Complaint IN00459009.			
R 0275	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(h) (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interviews and record reviews, the facility failed to ensure all residents had a diet order in their medical record. This deficient practice had the potential to affect 2 of 9 Residents (Resident J and Resident K) reviewed for appropriate diet orders.	R 0275	R275 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a **2 How the facility will identify other residents having the potential**	09/01/2025

	Findings include: 1. On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced amount of hemoglobin). Upon review of Resident J's physician orders, it was found that the Resident had no orders in the medical record. On 7/14/25 at 2:45 p.m. a list of Resident J's current physician orders was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a list of current physician orders for Resident J. On 7/15/25 at 10:45 a.m. a list of current physician orders for Resident J was requested from the ED for a second time. On 7/15/25 at 11:15 a.m. the interim Director of Nursing (DON) provided a list of current physician orders for Resident J. This list did not include a diet order. The diet order was		**to be affected by the same deficient practice** **and what corrective will be taken** a All residents had the potential to be affected by the alleged deficient practice. The DON or designee will ensure all residents have a diet order upon admission. **3 What measures will be put into place** **or what systemic changes the facility will make to ensure that the deficient** **practice does not recur:** a The DON or designee will ensure all residents residing in the facility have a proper diet order. **4 How the corrective action(s) will be** **monitored to ensure the deficient practice will not recur, i.e what quality**	

	requested from the interim DON for a third time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident J. 2. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's physician orders, it was found that the Resident had no orders in the medical record. On 7/14/25 at 2:45 p.m. a list of Resident K's current physician orders was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a list of current physician orders for Resident K. On 7/15/25 at 11:00 a.m. a list of current physician orders for Resident K was requested from the ED and the interim DON for a second time. On 7/15/25 at 11:15 a.m. the		**assurance program will be put into place:** a The DON, Executive Director/designee will audit all new admission to ensure a diet order is in place for each resident (2) times a week for two (2) weeks, and then weekly for three (3) weeks, then as needed to ensure that the proper procedure is properly executed. **5 By what date will the systematic changes be completed:** a 09/01/25	

	interim Director of Nursing (DON) provided a list of current physician orders for Resident K. This list did not include a diet order. The diet order was requested from the interim DON for a third time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to appropriate diet orders in Residents medical records, they only follow the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. a diet order was not provided for Resident J or Resident K. Based on interviews and record reviews, the facility failed to ensure all residents had a diet order in their medical record. This deficient practice had the potential to affect 2 of 9 Residents (Resident J and Resident K) reviewed for appropriate diet orders. Findings include: 1. On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed.			

	She was an assisted living Resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced amount of hemoglobin). Upon review of Resident J's physician orders, it was found that the Resident had no orders in the medical record. On 7/14/25 at 2:45 p.m. a list of Resident J's current physician orders was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a list of current physician orders for Resident J. On 7/15/25 at 10:45 a.m. a list of current physician orders for Resident J was requested from the ED for a second time. On 7/15/25 at 11:15 a.m. the interim Director of Nursing (DON) provided a list of current physician orders for Resident J. This list did not include a diet order. The diet order was requested from the interim DON for a third time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide			

for Resident J.

2. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's physician orders, it was found that the Resident had no orders in the medical record.

On 7/14/25 at 2:45 p.m. a list of Resident K's current physician orders was requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a list of current physician orders for Resident K.

On 7/15/25 at 11:00 a.m. a list of current physician orders for Resident K was requested from the ED and the interim DON for a second time.

On 7/15/25 at 11:15 a.m. the interim Director of Nursing (DON) provided a list of current physician orders for Resident K. This list did not include a diet order. The diet order was requested from the interim DON

	for a third time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to appropriate diet orders in Residents medical records, they only follow the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. a diet order was not provided for Resident J or Resident K.			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observations and interviews, the facility failed to ensure all residents who self-administer their own medications had those medications in a locked and secure place in their apartment. This deficient practice had the potential to affect 2 of 2 residents (Resident J and	R 0295	R295 1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. No residents experienced adverse effects from the alleged deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken	09/01/2025

	Resident K) reviewed for proper medication storage. Findings include: 1. On 7/14/25 at 11:00 a.m. Resident K was observed as she sat in her recliner. There was an unknown number of pill organizers observed on top of the Residents refrigerator. On 7/14/25 at 11:05 a.m. Resident K indicated she manages her own medications, and she stores them in pill organizers on top of her refrigerator. She indicated she knew she was supposed to store her medications in the locked cabinet, but it was easier for her to store them on top of her refrigerator. 2. On 7/14/25 at 11:30 a.m. Resident J was observed as she sat on her couch. The apartment was cluttered but clean and no foul odors were present. On 7/14/25 at 11:35 a.m. Resident J indicated she stored her medications in her walk-in closet in her room. She indicated she was unaware she had a locked cabinet in her apartment, and she was unaware she was supposed to store them there. On 7/16/25 at 12:00 p.m. the Executive Director (ED) indicated they did not have a		a. All residents that self-administer medications had the potential to be affected by the alleged deficient practice. The DON or designee will ensure all residents that self-administer medications, that include narcotics, are safely locked and stored. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: a. The DON/designee will ensure all residents that self-administer medications, that include narcotics, are educated about ensuring medications are safely locked and stored. 4. 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: a. The DON, Executive Director or designee will audit all residents that self-administer medications, that include narcotics, to ensure medications are properly locked and stored (2) times a week for two (2) weeks, and then weekly for three (3) weeks, then as needed to ensure that the proper procedure is properly executed. 5. By what date will the systematic changes be completed:	

	policy that spoke to how and where residents who self-administer their own medications should be storing their medications, they only follow the state regulations. Based on observations and interviews, the facility failed to ensure all residents who self-administer their own medications had those medications in a locked and secure place in their apartment. This deficient practice had the potential to affect 2 of 2 residents (Resident J and Resident K) reviewed for proper medication storage. Findings include: 1. On 7/14/25 at 11:00 a.m. Resident K was observed as she sat in her recliner. There was an unknown number of pill organizers observed on top of the Residents refrigerator. On 7/14/25 at 11:05 a.m. Resident K indicated she manages her own medications, and she stores them in pill organizers on top of her refrigerator. She indicated she knew she was supposed to store her medications in the locked cabinet, but it was easier for her to store them on top of her refrigerator. 2. On 7/14/25 at 11:30 a.m. Resident J was observed as she sat on her couch. The		a. 09/01/25 INFORMAL DISPUTE RESOLUTION FOR R295 -Residents whom self-administer medications are not required to lock up their medications. Residents are only required to do so if their medications include controlled substances. Neither resident, in the afore named citation, have any controlled substances on their medication profile	

	apartment was cluttered but clean and no foul odors were present. On 7/14/25 at 11:35 a.m. Resident J indicated she stored her medications in her walk-in closet in her room. She indicated she was unaware she had a locked cabinet in her apartment, and she was unaware she was supposed to store them there. On 7/16/25 at 12:00 p.m. the Executive Director (ED) indicated they did not have a policy that spoke to how and where residents who self-administer their own medications should be storing their medications, they only follow the state regulations.			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to ensure policies and procedures were in place provide ongoing competencies for medication staff. This deficient practice had the potential to effect 61 of 61	R 0296	R296 **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 How**	09/01/2025

	residents who received nursing services from qualified medication aides (QMA). Findings include: On 7/14/25 a random QMA employee record was reviewed and their annual QMA In-Service record was requested. QMA 12's employee file was reviewed. She was hired on 4/20/25. Her record lacked documentation of an annual QMA-specific In-Service record. During an interview on 7/16/25 at 10:45 a.m. the ED indicated she spoke to her corporate supervisors who indicated it was the QMAs responsibility to obtain and maintain their own annual in-services forms. The ED indicated she would double check if there was a policy to address the facility's responsibilities regarding medication aides. No policy or procedure for ongoing training to ensure competence of medication staff was provided before the time of exit. On 7/16/25 at 12:00 p.m., the ED indicated the facility did not have a policy to address QMA Annual In-Service requirements. Based on record review and interview, the facility failed to		**the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** a No residents had the potential to be affected by the alleged deficient practice. ED and/or Designee will ensure policies and procedures are in place to provide ongoing competencies for medication staff. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a ED and/or Designee will ensure policies and procedures are in place to provide ongoing competencies for medication staff	

	ensure policies and procedures were in place provide ongoing competencies for medication staff. This deficient practice had the potential to effect 61 of 61 residents who received nursing services from qualified medication aides (QMA). Findings include: On 7/14/25 a random QMA employee record was reviewed and their annual QMA In-Service record was requested. QMA 12's employee file was reviewed. She was hired on 4/20/25. Her record lacked documentation of an annual QMA-specific In-Service record. During an interview on 7/16/25 at 10:45 a.m. the ED indicated she spoke to her corporate supervisors who indicated it was the QMAs responsibility to obtain and maintain their own annual in-services forms. The ED indicated she would double check if there was a policy to address the facility's responsibilities regarding medication aides. No policy or procedure for ongoing training to ensure competence of medication staff was provided before the time of exit. On 7/16/25 at 12:00 p.m., the ED indicated the facility did not		b **4 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:** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.	

	have a policy to address QMA Annual In-Service requirements.		**5** **By** **what date the systemic changes will be completed: 9/1/25**	
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and	R 0298	R298 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken**	09/01/2025

	(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation and interview, the facility failed to date medications and remove expired medications from the medication supply for 1 of 1 medication cart reviewed (Memory Care). Findings include: On 7/15/25 at 7:20 a.m., the Memory Care medication cart was observed. The following items were identified in the cart: a.) Resident N had a bottle polyvinyl 1.4% eye drops and ciprofloxacin eye drops 0.3% in the medication cart with no date to indicate when they were opened. b.) Resident C had a bottle of latanoprost 0.005% eye drops in the medication cart. They had a date opened of 5/18/25. c.) Resident O had a bottle of latanoprost 0.005% eye drops in the medication cart. They had a date opened of 5/18/25. d.) Resident D had two bottle of latanoprost 0.005% eye drops in the medication cart. The bottles lacked a date to indicate when they were opened. She had a bottle of melatonin (a sleep aid) in the medication cart with no		a All residents that receive medications had the potential to be affected by the alleged deficient practice. The DON/designee will ensure all medications are dated and remove any expired medications immediately. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a The DON/designee will ensure all medications are dated and remove any expired medications immediately. **4 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:**	

	label on it. e.) Resident P had two bottles of dorzalamide-tim eye drops in the medication cart. The bottles lacked a date to indicate when they were opened. f.) Resident Q had a humalog insulin pen and a novolog insulin pen with no date on them to indicate when they were opened. On 7/15/25 at 7:30 a.m., Qualified Medication Assistant (QMA) 7 indicated she was unsure of how long the latanoprost eye drops were good for once opened and she would check with the Interim Director of Nursing. On 7/16/25 at 12:03 p.m., the Executive Director (ED) provided a policy titled, "Medication Management, Administration, and Storage (Indiana and Ohio only)." It indicated, " ...The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines. The community will have available, on the premises or on call, the services of a licensed nurse at all times ...." Based on observation and interview, the facility failed to date medications and remove		a The DON, Executive Director/designee will audit medication carts (2) times a week for two (2) weeks, and then weekly for three (3) weeks, then as needed to ensure that the proper procedure is properly executed. **5 By what date will the systematic changes be completed** a 09/01/25	

	expired medications from the medication supply for 1 of 1 medication cart reviewed (Memory Care). Findings include: On 7/15/25 at 7:20 a.m., the Memory Care medication cart was observed. The following items were identified in the cart: a.) Resident N had a bottle polyvinyl 1.4% eye drops and ciprofloxacin eye drops 0.3% in the medication cart with no date to indicate when they were opened. b.) Resident C had a bottle of latanoprost 0.005% eye drops in the medication cart. They had a date opened of 5/18/25. c.) Resident O had a bottle of latanoprost 0.005% eye drops in the medication cart. They had a date opened of 5/18/25. d.) Resident D had two bottle of latanoprost 0.005% eye drops in the medication cart. The bottles lacked a date to indicate when they were opened. She had a bottle of melatonin (a sleep aid) in the medication cart with no label on it. e.) Resident P had two bottles of dorzalamide-tim eye drops in the medication cart. The bottles lacked a date to indicate when they were opened.			

	f.) Resident Q had a humalog insulin pen and a novolog insulin pen with no date on them to indicate when they were opened. On 7/15/25 at 7:30 a.m., Qualified Medication Assistant (QMA) 7 indicated she was unsure of how long the latanoprost eye drops were good for once opened and she would check with the Interim Director of Nursing. On 7/16/25 at 12:03 p.m., the Executive Director (ED) provided a policy titled, "Medication Management, Administration, and Storage (Indiana and Ohio only)." It indicated, " ...The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines. The community will have available, on the premises or on call, the services of a licensed nurse at all times ...."			
R 0378	Mental Health Screening-Deficiency 410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation	R 0378	R378 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/01/2025

	provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on interviews and record reviews, the facility failed to ensure a Resident (Resident J) who was a Medicaid recipient with a major mental health		**practice:** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a All residents that have a major mental health diagnosis had the potential to be affected by the alleged deficient practice. The DON/designee will ensure all residents, upon admission, and every 6 months, are given the SLUMS assessment. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	

	diagnosis had a mental health screen in her medical record. This deficient practice had the potential to affect 1 of 9 residents reviewed for mental health screenings. Findings include: On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced amount of hemoglobin). Resident J was a Medicaid recipient with a major mental health diagnosis. Upon review of Resident J's medical record, it was found that the resident had no mental health screen in the medical record. On 7/14/25 at 2:45 p.m. a mental health screen for Resident J was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a mental health screen for Resident J. On 7/15/25 at 10:45 a.m. a mental health screen for		a The DON or designee will ensure all residents, upon admission, and every 6 months, are given the SLUMS assessment. **4 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:** a The DON, Executive Director or designee will audit all admissions to ensure a SLUMS assessment has been completed upon admission, and every 6 months thereafter, then as needed to ensure that the proper procedure is properly executed. **5 By what date will the systematic changes be completed**	

	Resident J was requested from the ED for a second time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident J. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to annual health statements, they only follow the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. an appropriate annual health statement was not provided for Resident J. Based on interviews and record reviews, the facility failed to ensure a Resident (Resident J) who was a Medicaid recipient with a major mental health diagnosis had a mental health screen in her medical record. This deficient practice had the potential to affect 1 of 9 residents reviewed for mental health screenings. Findings include: On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced		a 09/01/25	

	amount of hemoglobin). Resident J was a Medicaid recipient with a major mental health diagnosis. Upon review of Resident J's medical record, it was found that the resident had no mental health screen in the medical record. On 7/14/25 at 2:45 p.m. a mental health screen for Resident J was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included a mental health screen for Resident J. On 7/15/25 at 10:45 a.m. a mental health screen for Resident J was requested from the ED for a second time. On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident J. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to annual health statements, they only follow the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. an appropriate annual health statement was not provided for Resident J.			

R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure there was an appropriate infection control program in place. This deficient practice had the potential to affect 61 of 61 residents who resided in the facility. Findings include: During an interview on 7/16/25 at 11:50 a.m. the interim Director of Nursing (DON) indicated she was talking with her regional support team to see if they have anything in regard to the infection control program. She indicated she had only	R 0407	R407 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** a **2 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:** a All residents requiring an infection control program to analyze and track infections within the community, had the potential to be affected by the alleged deficient practice. ED/designee will provide re-education to the DON and/or ADON on procedures of proper infection control tracking. Employees found to be out of compliance	09/01/2025

	been in the role for approximately two weeks, and the DON before her was only in the role for two weeks as well so she was unsure what they had for their infection control program. During an interview on 7/16/25 at 12:15 p.m. the interim DON provided a list of Residents who had been prescribed antibiotics in the previous four months and the infection prevention and control policy. She indicated that was all they had for their infection control program. On 7/16/25 at 12:15 p.m. the DON provided a copy of a current facility policy titled, "Infection Prevention &Control", dated 1/2025. This policy spoke to various types of precautions and isolation but did not speak to the facility's infection control program itself. This citation relates to Complaint IN00459210. Based on interview and record review, the facility failed to ensure there was an appropriate infection control program in place. This deficient practice had the potential to affect 61 of 61 residents who resided in the facility. Findings include: During an interview on 7/16/25 at 11:50 a.m. the interim		with proper infection control tracking will receive additional education and possible corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a DON and/or ADON will be educated and in-serviced on the infection control policy and proper procedure to track infection control, no later than **9/1/25.** Any clinical staff member out of compliance with facility's policies and protocols relating to infection control will receive progressive corrective action. The Director of Nursing/designee will educate all newly hired clinical staff on policies and protocols relating to infection control tracking during employee job-specific orientation moving forward.	

	Director of Nursing (DON) indicated she was talking with her regional support team to see if they have anything in regard to the infection control program. She indicated she had only been in the role for approximately two weeks, and the DON before her was only in the role for two weeks as well so she was unsure what they had for their infection control program. During an interview on 7/16/25 at 12:15 p.m. the interim DON provided a list of Residents who had been prescribed antibiotics in the previous four months and the infection prevention and control policy. She indicated that was all they had for their infection control program. On 7/16/25 at 12:15 p.m. the DON provided a copy of a current facility policy titled, "Infection Prevention &Control", dated 1/2025. This policy spoke to various types of precautions and isolation but did not speak to the facility's infection control program itself. This citation relates to Complaint IN00459210.		**4 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:** a The Director of Nursing or designee will audit the infection control binder weekly, for 6 weeks and then monthly thereafter, to ensure that proper infection control tracking is being executed. Results to be reviewed at monthly QI meetings for 6 months and make further recommendations based on audit results. **5 By what date will the systematic changes be completed: 9/1/25**	
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a	R 0409	R409 **1 What Corrective action(s)**	09/01/2025

	health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interviews and record reviews, the facility failed to ensure all residents had an appropriate annual health screen in their medical record. This deficient practice had the potential to affect 2 of 9 Residents (Resident J and Resident K) reviewed for appropriate annual health statements. Findings include: 1. On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced amount of hemoglobin). Upon review of Resident J's medical record, it was found that the Resident had no annual health statement in the medical record. On 7/14/25 at 2:45 p.m. an annual health statement for		**will be accomplished for those residents found to have been affected by the deficient practice** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a All residents had the potential to be affected by the alleged deficient practice. The DON or designee will ensure all residents, upon admission, and yearly thereafter, have a health screen in their medical record. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	

	Resident J was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. a document that had Resident J's name and "Annual Health Statement" at the top, was provided by the ED. This document indicated, " ... I certify the above resident is appropriate to reside in an assisted living community in their own private apartment ..." and was signed and dated 4/16/24 by the resident's physician. This document did not meet the requirements for an annual health statement as it did not indicated the Resident is free from communicable diseases and Tuberculosis in the infectious state. 2. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to Insomnia and Cognitive Communication Deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function). Upon review of Resident K's medical record, it was found that the Resident had no annual health statement in the medical record.		a The DON or designee will ensure all residents, upon admission, and yearly thereafter, have a health screen in their medical record. **4 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:** a The DON, Executive Director or designee will audit all admissions to ensure a health screen has been completed upon admission, which is included in the physician orders, and yearly thereafter, **5 By what date will the systematic changes be completed**	

	On 7/14/25 at 2:45 p.m. an annual health statement for Resident K was requested from the Executive Director (ED). On 7/15/25 at 9:00 a.m. a document that had Resident K's name and "Annual Health Statement" at the top, was provided by the ED. This document indicated, " ... I certify the above resident is appropriate to reside in an assisted living community in their own private apartment ..." and was signed and dated 4/16/24 by the Residents physician. This document did not meet the requirements for an annual health statement as it did not indicate the Resident is free from communicable diseases and Tuberculosis in the infectious state. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to annual health statements, they only follow the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. an appropriate annual health statement was not provided for Resident J or Resident K. Based on interviews and record reviews, the facility failed to ensure all residents had an appropriate annual health screen in their medical record.		a 09/01/25	

This deficient practice had the potential to affect 2 of 9 Residents (Resident J and Resident K) reviewed for appropriate annual health statements.

Findings include:

1. On 7/14/25 at 1:00 p.m. Resident J's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to major depressive disorder and anemia (a condition where the blood has a reduced ability to carry oxygen, typically due to a lower-than-normal number of red blood cells or a reduced amount of hemoglobin).

Upon review of Resident J's medical record, it was found that the Resident had no annual health statement in the medical record.

On 7/14/25 at 2:45 p.m. an annual health statement for Resident J was requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. a document that had Resident J's name and "Annual Health Statement" at the top, was provided by the ED. This document indicated, " ... I certify the above resident is appropriate to reside in an assisted living community in their own private apartment ..."

and was signed and dated 4/16/24 by the resident's physician.

This document did not meet the requirements for an annual health statement as it did not indicated the Resident is free from communicable diseases and Tuberculosis in the infectious state.

2. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to Insomnia and Cognitive Communication Deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's medical record, it was found that the Resident had no annual health statement in the medical record.

On 7/14/25 at 2:45 p.m. an annual health statement for Resident K was requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. a document that had Resident K's name and "Annual Health Statement" at the top, was provided by the ED. This document indicated, " ... I certify the above resident is appropriate to reside in an

	assisted living community in their own private apartment ..." and was signed and dated 4/16/24 by the Residents physician. This document did not meet the requirements for an annual health statement as it did not indicate the Resident is free from communicable diseases and Tuberculosis in the infectious state. On 7/16/25 at 12:00 p.m. the ED indicated they did not have a policy that spoke to annual health statements, they only follow the state regulations. At the time of exit on 7/16/25 at 12:30 p.m. an appropriate annual health statement was not provided for Resident J or Resident K.			
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	R 0410	R410 **1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	09/01/2025

	baseline tuberculin skin testing 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. 2. On 7/15/25 at 8:40 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, anemia, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease. Her record lacked documentation of an annual TB screen or testing. On 7/15/25 at 11:32 a.m., the Interim Director of Nursing (IDON) provided TB testing for Resident F. The last date TB testing was administered was on 2/12/23. 3. On 7/15/25 at 9:05 a.m., a record review was completed for Resident E. She had the following diagnoses which included but were not limited to hyperlipidemia, chronic kidney		a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a All residents had the potential to be affected by the alleged deficient practice. The DON or designee will ensure all residents, upon admission, receive a 2-step TB test and complete the yearly signs and symptoms checklist yearly thereafter. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a The DON or designee will ensure all residents, upon admission, receive a 2-step TB test and complete the yearly signs and symptoms checklist	

	disease, and hypertension. Her record lacked documentation of an annual TB screen or testing. On 7/15/25 at 11:32 a.m., the IDON provided TB testing for Resident E. The last date TB testing was administered on 3/23/21. A policy titled, "Tuberculosis Skin Testing and Follow Up (Residents and Employees) was provided by the Executive Director (ED) on 7/16/25 at 10:30 a.m. It indicated, " ...A signs and symptoms checklist will be completed upon admission and annually for residents ...." This citation relates to Complaint IN00459210. Based on interviews and record reviews, the facility failed to ensure a resident (Resident K, E and F) who was admitted to the facility in December of 2024 had a 1st and 2nd step Purified Protein Derivative (PPD) Test (a method used to detect latent or active tuberculosis (TB) infection) in their medical record. This deficient practice had the potential to affect 3 of 9 residents reviewed for PPD tests. Findings include: 1. On 7/14/25 at 1:00 p.m.		yearly thereafter. **4 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:** a The DON, Executive Director/designee will ensure all residents, upon admission, receive a 2-step TB test and complete the yearly signs and symptoms checklist yearly thereafter. **5 By what date will the systematic changes be completed** a 09/01/25	

Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's medical record, it was found that the Resident had no 1st or 2nd step PPD tests in the medical record.

On 7/14/25 at 2:45 p.m. 1st and 2nd step PPD tests for Resident K were requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included 1st or 2nd step PPD tests for Resident K.

On 7/15/25 at 10:45 a.m. 1st and 2nd step PPD tests for Resident K were requested from the ED for a second time.

On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K.

At the time of exit on 7/16/25 at 12:30 p.m. 1st and 2nd step PPD tests were not provided for Resident K.

2. On 7/15/25 at 8:40 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, anemia, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease.

Her record lacked documentation of an annual TB screen or testing.

On 7/15/25 at 11:32 a.m., the Interim Director of Nursing (IDON) provided TB testing for Resident F. The last date TB testing was administered was on 2/12/23.

3. On 7/15/25 at 9:05 a.m., a record review was completed for Resident E. She had the following diagnoses which included but were not limited to hyperlipidemia, chronic kidney disease, and hypertension.

Her record lacked documentation of an annual TB screen or testing.

On 7/15/25 at 11:32 a.m., the IDON provided TB testing for Resident E. The last date TB testing was administered on 3/23/21.

A policy titled, "Tuberculosis Skin Testing and Follow Up (Residents and Employees) was provided by the Executive

Director (ED) on 7/16/25 at 10:30 a.m. It indicated, " ...A signs and symptoms checklist will be completed upon admission and annually for residents ...."

This citation relates to Complaint IN00459210.

Based on interviews and record reviews, the facility failed to ensure a resident (Resident K, E and F) who was admitted to the facility in December of 2024 had a 1st and 2nd step Purified Protein Derivative (PPD) Test (a method used to detect latent or active tuberculosis (TB) infection) in their medical record. This deficient practice had the potential to affect 3 of 9 residents reviewed for PPD tests.

Findings include:

1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's medical record, it was found that the Resident had no 1st or 2nd step PPD tests in the medical

record.

On 7/14/25 at 2:45 p.m. 1st and 2nd step PPD tests for Resident K were requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included 1st or 2nd step PPD tests for Resident K.

On 7/15/25 at 10:45 a.m. 1st and 2nd step PPD tests for Resident K were requested from the ED for a second time.

On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K.

At the time of exit on 7/16/25 at 12:30 p.m. 1st and 2nd step PPD tests were not provided for Resident K.

2. On 7/15/25 at 8:40 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, anemia, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease.

Her record lacked documentation of an annual TB screen or testing.

On 7/15/25 at 11:32 a.m., the

Interim Director of Nursing (IDON) provided TB testing for Resident F. The last date TB testing was administered was on 2/12/23.

3. On 7/15/25 at 9:05 a.m., a record review was completed for Resident E. She had the following diagnoses which included but were not limited to hyperlipidemia, chronic kidney disease, and hypertension.

Her record lacked documentation of an annual TB screen or testing.

On 7/15/25 at 11:32 a.m., the IDON provided TB testing for Resident E. The last date TB testing was administered on 3/23/21.

A policy titled, "Tuberculosis Skin Testing and Follow Up (Residents and Employees) was provided by the Executive Director (ED) on 7/16/25 at 10:30 a.m. It indicated, " ...A signs and symptoms checklist will be completed upon admission and annually for residents ...."

This citation relates to Complaint IN00459210.

Based on interviews and record reviews, the facility failed to ensure a resident (Resident K, E and F) who was admitted to the facility in December of 2024 had a 1st and 2nd step Purified

Protein Derivative (PPD) Test (a method used to detect latent or active tuberculosis (TB) infection) in their medical record. This deficient practice had the potential to affect 3 of 9 residents reviewed for PPD tests.

Findings include:

1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's medical record, it was found that the Resident had no 1st or 2nd step PPD tests in the medical record.

On 7/14/25 at 2:45 p.m. 1st and 2nd step PPD tests for Resident K were requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included 1st or 2nd step PPD tests for Resident K.

On 7/15/25 at 10:45 a.m. 1st and 2nd step PPD tests for Resident K were requested from

the ED for a second time.

On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K.

At the time of exit on 7/16/25 at 12:30 p.m. 1st and 2nd step PPD tests were not provided for Resident K.

2. On 7/15/25 at 8:40 a.m., a record review was completed for Resident F. She had the following diagnoses which included but were not limited to type 2 diabetes mellitus, anemia, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease.

Her record lacked documentation of an annual TB screen or testing.

On 7/15/25 at 11:32 a.m., the Interim Director of Nursing (IDON) provided TB testing for Resident F. The last date TB testing was administered was on 2/12/23.

3. On 7/15/25 at 9:05 a.m., a record review was completed for Resident E. She had the following diagnoses which included but were not limited to hyperlipidemia, chronic kidney disease, and hypertension.

Her record lacked documentation of an annual TB

screen or testing.

On 7/15/25 at 11:32 a.m., the IDON provided TB testing for Resident E. The last date TB testing was administered on 3/23/21.

A policy titled, "Tuberculosis Skin Testing and Follow Up (Residents and Employees) was provided by the Executive Director (ED) on 7/16/25 at 10:30 a.m. It indicated, " ...A signs and symptoms checklist will be completed upon admission and annually for residents ...."

This citation relates to Complaint IN00459210.

Based on interviews and record reviews, the facility failed to ensure a resident (Resident K, E and F) who was admitted to the facility in December of 2024 had a 1st and 2nd step Purified Protein Derivative (PPD) Test (a method used to detect latent or active tuberculosis (TB) infection) in their medical record. This deficient practice had the potential to affect 3 of 9 residents reviewed for PPD tests.

Findings include:

1. On 7/14/25 at 1:00 p.m. Resident K's medical record was reviewed. She was an assisted living Resident whose diagnoses included but were not

limited to insomnia and cognitive communication deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive function).

Upon review of Resident K's medical record, it was found that the Resident had no 1st or 2nd step PPD tests in the medical record.

On 7/14/25 at 2:45 p.m. 1st and 2nd step PPD tests for Resident K were requested from the Executive Director (ED).

On 7/15/25 at 9:00 a.m. the ED provided various requested documents, none of which included 1st or 2nd step PPD tests for Resident K.

On 7/15/25 at 10:45 a.m. 1st and 2nd step PPD tests for Resident K were requested from the ED for a second time.

On 7/16/25 at 10:30 a.m. the ED indicated they did not have any more documents to provide for Resident K.

At the time of exit on 7/16/25 at 12:30 p.m. 1st and 2nd step PPD tests were not provided for Resident K.

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