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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE SENIOR LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN, PLAINFIELD, , 46168		

(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 Complaint IN00461541. Complaint IN00461541- No deficiencies related to the allegations are cited. Survey dates: July 7 and 8, 2025 Facility number: 012394 Residential Census: 115 Sugar Grove was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00461541. Quality review completed on July 14, 2025.	R 0000		
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3)	R 0120	Preparation and submission of this statement of correction does not	08/08/2025

	(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 (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.		constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R120—Completion of annual in-services. **A** **What corrective action(s) will be accomplished for** **those residents found to have been affected by the deficient practice.** Staff will be assigned and complete the 3-hour Dementia in-service for all employees on Relias. No residents experienced harm, but to ensure resident safety E9 & E10’s employee files were reviewed and neither party	

	(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 observations and interview, the facility failed to provide the required 3 hour dementia training for 2 of 10 employees reviewed (LPN 9 and CNA 10). Findings include: 1. On 7/8/25 at 10:30 a.m., LPN 9's employee file was reviewed. It lacked 3 hours of dementia training. 2. On 7/8/25 at 10:35 a.m., CNA 10's employee file was reviewed. It lacked 3 hours of dementia training. On 7/8/25 at 11:00 a.m., the Executive Director (ED) indicated he could not locate LPN 9 or CNA 10's dementia training. On 7/8/25 at 11:00 a.m., the ED indicated they followed the state rules regarding dementia training. Based on observations and interview, the facility failed to provide the required 3 hour dementia training for 2 of 10		had any disciplinary actions for conduct towards any residents on 7/8/25. **B** **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;** ED/Designee will complete an audit of employee files to ensure the completion of the Dementia inservice. All residents who have a dx of dementia have the potential to be affected. ED or designee will complete an audit of employee files to identify direct care staff who have not completed the required 3 hours of annual dementia education. Those who have not completed the training will do so prior to their next shift.	

	employees reviewed (LPN 9 and CNA 10). Findings include: 1. On 7/8/25 at 10:30 a.m., LPN 9's employee file was reviewed. It lacked 3 hours of dementia training. 2. On 7/8/25 at 10:35 a.m., CNA 10's employee file was reviewed. It lacked 3 hours of dementia training. On 7/8/25 at 11:00 a.m., the Executive Director (ED) indicated he could not locate LPN 9 or CNA 10's dementia training. On 7/8/25 at 11:00 a.m., the ED indicated they followed the state rules regarding dementia training.		**C** **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;** ED/Designee will complete an audit tool and submit findings to QAPI committee. Using the Relias training platform, all employees who have contact with residents will be assigned 3 hours of dementia training annually. ED & DON will ensure that the moducles are in place. (completion date for updating learning plans) All staff have been re-educated on the use of Relias and the completion of required education.	

			D **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;** Department managers will review Relias compliance reports monthly & results will be discussed with ED. All non-compliant staff will be subject to progressive discipline. This process will be ongoing as a best practice for the community. ED or designee will complete an audit of 5 employees weekly for 4 weeks, then 1 time a month for 3 months, then quarterly for 1 year, and then annually all findings and any plans of action will be submitted to QAPI committee. **E** **systemic changes will be completed.**	

			8/8/25	
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 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 observation, interview, and record review, the facility failed to prevent the potential for accidents when half side rails were installed without initial assessment and/or	R 0148	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R148—Sanitation and Safety Standards **A** **What corrective action(s) will be accomplished for** **those residents found to have been affected by the deficient practice;** ED/Designee to complete inservice with staff regarding safety of potential accidents from equipment, assessments and	08/08/2025

	ongoing monitoring for safety for 1 of 1 resident reviewed for accidents (Resident 3). Findings include: On 7/7/25 at 12:05 p.m., a record review was completed for Resident 3. She had the following diagnoses which included, but were not limited to, generalized anxiety disorder, hypertension, vision loss, and dementia. On 7/7/25 at 10:30 a.m., Resident 3 was observed in bed with a half side rail on each side of her bed. The left side rail was observed to be loose and was wobbly when manually touched. The record lacked documentation of a physician's order for side rails or mobility bars. The most recent service plan lacked documentation of the side rails or mobility bars installation and ongoing monitoring for safety and appropriateness. The record lacked documentation of any initial and/or ongoing assessments for appropriateness and/or the residents ability to utilize the rails. The record lacked documentation for the purpose of the installation of the side		documentation of the service plan per community policy. A Device/Restraint Evaluation was completed on 7/7/2025. Bed rails were removed from bed that same day due to the results of the evaluation. **B** **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;** ED/Designee to complete an audit of rooms and charts to ensure no new equipment has been brought in and not notified to the facility. 100% audit for all residents utilizing bed side rails. Any usage that does not meet the regulatory standards will be immediately addressed by	

	rails, whether for mobility assistance, bed boundaries, or other purposes. On 7/7/25 at 1:30 p.m., the Director of Nursing (DON) indicated she would provide a side rail assessment and remove the side rails because Resident 3 did not need or require the rails for assistance. A side rail assessment was provide and dated 7/7/25. Prior to 7/7/25, the record lacked a side rail assessment. On 7/8/25 at 1:00 p.m., a policy titled, "Bed Mobility Enabler Management" was provided by the Executive Director (ED). It indicated, " ...Prior to approved enabler installation, the resident will be assessed for the use of approved enabler, in the risk of entrapment, and informed consent is obtained from the resident or resident's representative ...." Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when half side rails were installed without initial assessment and/or ongoing monitoring for safety for 1 of 1 resident reviewed for accidents (Resident 3). Findings include: On 7/7/25 at 12:05 p.m., a record review was completed for Resident 3. She had the		removing side rails and re-assessment of the resident’s needs. Audit to be completed by 7/30/25 **C** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ED/Designee will complete an audit tool and submit findings to QAPI committee. DON will provide re-education to clinical staff bed rail policy and procedure then the proper communication to nursing leadership by 7/18/25 DON or ED will remind third party providers of the zero restraint policy and advise them of the process that must be followed for bed mobility	

	following diagnoses which included, but were not limited to, generalized anxiety disorder, hypertension, vision loss, and dementia. On 7/7/25 at 10:30 a.m., Resident 3 was observed in bed with a half side rail on each side of her bed. The left side rail was observed to be loose and was wobbly when manually touched. The record lacked documentation of a physician's order for side rails or mobility bars. The most recent service plan lacked documentation of the side rails or mobility bars installation and ongoing monitoring for safety and appropriateness. The record lacked documentation of any initial and/or ongoing assessments for appropriateness and/or the residents ability to utilize the rails. The record lacked documentation for the purpose of the installation of the side rails, whether for mobility assistance, bed boundaries, or other purposes. On 7/7/25 at 1:30 p.m., the Director of Nursing (DON) indicated she would provide a side rail assessment and remove the side rails because		devices, and that no new DME is to be brought in without DON consent. 7/18/25 **D** **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;** conduct weekly audit of Hospice resident beds to observe for side rails & remove if present. Audits will be ongoing and results will be shared at routine QAPI meetings until committee determines a stop date. 8/8/25 **E** **By what date the systemic changes will be completed.**	

	Resident 3 did not need or require the rails for assistance. A side rail assessment was provide and dated 7/7/25. Prior to 7/7/25, the record lacked a side rail assessment. On 7/8/25 at 1:00 p.m., a policy titled, "Bed Mobility Enabler Management" was provided by the Executive Director (ED). It indicated, " ...Prior to approved enabler installation, the resident will be assessed for the use of approved enabler, in the risk of entrapment, and informed consent is obtained from the resident or resident's representative ...."		8/8/25	
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.	R 0216	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R216—Medication at Bedside	08/08/2025

	(d) The evaluation shall be documented in writing and kept in the facility. Based on observations, interviews, and record review, the facility failed to prevent the potential for accidents for a resident who had medications at bedside without being properly assessed for the ability to safely self-administer medications for 1 of 1 resident reviewed for self -administration (Resident 14). Findings include: On 7/8/25 at 9:30 a.m. Resident 14 was observed as she sat in her recliner in her room. Two large bottles of Flintstone brand vitamins were observed on her side table next to her chair. On 7/8/25 at 10:00 a.m. Resident 14's medical record was reviewed. She was a Resident who resided in an assisted living facility whose diagnoses included but were not limited to gas pain and a history of falls. Resident 14's orders were reviewed, and it was found that she did not have a current order for Flintstone brand vitamins. Resident 14's most recent self-administration of medications assessment was dated 8/16/23. This assessment		**A** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident refused to give vitamins to clinical staff. New order was obtained for the vitamin at bedside, self administration assessment was complete and passed, and service plan was updated. All were complete on 7/8/25. **B** **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;** DON, ED, ADON, or designees will conduct a 100 % audit and verbal acknowledgement of Assisted Living unit to ensure that no medications, including over-the-counter items were being stored in resident rooms unless authorized by	

	indicated Resident 14 was not capable of safely administering her own medications. During an interview on 7/8/25 at 11:30 a.m. with the Director of Nursing (DON) she indicated she was unaware Resident 14 had medications in her room. She indicated all of the resident's medications were managed by the facility so she did not think the resident had a current self-administration of medications assessment indicating she could safely administer her own medications. The DON indicated she did not think Resident 14 had a current order for Flintstone vitamins. On 7/8/25 at 1:15 p.m. a copy of a current facility policy titled, "Self-Administration of Medication," was provided by the Executive Director (ED). This policy indicated, " ...1. If a resident wishes to self-administer medications an assessment must be performed to ensure that the resident can safely self-administer medications ...." Based on observations, interviews, and record review, the facility failed to prevent the potential for accidents for a resident who had medications at bedside without being properly assessed for the ability to safely self-administer medications for 1 of 1 resident reviewed for self		physician order and service plan. Will be completed by 8/8/25 **C** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DON or designee to re-educate clinical staff on how to respond and document when unauthorized medications are discovered. 7/18/25 Residents and families will be reminded of community policy with letter sent out to all responsible parties.	

	-administration (Resident 14). Findings include: On 7/8/25 at 9:30 a.m. Resident 14 was observed as she sat in her recliner in her room. Two large bottles of Flintstone brand vitamins were observed on her side table next to her chair. On 7/8/25 at 10:00 a.m. Resident 14's medical record was reviewed. She was a Resident who resided in an assisted living facility whose diagnoses included but were not limited to gas pain and a history of falls. Resident 14's orders were reviewed, and it was found that she did not have a current order for Flintstone brand vitamins. Resident 14's most recent self-administration of medications assessment was dated 8/16/23. This assessment indicated Resident 14 was not capable of safely administering her own medications. During an interview on 7/8/25 at 11:30 a.m. with the Director of Nursing (DON) she indicated she was unaware Resident 14 had medications in her room. She indicated all of the resident's medications were managed by the facility so she did not think the resident had a current self-administration of		Family members will be reminded of medication policies during service plan meetings. (start date) **D** **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; and** DON, ED, or designee will identify 3 residents who require staff to administer medications and audit their rooms to ensure that no medications are being stored in resident authorized by physician order and service plan. 3 audits will be done weekly for 8 weeks, 1 audit weekly for 4 weeks. Results will be shared at routine QAPI meetings to determine stop date.	

	medications assessment indicating she could safely administer her own medications. The DON indicated she did not think Resident 14 had a current order for Flintstone vitamins. On 7/8/25 at 1:15 p.m. a copy of a current facility policy titled, "Self-Administration of Medication," was provided by the Executive Director (ED). This policy indicated, " ...1. If a resident wishes to self-administer medications an assessment must be performed to ensure that the resident can safely self-administer medications ...."		**E** **By what date the systemic changes will be completed.** 8/8/25	
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.	R 0217	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R217—Service plans	08/08/2025

	(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review, observation, and interview, the facility failed to ensure a resident's service plan matched her current level of care, hospice, and nutritional status for 1 of 7 residents reviewed for service plans (Resident 3). Findings include: On 7/7/25 at 10:00 a.m., Resident 3 was observed sleeping in a bed. She was unable to communicate and only replied with moaning. She was		**A** **What corrective action(s) will be accomplished for** **those residents found to have been affected by the deficient practice;** Resident's service plan will be revised to reflect current care needs, and a significant change Level of Care assessment with service plans will be scheduled. 7/8/25 **B** **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;** 100% audit of Hospice residents to ensure that a significant change of condition LOC with service plans has been done. Those who are identified as not having a current assessment & service plans will be scheduled	

	reaching up with her left arm. She was dependent with care to include mobility, transferring, toileting, bathing, and eating. The hospice aide was in the room providing residents with a bed bath. On 7/7/25 at 12:05 p.m., a record review was completed for Resident 3. She had the following diagnoses which included, but were not limited to generalized anxiety disorder, hypertension, vision loss, and dementia. Resident 3 had a service plan dated 6/12/25. The service did not match up with residents' current condition. On 7/7/25 at 1:00 p.m., Resident 3 was observed lying in bed. She had not been served lunch yet. QMA 8 was summoned. She indicated Resident 3's husband was at an appointment and he usually took care of her nutrition. QMA 8 offered Resident 3 an Ensure (liquid supplement). QMA 8 indicated Resident 3 normally did not get her food from the kitchen at the facility and that her husband usually gave her liquids to drink including Ensure. Her service plan, dated 6/12/25, indicated she slept in a recliner. It indicated she could follow sub-tasking with her care. The service plan indicated she could		and completed by 8/8/25 100% audit of resident's who have nutritional needs such as supplements to ensure that needs are reflected on their service plan. 8/8/25 **C** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DON will receive training on what triggers a service plan review and update. 7/24/25 **D** **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; and**	

	transfer by herself. It indicated she could toilet herself independently.The service plan lacked a care plan for hospice services. The service plan lacked a care plan for nutrition. On 7/7/25 at 1:30 p.m., during an interview, the Director of Nursing (DON) indicated she was unaware that the service plan was not updated. On 7/7/25 at 1:32 p.m., the Executive Director (ED) indicated the facility did not have a policy regarding service plans. Based on record review, observation, and interview, the facility failed to ensure a resident's service plan matched her current level of care, hospice, and nutritional status for 1 of 7 residents reviewed for service plans (Resident 3). Findings include: On 7/7/25 at 10:00 a.m., Resident 3 was observed sleeping in a bed. She was unable to communicate and only replied with moaning. She was reaching up with her left arm. She was dependent with care to include mobility, transferring, toileting, bathing, and eating. The hospice aide was in the room providing residents with a bed bath. On 7/7/25 at 12:05 p.m., a		DON or designee will review five service plans weekly for four weeks, then 3 service plans weekly for four weeks, then 1 service plan weekly to ensure plans accurately reflect resident's current needs. **E** **By what date the systemic changes will be completed.** 8/8/25	

	record review was completed for Resident 3. She had the following diagnoses which included, but were not limited to generalized anxiety disorder, hypertension, vision loss, and dementia. Resident 3 had a service plan dated 6/12/25. The service did not match up with residents' current condition. On 7/7/25 at 1:00 p.m., Resident 3 was observed lying in bed. She had not been served lunch yet. QMA 8 was summoned. She indicated Resident 3's husband was at an appointment and he usually took care of her nutrition. QMA 8 offered Resident 3 an Ensure (liquid supplement). QMA 8 indicated Resident 3 normally did not get her food from the kitchen at the facility and that her husband usually gave her liquids to drink including Ensure. Her service plan, dated 6/12/25, indicated she slept in a recliner. It indicated she could follow sub-tasking with her care. The service plan indicated she could transfer by herself. It indicated she could toilet herself independently.The service plan lacked a care plan for hospice services. The service plan lacked a care plan for nutrition. On 7/7/25 at 1:30 p.m., during an interview, the Director of			

	Nursing (DON) indicated she was unaware that the service plan was not updated. On 7/7/25 at 1:32 p.m., the Executive Director (ED) indicated the facility did not have a policy regarding service plans.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to ensure a resident on the memory care unit was cued and encouraged to eat or offered a substitution for a meal for 1 of approximately 20 residents observed in the memory care dining room during a meal (Resident 8). Findings include: On 7/7/25 at 12:15 p.m. Resident 8 was observed as he sat at a dining table alone. An identified staff member gave Resident 8 his tray. It consisted of a ground chicken sandwich, a bowl of oranges, a bowl of cottage cheese, and a glass of juice. The staff member did not offer to help the resident set up	R 0240	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R240—Personal care and assistance with ADL's **A** **What corrective action(s) will be accomplished for** **those residents found to have been affected by the deficient practice;**	08/08/2025

	his tray or ask if he needed any assistance. After giving Resident 8 his tray the unidentified staff member passed individual desserts to the other residents, but Resident 8 did not receive one. On 7/7/25 at 12:25 p.m. Resident 8 appeared to be resting with his eyes closed, at this time the resident had not touched his meal. Three staff members were observed in the dining room helping residents eat, asking residents how the food tastes and assisting residents who were finished eating to leave the dining room. No staff member asked Resident 8 if he needed help eating or if he would like something different to eat. On 7/7/25 at 12:45 p.m. Resident 8 appeared to be awake staring off into the distance, he had picked his wrapped silverware up and looked at it but had not touched his food. Two staff members were observed in the dining room helping residents eat and cleaning trays in the dinette area. No staff member had offered Resident 8 assistance, encouraged him to eat, or offered him a substitution at this time. On 7/7/25 at 1:00 p.m. the Activities Director sat down in front of Resident 8 and asked		R 8's service plan will be updated to reflect the need to provide cueing at meals. 7/8/25 **B** **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;** ED/Designee to complete an audit of a dining service and reeducate as needed. 100% audit of dining support and service plans for all Memory Care residents to ensure those needing assistance or cueing during meals are identified. Completed by 7/30/25	

	him if she could eat her lunch with him. At this time, she asked the resident if he was hungry, needed any help eating or wanted something different to eat. Resident 8 shook his head no. There were three additional staff members in the dining room cleaning up trays, none of these staff members acknowledged the resident. On 7/7/25 at 1:05 p.m. the Activities Director indicated Resident 8 prefers to eat alone, but he must not be hungry today. She indicated the resident's daughter normally came in and brought things he liked to eat like peanut butter and jelly sandwiches or sweets. She indicated Resident 8 really liked sweets. On 7/7/25 at 1:15 p.m. a Therapy Staff member approached Resident 8. The Occupational Therapist (OT) asked the resident if he needed help eating and unwrapped his silverware for him. The resident did not answer him or attempt to eat. The OT went to the resident's room and got him an Ensure type drink. The OT indicated Resident 8 would feed himself but required a lot of cuing and encouragement. He indicated if staff came up to him and reminded him the food was there, and he needed to eat then walked away he might		**C** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DON & ADON to receive Courtyard Training by 7/22/25 DON & ADON will provide education to clinical staff on person centered dining practices, including tray setup, encouragement to eat, prompting and cueing, offering substituations when meals are refused, and documentation. An “all hands on deck” approach to assisting with meals will be implemented in Memory Care to ensure that residents are receiving the assistance that they need. **D**	

	shake his head no but after several attempts he would usually start eating. On 7/7/25 at 2:00 p.m. Resident 8's medical record was reviewed. He was a resident who resided on the memory care unit in an assisted living facility, whose diagnoses included but were not limited to dementia and dysphagia (difficulty swallowing). A level of care determination, dated 6/9/25, indicated the resident did need prompts and cues for adequate nutrition. Resident 8's service plan, dated 6/19/25, indicated the resident refused care at times. An intervention for this service plan was to provide cuing. Resident 8's eating/meals service plan, dated 6/19/25, did not indicate specifically that the resident required a lot of cueing and encouragement to comply with eating his meals. During an interview on 7/8/25 at 12:40 p.m. with the Director of Nursing (DON) she indicated she was very concerned that Resident 8 waited so long before staff asked him if he needed help eating or wanted a substitute. She indicated she wasn't aware that encouragement and cuing were successful interventions for this resident and indicated she		**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; and** DON or designee will observe and document one full meal service daily for 4 weeks, then weekly for 3 months. All observations will be reviewed during routine QAPI meetings. Deficiencies noted during observation will be addressed with targeted retraining. **E** **By what date the systemic changes will be completed.** 8/8/25	

would speak with staff and update his service plans to reflect these changes.

On 7/8/25 at 1:15 p.m. a partial copy of the facility's dementia care handbook was provided by the Executive Director (ED). This handbook indicated, " ... staff need to evaluate each individual's tendencies and attempt to develop effective strategies to assure that nutritional needs are met ... it is essential to ensure queuing and assist tables are available to ensure appropriate staff assistance ...."

Based on observation, interview, and record review, the facility failed to ensure a resident on the memory care unit was cued and encouraged to eat or offered a substitution for a meal for 1 of approximately 20 residents observed in the memory care dining room during a meal (Resident 8).

Findings include:

On 7/7/25 at 12:15 p.m. Resident 8 was observed as he sat at a dining table alone. An identified staff member gave Resident 8 his tray. It consisted of a ground chicken sandwich, a bowl of oranges, a bowl of cottage cheese, and a glass of juice. The staff member did not offer to help the resident set up his tray or ask if he needed any

	assistance. After giving Resident 8 his tray the unidentified staff member passed individual desserts to the other residents, but Resident 8 did not receive one. On 7/7/25 at 12:25 p.m. Resident 8 appeared to be resting with his eyes closed, at this time the resident had not touched his meal. Three staff members were observed in the dining room helping residents eat, asking residents how the food tastes and assisting residents who were finished eating to leave the dining room. No staff member asked Resident 8 if he needed help eating or if he would like something different to eat. On 7/7/25 at 12:45 p.m. Resident 8 appeared to be awake staring off into the distance, he had picked his wrapped silverware up and looked at it but had not touched his food. Two staff members were observed in the dining room helping residents eat and cleaning trays in the dinette area. No staff member had offered Resident 8 assistance, encouraged him to eat, or offered him a substitution at this time. On 7/7/25 at 1:00 p.m. the Activities Director sat down in front of Resident 8 and asked him if she could eat her lunch			

with him. At this time, she asked the resident if he was hungry, needed any help eating or wanted something different to eat. Resident 8 shook his head no. There were three additional staff members in the dining room cleaning up trays, none of these staff members acknowledged the resident.

On 7/7/25 at 1:05 p.m. the Activities Director indicated Resident 8 prefers to eat alone, but he must not be hungry today. She indicated the resident's daughter normally came in and brought things he liked to eat like peanut butter and jelly sandwiches or sweets. She indicated Resident 8 really liked sweets.

On 7/7/25 at 1:15 p.m. a Therapy Staff member approached Resident 8. The Occupational Therapist (OT) asked the resident if he needed help eating and unwrapped his silverware for him. The resident did not answer him or attempt to eat. The OT went to the resident's room and got him an Ensure type drink. The OT indicated Resident 8 would feed himself but required a lot of cuing and encouragement. He indicated if staff came up to him and reminded him the food was there, and he needed to eat then walked away he might shake his head no but after

	several attempts he would usually start eating. On 7/7/25 at 2:00 p.m. Resident 8's medical record was reviewed. He was a resident who resided on the memory care unit in an assisted living facility, whose diagnoses included but were not limited to dementia and dysphagia (difficulty swallowing). A level of care determination, dated 6/9/25, indicated the resident did need prompts and cues for adequate nutrition. Resident 8's service plan, dated 6/19/25, indicated the resident refused care at times. An intervention for this service plan was to provide cuing. Resident 8's eating/meals service plan, dated 6/19/25, did not indicate specifically that the resident required a lot of cueing and encouragement to comply with eating his meals. During an interview on 7/8/25 at 12:40 p.m. with the Director of Nursing (DON) she indicated she was very concerned that Resident 8 waited so long before staff asked him if he needed help eating or wanted a substitute. She indicated she wasn't aware that encouragement and cuing were successful interventions for this resident and indicated she would speak with staff and			

	update his service plans to reflect these changes. On 7/8/25 at 1:15 p.m. a partial copy of the facility's dementia care handbook was provided by the Executive Director (ED). This handbook indicated, " ... staff need to evaluate each individual's tendencies and attempt to develop effective strategies to assure that nutritional needs are met ... it is essential to ensure queuing and assist tables are available to ensure appropriate staff assistance ...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure bulk food storage containers were properly labeled and dated. This had the potential to affect 115 of 115 residents who ate meals provided by the facility. Findings include: On 7/7/25 at 9:20 a.m. the facility kitchen was observed.	R 0273	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R273—Labeling of food **A**	08/08/2025

	Upon review of the dry storage area there were two bulk storage containers, one with what appeared to be flour and one with an unidentifiable powder, neither container had a label or date. A Dietary Aide indicated all bulk containers should have a label indicating what they contain, when they were received, when they were opened and when they expire. She indicated she would throw out the contents of the containers, replace them, and ensure there was a proper label in place. On 7/8/25 at 1:15 p.m. a copy of a current facility policy titled, "Food Storage (Dry, Refrigerated, and Frozen)," was provided by the Executive Director (ED). This policy indicated, " ...a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold consumed or discarded ...." Based on observation and interview, the facility failed to ensure bulk food storage containers were properly labeled and dated. This had the potential to affect 115 of 115 residents who ate meals provided by the facility. Findings include: On 7/7/25 at 9:20 a.m. the		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Unlabeled items were removed immediately by dietary staff. **B** **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;** ED/Designee to complete an audit of the dry and cold storage to ensure all items are labeled properly. **C** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	

	facility kitchen was observed. Upon review of the dry storage area there were two bulk storage containers, one with what appeared to be flour and one with an unidentifiable powder, neither container had a label or date. A Dietary Aide indicated all bulk containers should have a label indicating what they contain, when they were received, when they were opened and when they expire. She indicated she would throw out the contents of the containers, replace them, and ensure there was a proper label in place. On 7/8/25 at 1:15 p.m. a copy of a current facility policy titled, "Food Storage (Dry, Refrigerated, and Frozen)," was provided by the Executive Director (ED). This policy indicated, " ...a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold consumed or discarded ...."		**practice does not recur;** ED/Designee to complete an audit tool and submit findings to QAPI committee. **D** **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;** Audit will be completed 5 times a week for 4 weeks, then 1 time a week for 3 months, then quarterly for 1 year, and then annually all findings and any plans of action will be submitted to QAPI committee. **E** **By what date the systemic**	

			changes will be completed. 8/8/25	
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observations and interviews, the facility failed to ensure medications were properly labeled and dated. This deficient practice had the potential to affect 5 of 5 residents (Residents 9,10,11,12, and 13) whose medications were improperly labeled or dated. Findings include: On 7/7/25 at 9: 45 a.m. the 100-hall medication cart was observed with Licensed Practical Nurse (LPN) 7.	R 0300	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. Alleged Deficiency: R300—Pharmaceutical Services-Medication Labels **A** **What corrective action(s) will be accomplished for** **those residents found to have been affected by the deficient practice;**	08/08/2025

	The medications reviewed were as follows: 1. Resident 9 had Liquigel eye drops with no open date. 2. Resident 10 had Over the Counter (OTC) Cranberry vitamins with no proper label. 3. Resident 11 had OTC Vitamin D3 capsules with no proper label. 4. Resident 12 had OTC Senna-S tablets that were discontinued but still in the medication cart without a label. During this observation LPN 7 indicated these medications were incorrectly labeled and dated. She indicated she would throw these medications out and ensure the replacements were properly labeled and dated. On 7/7/25 at 9:55 a.m. the 200-hall medication cart was observed with Qualified Medication Aide (QMA) 8. Resident 13 had OTC Calcium Mini supplements that had no proper label. During this observation QMA 8 indicated these medications were incorrectly labeled and dated. She indicated she would throw these medications out and ensure the replacements were properly labeled and dated.		The identified medications were removed from the medication carts upon discovery. 7/7/25 Resident medication records were reviewed to verify current active orders. 7/725 **B** **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;** 100% audit of all medication carts, all outdated, unlabeled, or improperly labeled OTC or prescription medications will be removed or relabeled according to pharmacy guidelines. **C**	

	On 7/8/25 at 1:15 p.m. a copy of a current facility policy titled, "Medication Administration Policy for Senior Living," was provided by the Executive Director (ED). This policy indicated, " ... adherence to this medication administration policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy ... Medication Storage: 1. expired or discontinued medications should not be stored and should be disposed of according to proper procedures ... Medication Identification and Verification: 1. All medications must be labeled correctly with the resident's name's medication name dosage and administration instructions ...." Based on observations and interviews, the facility failed to ensure medications were properly labeled and dated. This deficient practice had the potential to affect 5 of 5 residents (Residents 9,10,11,12, and 13) whose medications were improperly labeled or dated. Findings include: On 7/7/25 at 9: 45 a.m. the 100-hall medication cart was observed with Licensed		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All staff that administers medications will be re-educated on proper labeling of OTC & prescribed medications, recording dates, disposal of discontinue medications, pharmacy labeling requirements. (date) **D** **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;** DON or designee will perform weekly audits of all med carts for 8 weeks, then 1 cart per week as an ongoing best practice,	

	Practical Nurse (LPN) 7. The medications reviewed were as follows: 1. Resident 9 had Liquigel eye drops with no open date. 2. Resident 10 had Over the Counter (OTC) Cranberry vitamins with no proper label. 3. Resident 11 had OTC Vitamin D3 capsules with no proper label. 4. Resident 12 had OTC Senna-S tablets that were discontinued but still in the medication cart without a label. During this observation LPN 7 indicated these medications were incorrectly labeled and dated. She indicated she would throw these medications out and ensure the replacements were properly labeled and dated. On 7/7/25 at 9:55 a.m. the 200-hall medication cart was observed with Qualified Medication Aide (QMA) 8. Resident 13 had OTC Calcium Mini supplements that had no proper label. During this observation QMA 8 indicated these medications were incorrectly labeled and dated. She indicated she would throw these medications out and ensure the replacements were		corrective action will be taken for noncompliance. Consultant pharmacist will review compliance during quarterly (?) medication reviews. Audit findings will be reviewed during routine QAPI meetings. **E** **By what date the systemic changes will be completed.** 8/8/25	

	properly labeled and dated. On 7/8/25 at 1:15 p.m. a copy of a current facility policy titled, "Medication Administration Policy for Senior Living," was provided by the Executive Director (ED). This policy indicated, " ... adherence to this medication administration policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy ... Medication Storage: 1. expired or discontinued medications should not be stored and should be disposed of according to proper procedures ... Medication Identification and Verification: 1. All medications must be labeled correctly with the resident's name's medication name dosage and administration instructions ...."			
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer.	R 0354	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and	08/08/2025

(4) Resident ' s personal property when transferred to an acute care facility.

(5) Nurses ' notes relating to the resident ' s:

(A) functional abilities and physical limitations;

(B) nursing care;

(C) medications;

(D) treatment; and

(E) current diet and condition on transfer.

(6) Diagnosis.

(7) Date of chest x-ray and skin test for tuberculosis.

Based on record review and interview, the facility failed to administer an initial and second step tuberculin test (used to test for tuberculosis) to a resident upon admission for 1 of 7 residents reviewed (Resident 3).

Findings include:

On 7/7/25 at 12:05 p.m., a record review was completed for Resident 3. She had the following diagnoses which included, but were not limited to generalized anxiety disorder, hypertension, vision loss, and dementia.

Resident 3's record lacked documentation of a first or second step PPD (tuberculosis

federal laws.

Alleged Deficiency: R354—Clinical Records-1^{st} or 2^{nd} step TB upon Admission

A
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident 3 will receive a two-step TB test per policy. 7/28/25

B
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;

100% audit of all residents admitted within the past 12 months have documentation of a completed

	test). The Director of Nursing (DON) provided a TB (tuberculosis) questionnaire dated 2/5/25. She indicated she could not locate Resident 3's first or second step PPD. A policy titled, "Infection Prevention and Control Manual TB Control Plan," was provided by the Executive Director (ED) on 7/7/25 at 1:41 p.m. It indicated, " ...For all new admissions, a tuberculin skin test will be done within 72 hours after admission if there is no documented TST (tuberculin skin test) result from within three months before admission. The 2 step TST method will be performed using five units (0.1ml (milliliter)) of purified protein derivative tuberculin given intracutaneously (see procedure) ...." Based on record review and interview, the facility failed to administer an initial and second step tuberculin test (used to test for tuberculosis) to a resident upon admission for 1 of 7 residents reviewed (Resident 3). Findings include: On 7/7/25 at 12:05 p.m., a record review was completed for Resident 3. She had the following diagnoses which included, but were not limited to generalized anxiety disorder,		two-step TB test or a documented negative result from prior test within three months of move-in. Any resident lacking appropriate documentation will be scheduled to receive a two-step Tuberculin Skin Test. **C** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DON, ADON, ED, and sales staff have been re-educated on the requirement for TB testing. 7/28/25 DON & ADON have been re-educated on the use of TB questionnaires as supplemental. 7/28/25	

	hypertension, vision loss, and dementia. Resident 3's record lacked documentation of a first or second step PPD (tuberculosis test). The Director of Nursing (DON) provided a TB (tuberculosis) questionnaire dated 2/5/25. She indicated she could not locate Resident 3's first or second step PPD. A policy titled, "Infection Prevention and Control Manual TB Control Plan," was provided by the Executive Director (ED) on 7/7/25 at 1:41 p.m. It indicated, " ...For all new admissions, a tuberculin skin test will be done within 72 hours after admission if there is no documented TST (tuberculin skin test) result from within three months before admission. The 2 step TST method will be performed using five units (0.1ml (milliliter)) of purified protein derivative tuberculin given intracutaneously (see procedure) ...."		Nurses have been re-educated on TB screening for new move-ins. 7/28/25 **D** **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;** DON or designee will audit all new admissions for TB screening compliance for 8 weeks, then monthly as an ongoing best practice. **E** **By what date the systemic changes will be completed.** 8/8/25	

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