STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES AT DEER CREEK	401 EAST US 30, SCHERERVILLE, , 46375

(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 IN00462102. Complaint IN00462102 - No deficiencies related to the allegations are cited. Survey dates: July 7 and 8, 2025 Facility number: 013069 Residential Census: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/15/25.	R 0000	Residences at Deer Creek (the “Provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by	

			the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for	R 0045	Resident # 3 was not affected by this citation. Resident # 6 was not affected by this citation.Resident # 7 was not affected by this citation.Resident # 8 was not affected by this citation. An audit was completed of all other residents who were transferred or discharged to ensure appropriate Transfer or Discharge form completed and given to residents and copy maintained in facility. The Licensed Nurse will continue to be responsible for ensuring the form is completed upon transfer or discharge and copy maintained in facility. The Director of Nursing /Designee will conduct in-services with nursing staff regarding timely completion of form retaining a copy for facility. Director of Nursing/Designee will review transfer/discharge binder 5 days per week for the next or until 100% compliance is achieved.	07/28/2025

	involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;			

	(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number			

listed below. " .

(E) The name of the director and the address, telephone number, and hours of operation of the division.

(F) A hearing request form prescribed by the department.

(G) The name, address, and telephone number of the state and local long term care ombudsman.

(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 4 of 7 records reviewed. (Residents 6, 3, 7, and 8)

Findings include:

1. The record for Resident 6 was reviewed on 7/8/25 at 10:53 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anxiety, and hypertension.

A Nurse's Note, dated 1/27/25 at 10:28 a.m., indicated at 8:00 a.m. the resident was having trouble breathing. The resident had used her nebulizer but she

indicated it had not helped. The resident was short of breath and her lung sounds were diminished. She requested to be sent to the emergency room.

A Nurse's Note, dated 1/27/25 at 1:29 p.m., indicated the resident was admitted to the hospital with exacerbation of COPD and Influenza A. The resident returned to the facility on 2/11/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 1:30 p.m., the Director of Nursing (DON) indicated the new staff needed to be trained on completing the transfer and discharge notice.

2. The record for Resident 3 was reviewed on 7/7/25 at 11:27 a.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension and type 2 diabetes mellitus.

A Nurse's Note, dated 2/11/25 at 5:22 p.m., indicated the resident was in the dining room when she became unresponsive and slumped over. She then became responsive and complained of dizziness and nausea. She was assisted to her room where she continued to complain of dizziness and

nausea. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 2/11/25 at 9:11 p.m., indicated the resident was admitted to the hospital with symptomatic bradycardia. She returned to the facility on 2/14/25.

A Nurse's Note, dated 3/29/25 at 11:58 p.m., indicated the resident was complaining of nausea, indigestion, and left side pain. She had become short of breath when ambulating and requested to go to the hospital. 911 was called and the resident was sent to the hospital for evaluation

A Nurse's Note, dated 3/30/25 at 4:36 a.m., indicated the resident was admitted to the hospital with colitis. She returned to the facility on 3/31/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

3. The closed record for Resident 7 was reviewed on 7/7/25 at 2:09 p.m. Diagnoses

included, but were not limited to, arthritis, glaucoma, and hypertension.

A Nurse's Note, dated 5/13/25 at 9:08 a.m., indicated the resident was coughing and his face was purple/blue in color. The resident indicated he didn't feel good and was having trouble with his vision. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 5/13/25 at 10:54 a.m., indicated the resident was admitted to the hospital with congestive heart failure. He returned to the facility on 5/16/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

4. The closed record for Resident 8 was reviewed on 7/7/25 at 3:17 p.m. Diagnoses included, but were not limited to, complicated urinary tract infection and rhabdomyolysis.

A Nurse's Note, dated 1/22/25 at 9:07 a.m., indicated the resident was found sitting on the floor in front of the sink in her room. She indicated she had

fallen out of bed and now her leg would not work. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 1/22/25 at 10:16 a.m., indicated the resident was admitted to the hospital with a right hip fracture. She returned to the facility on 2/16/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 4 of 7 records reviewed. (Residents 6, 3, 7, and 8)

Findings include:

1. The record for Resident 6 was reviewed on 7/8/25 at 10:53 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anxiety, and hypertension.

A Nurse's Note, dated 1/27/25 at 10:28 a.m., indicated at 8:00

a.m. the resident was having trouble breathing. The resident had used her nebulizer but she indicated it had not helped. The resident was short of breath and her lung sounds were diminished. She requested to be sent to the emergency room.

A Nurse's Note, dated 1/27/25 at 1:29 p.m., indicated the resident was admitted to the hospital with exacerbation of COPD and Influenza A. The resident returned to the facility on 2/11/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 1:30 p.m., the Director of Nursing (DON) indicated the new staff needed to be trained on completing the transfer and discharge notice.

2. The record for Resident 3 was reviewed on 7/7/25 at 11:27 a.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension and type 2 diabetes mellitus.

A Nurse's Note, dated 2/11/25 at 5:22 p.m., indicated the resident was in the dining room when she became unresponsive and slumped over. She then became responsive and complained of dizziness and

nausea. She was assisted to her room where she continued to complain of dizziness and nausea. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 2/11/25 at 9:11 p.m., indicated the resident was admitted to the hospital with symptomatic bradycardia. She returned to the facility on 2/14/25.

A Nurse's Note, dated 3/29/25 at 11:58 p.m., indicated the resident was complaining of nausea, indigestion, and left side pain. She had become short of breath when ambulating and requested to go to the hospital. 911 was called and the resident was sent to the hospital for evaluation

A Nurse's Note, dated 3/30/25 at 4:36 a.m., indicated the resident was admitted to the hospital with colitis. She returned to the facility on 3/31/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

	3. The closed record for Resident 7 was reviewed on 7/7/25 at 2:09 p.m. Diagnoses included, but were not limited to, arthritis, glaucoma, and hypertension. A Nurse's Note, dated 5/13/25 at 9:08 a.m., indicated the resident was coughing and his face was purple/blue in color. The resident indicated he didn't feel good and was having trouble with his vision. 911 was called and the resident was sent to the hospital for evaluation. A Nurse's Note, dated 5/13/25 at 10:54 a.m., indicated the resident was admitted to the hospital with congestive heart failure. He returned to the facility on 5/16/25. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice. During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge. 4. The closed record for Resident 8 was reviewed on 7/7/25 at 3:17 p.m. Diagnoses included, but were not limited to, complicated urinary tract infection and rhabdomyolysis. A Nurse's Note, dated 1/22/25 at 9:07 a.m., indicated the			

	resident was found sitting on the floor in front of the sink in her room. She indicated she had fallen out of bed and now her leg would not work. 911 was called and the resident was sent to the hospital for evaluation. A Nurse's Note, dated 1/22/25 at 10:16 a.m., indicated the resident was admitted to the hospital with a right hip fracture. She returned to the facility on 2/16/25. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice. During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge. Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 4 of 7 records reviewed. (Residents 6, 3, 7, and 8) Findings include:			

	1. The record for Resident 6 was reviewed on 7/8/25 at 10:53 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anxiety, and hypertension. A Nurse's Note, dated 1/27/25 at 10:28 a.m., indicated at 8:00 a.m. the resident was having trouble breathing. The resident had used her nebulizer but she indicated it had not helped. The resident was short of breath and her lung sounds were diminished. She requested to be sent to the emergency room. A Nurse's Note, dated 1/27/25 at 1:29 p.m., indicated the resident was admitted to the hospital with exacerbation of COPD and Influenza A. The resident returned to the facility on 2/11/25. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice. During an interview on 7/8/25 at 1:30 p.m., the Director of Nursing (DON) indicated the new staff needed to be trained on completing the transfer and discharge notice. 2. The record for Resident 3 was reviewed on 7/7/25 at 11:27 a.m. Diagnoses included, but were not limited to, congestive heart failure,			

hypertension and type 2 diabetes mellitus.

A Nurse's Note, dated 2/11/25 at 5:22 p.m., indicated the resident was in the dining room when she became unresponsive and slumped over. She then became responsive and complained of dizziness and nausea. She was assisted to her room where she continued to complain of dizziness and nausea. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 2/11/25 at 9:11 p.m., indicated the resident was admitted to the hospital with symptomatic bradycardia. She returned to the facility on 2/14/25.

A Nurse's Note, dated 3/29/25 at 11:58 p.m., indicated the resident was complaining of nausea, indigestion, and left side pain. She had become short of breath when ambulating and requested to go to the hospital. 911 was called and the resident was sent to the hospital for evaluation

A Nurse's Note, dated 3/30/25 at 4:36 a.m., indicated the resident was admitted to the hospital with colitis. She returned to the facility on 3/31/25.

There was no documentation that the resident had received a

	copy of the State approved transfer and discharge notice for either hospitalization. During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge. 3. The closed record for Resident 7 was reviewed on 7/7/25 at 2:09 p.m. Diagnoses included, but were not limited to, arthritis, glaucoma, and hypertension. A Nurse's Note, dated 5/13/25 at 9:08 a.m., indicated the resident was coughing and his face was purple/blue in color. The resident indicated he didn't feel good and was having trouble with his vision. 911 was called and the resident was sent to the hospital for evaluation. A Nurse's Note, dated 5/13/25 at 10:54 a.m., indicated the resident was admitted to the hospital with congestive heart failure. He returned to the facility on 5/16/25. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.			

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

4. The closed record for Resident 8 was reviewed on 7/7/25 at 3:17 p.m. Diagnoses included, but were not limited to, complicated urinary tract infection and rhabdomyolysis.

A Nurse's Note, dated 1/22/25 at 9:07 a.m., indicated the resident was found sitting on the floor in front of the sink in her room. She indicated she had fallen out of bed and now her leg would not work. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 1/22/25 at 10:16 a.m., indicated the resident was admitted to the hospital with a right hip fracture. She returned to the facility on 2/16/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

Based on record review and interview, the facility failed to ensure the State approved

transfer and discharge form was completed prior to a transfer to the hospital for 4 of 7 records reviewed. (Residents 6, 3, 7, and 8)

Findings include:

1. The record for Resident 6 was reviewed on 7/8/25 at 10:53 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anxiety, and hypertension.

A Nurse's Note, dated 1/27/25 at 10:28 a.m., indicated at 8:00 a.m. the resident was having trouble breathing. The resident had used her nebulizer but she indicated it had not helped. The resident was short of breath and her lung sounds were diminished. She requested to be sent to the emergency room.

A Nurse's Note, dated 1/27/25 at 1:29 p.m., indicated the resident was admitted to the hospital with exacerbation of COPD and Influenza A. The resident returned to the facility on 2/11/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 1:30 p.m., the Director of Nursing (DON) indicated the new staff needed to be trained

on completing the transfer and discharge notice.

2. The record for Resident 3 was reviewed on 7/7/25 at 11:27 a.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension and type 2 diabetes mellitus.

A Nurse's Note, dated 2/11/25 at 5:22 p.m., indicated the resident was in the dining room when she became unresponsive and slumped over. She then became responsive and complained of dizziness and nausea. She was assisted to her room where she continued to complain of dizziness and nausea. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 2/11/25 at 9:11 p.m., indicated the resident was admitted to the hospital with symptomatic bradycardia. She returned to the facility on 2/14/25.

A Nurse's Note, dated 3/29/25 at 11:58 p.m., indicated the resident was complaining of nausea, indigestion, and left side pain. She had become short of breath when ambulating and requested to go to the hospital. 911 was called and the resident was sent to the hospital for evaluation

A Nurse's Note, dated 3/30/25

at 4:36 a.m., indicated the resident was admitted to the hospital with colitis. She returned to the facility on 3/31/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

3. The closed record for Resident 7 was reviewed on 7/7/25 at 2:09 p.m. Diagnoses included, but were not limited to, arthritis, glaucoma, and hypertension.

A Nurse's Note, dated 5/13/25 at 9:08 a.m., indicated the resident was coughing and his face was purple/blue in color. The resident indicated he didn't feel good and was having trouble with his vision. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 5/13/25 at 10:54 a.m., indicated the resident was admitted to the hospital with congestive heart failure. He returned to the facility on 5/16/25.

There was no documentation that the resident had received a

copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

4. The closed record for Resident 8 was reviewed on 7/7/25 at 3:17 p.m. Diagnoses included, but were not limited to, complicated urinary tract infection and rhabdomyolysis.

A Nurse's Note, dated 1/22/25 at 9:07 a.m., indicated the resident was found sitting on the floor in front of the sink in her room. She indicated she had fallen out of bed and now her leg would not work. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 1/22/25 at 10:16 a.m., indicated the resident was admitted to the hospital with a right hip fracture. She returned to the facility on 2/16/25.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice.

During an interview on 7/8/25 at 11:08 a.m., the Director of Nursing (DON) indicated they had not provided the notice of transfer/discharge.

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.	R 0090	Resident # 8 was not affected by this finding. A review of the nursing notes for all residents will be conducted by the Director of Nursing and Executive Director or Designee to identify any situations meeting the Indiana Department of Health “Incident Reporting Policy.” This review will be done 5 days a week for 30 days or until 100 percent compliance is achieved.	07/28/2025

	(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure a fracture was reported to the Indiana Department of Health (IDOH) for 1 of 7 residents reviewed. (Resident 8) Finding includes: The closed record for Resident 8 was reviewed on 7/7/25 at 3:17 p.m. Diagnoses included, but were not limited to,			

complicated urinary tract infection and rhabdomyolysis.

A Nurse's Note, dated 1/22/25 at 9:07 a.m., indicated the resident was found sitting on the floor in front of the sink in her room. She indicated she had fallen out of bed and now her leg would not work. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 1/22/25 at 10:16 a.m., indicated the resident was admitted to the hospital with a right hip fracture. She returned to the facility on 2/16/25.

During an interview on 7/8/25 at 11:26 a.m., the Administrator indicated she was aware of the fracture but could not find where she had reported it to the Indiana Department of Health.

The Indiana Department of Health Long Term Care Abuse and Incident Reporting Policy, updated 12/6/22, indicated "...Licensed Residential Care Facilities...C. Types of incidents reportable under state rules. Any occurrence that directly threatens the welfare, safety, or health of a resident, such as:...10. Major accidents: Required to report examples include but are not limited to: a. All fractures..."

Based on record review and interview, the facility failed to

ensure a fracture was reported to the Indiana Department of Health (IDOH) for 1 of 7 residents reviewed. (Resident 8)

Finding includes:

The closed record for Resident 8 was reviewed on 7/7/25 at 3:17 p.m. Diagnoses included, but were not limited to, complicated urinary tract infection and rhabdomyolysis.

A Nurse's Note, dated 1/22/25 at 9:07 a.m., indicated the resident was found sitting on the floor in front of the sink in her room. She indicated she had fallen out of bed and now her leg would not work. 911 was called and the resident was sent to the hospital for evaluation.

A Nurse's Note, dated 1/22/25 at 10:16 a.m., indicated the resident was admitted to the hospital with a right hip fracture. She returned to the facility on 2/16/25.

During an interview on 7/8/25 at 11:26 a.m., the Administrator indicated she was aware of the fracture but could not find where she had reported it to the Indiana Department of Health.

The Indiana Department of Health Long Term Care Abuse and Incident Reporting Policy, updated 12/6/22, indicated "...Licensed Residential Care Facilities...C. Types of incidents

	reportable under state rules. Any occurrence that directly threatens the welfare, safety, or health of a resident, such as:...10. Major accidents: Required to report examples include but are not limited to: a. All fractures..."			
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. Based on record review and interview, the facility failed to ensure the needs assessment included the resident's weight upon admission for 1 of 7 resident records reviewed.	R 0216	Resident #2 was not affected by this citation. An audit was completed of all other residents who were admitted, to ensure an admission weight was present. No other admission weights were missing. The Licensed Nurse will continue to be responsible for ensuring weight is documented on admission. The Director of Nursing /Designee will conduct in-services with nursing staff regarding timely completion of admission. Director of Nursing/Designee will review all admissions 5 days per week for the next 30 or until 100% compliance is achieved.	07/28/2025

	(Resident 2) Finding includes: The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke. The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment. The assessment lacked the resident's weight. During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing indicated the resident's weight should have been included in the admission assessment. Based on record review and interview, the facility failed to ensure the needs assessment included the resident's weight upon admission for 1 of 7 resident records reviewed. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke. The 6/25/25 Admission Assessment indicated the			

	resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment. The assessment lacked the resident's weight. During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing indicated the resident's weight should have been included in the admission assessment.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.	R 0241	Resident #9 was not affected by this citation. Resident #11 was not affected by this citation; additional vitamins administered as per orders.The Licensed Nurse will continue to be responsible for ensuring Medications are administered per Physician orders. The Director of Nursing Designee will conduct in-services with nursing staff on Medication Administration and priming insulin pen prior to administration. Director of Nursing/Designee will review Medication Administration 5 days per week for the next 30days or until 100% compliance is achieved.	07/28/2025

	Based on observation, record review, and interview the facility failed to ensure medications were administered as ordered, insulin pens were primed before use, and home health services were arranged timely related for wound care for 1 of 7 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 11, 9, and 2) Findings include: 1. On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The LPN placed one Preservision tablet (an eye vitamin) into the medication cup with the other pills the resident was going to receive and administered them to the resident. The record for Resident 11 was reviewed on 7/8/25 at 10:30 a.m. A Physician's Order, dated 6/9/25, indicated the resident was to receive Preservision AREDS 2, take two tablets every morning. During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing indicated the resident should have received two Preservision tablets as ordered. 2. On 7/7/25 at 4:20 p.m., RN 1 was observed preparing Resident 9's medications, which			

	included a Humalog insulin pen (insulin lispro, fast-acting insulin) and a Humalog 75-25 mix insulin pen (insulin lispro protamine/insulin lispro mix, intermediate-acting insulin/fast-acting insulin mix). RN 1 removed the resident's Humalog 75-25 insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 40 units, cleaned the resident's right arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. RN 1 removed the resident's Humalog insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 6 units, cleaned the resident's left arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. During an interview on 7/7/25 at 4:43 p.m., RN 1 indicated she had not primed the insulin pens prior to administering the injections. The insulin pens were primed when they were new and first opened. During an interview on 7/7/25 at			

	5:16 p.m., the Director of Nursing was made aware that RN 1 had not primed the insulin pens prior to administering the insulin. The applicable policy was requested. A policy titled, Injectable Medication Administration, received from the Director or Nursing as current, indicated "...Insulin Pen Technique...Prime [per manufacturers recommendation] prior to each injection..." 3. On 7/8/25 at 10:41 a.m., an undated dressing was observed to Resident 2's right lower leg. The resident indicated the bandage was covering a skin tear from when she fell prior to admission to the facility. The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke. The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment. A 6/27/25 Physician's Order indicated home health services for right leg wound care. The resident's record lacked a nursing assessment or documentation of a leg wound.			

The record lacked visit notes or any documentation of home health services provided.

During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing (DON) indicated the resident's wound and wound care from home health services should have been included in the admission assessment and service plan. She did not know what kind of wound the resident had or if the home health nurse had been providing wound care. The DON indicated she could not find documentation of visits from the home health nurse.

Based on observation, record review, and interview the facility failed to ensure medications were administered as ordered, insulin pens were primed before use, and home health services were arranged timely related for wound care for 1 of 7 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 11, 9, and 2)

Findings include:

1. On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The LPN placed one Preservision tablet (an eye vitamin) into the medication cup with the other pills the resident was going to receive and administered them to the resident.

	The record for Resident 11 was reviewed on 7/8/25 at 10:30 a.m. A Physician's Order, dated 6/9/25, indicated the resident was to receive Preservision AREDS 2, take two tablets every morning. During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing indicated the resident should have received two Preservision tablets as ordered. 2. On 7/7/25 at 4:20 p.m., RN 1 was observed preparing Resident 9's medications, which included a Humalog insulin pen (insulin lispro, fast-acting insulin) and a Humalog 75-25 mix insulin pen (insulin lispro protamine/insulin lispro mix, intermediate-acting insulin/fast-acting insulin mix). RN 1 removed the resident's Humalog 75-25 insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 40 units, cleaned the resident's right arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. RN 1 removed the resident's Humalog insulin pen from the medication drawer and put the needle on the pen.			

She donned gloves, dialed the pen to 6 units, cleaned the resident's left arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer.

During an interview on 7/7/25 at 4:43 p.m., RN 1 indicated she had not primed the insulin pens prior to administering the injections. The insulin pens were primed when they were new and first opened.

During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not primed the insulin pens prior to administering the insulin. The applicable policy was requested.

A policy titled, Injectable Medication Administration, received from the Director or Nursing as current, indicated "...Insulin Pen Technique...Prime [per manufacturers recommendation] prior to each injection..."

3. On 7/8/25 at 10:41 a.m., an undated dressing was observed to Resident 2's right lower leg. The resident indicated the bandage was covering a skin tear from when she fell prior to admission to the facility.

The record for Resident 2 was

reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke.

The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment.

A 6/27/25 Physician's Order indicated home health services for right leg wound care.

The resident's record lacked a nursing assessment or documentation of a leg wound. The record lacked visit notes or any documentation of home health services provided.

During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing (DON) indicated the resident's wound and wound care from home health services should have been included in the admission assessment and service plan. She did not know what kind of wound the resident had or if the home health nurse had been providing wound care. The DON indicated she could not find documentation of visits from the home health nurse.

Based on observation, record review, and interview the facility failed to ensure medications were administered as ordered, insulin pens were primed before use, and home health services

	were arranged timely related for wound care for 1 of 7 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 11, 9, and 2) Findings include: 1. On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The LPN placed one Preservision tablet (an eye vitamin) into the medication cup with the other pills the resident was going to receive and administered them to the resident. The record for Resident 11 was reviewed on 7/8/25 at 10:30 a.m. A Physician's Order, dated 6/9/25, indicated the resident was to receive Preservision AREDS 2, take two tablets every morning. During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing indicated the resident should have received two Preservision tablets as ordered. 2. On 7/7/25 at 4:20 p.m., RN 1 was observed preparing Resident 9's medications, which included a Humalog insulin pen (insulin lispro, fast-acting insulin) and a Humalog 75-25 mix insulin pen (insulin lispro protamine/insulin lispro mix, intermediate-acting			

	insulin/fast-acting insulin mix). RN 1 removed the resident's Humalog 75-25 insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 40 units, cleaned the resident's right arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. RN 1 removed the resident's Humalog insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 6 units, cleaned the resident's left arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. During an interview on 7/7/25 at 4:43 p.m., RN 1 indicated she had not primed the insulin pens prior to administering the injections. The insulin pens were primed when they were new and first opened.			

During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not primed the insulin pens prior to administering the insulin. The applicable policy was requested.

A policy titled, Injectable Medication Administration, received from the Director or Nursing as current, indicated "...Insulin Pen Technique...Prime [per manufacturers recommendation] prior to each injection..."

3. On 7/8/25 at 10:41 a.m., an undated dressing was observed to Resident 2's right lower leg. The resident indicated the bandage was covering a skin tear from when she fell prior to admission to the facility.

The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke.

The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment.

A 6/27/25 Physician's Order indicated home health services for right leg wound care.

The resident's record lacked a nursing assessment or

documentation of a leg wound. The record lacked visit notes or any documentation of home health services provided.

During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing (DON) indicated the resident's wound and wound care from home health services should have been included in the admission assessment and service plan. She did not know what kind of wound the resident had or if the home health nurse had been providing wound care. The DON indicated she could not find documentation of visits from the home health nurse.

Based on observation, record review, and interview the facility failed to ensure medications were administered as ordered, insulin pens were primed before use, and home health services were arranged timely related for wound care for 1 of 7 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 11, 9, and 2)

Findings include:

1. On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The LPN placed one Preservision tablet (an eye vitamin) into the medication cup with the other pills the resident was going to receive and administered them

to the resident.

The record for Resident 11 was reviewed on 7/8/25 at 10:30 a.m.

A Physician's Order, dated 6/9/25, indicated the resident was to receive Preservision AREDS 2, take two tablets every morning.

During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing indicated the resident should have received two Preservision tablets as ordered.

2. On 7/7/25 at 4:20 p.m., RN 1 was observed preparing Resident 9's medications, which included a Humalog insulin pen (insulin lispro, fast-acting insulin) and a Humalog 75-25 mix insulin pen (insulin lispro protamine/insulin lispro mix, intermediate-acting insulin/fast-acting insulin mix).

RN 1 removed the resident's Humalog 75-25 insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 40 units, cleaned the resident's right arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. RN 1 removed the resident's Humalog insulin pen from the medication drawer

and put the needle on the pen. She donned gloves, dialed the pen to 6 units, cleaned the resident's left arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer.

During an interview on 7/7/25 at 4:43 p.m., RN 1 indicated she had not primed the insulin pens prior to administering the injections. The insulin pens were primed when they were new and first opened.

During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not primed the insulin pens prior to administering the insulin. The applicable policy was requested.

A policy titled, Injectable Medication Administration, received from the Director or Nursing as current, indicated "...Insulin Pen Technique...Prime [per manufacturers recommendation] prior to each injection..."

3. On 7/8/25 at 10:41 a.m., an undated dressing was observed to Resident 2's right lower leg. The resident indicated the bandage was covering a skin tear from when she fell prior to admission to the facility.

	The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke. The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment. A 6/27/25 Physician's Order indicated home health services for right leg wound care. The resident's record lacked a nursing assessment or documentation of a leg wound. The record lacked visit notes or any documentation of home health services provided. During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing (DON) indicated the resident's wound and wound care from home health services should have been included in the admission assessment and service plan. She did not know what kind of wound the resident had or if the home health nurse had been providing wound care. The DON indicated she could not find documentation of visits from the home health nurse. Based on observation, record review, and interview the facility failed to ensure medications were administered as ordered, insulin pens were primed before			

use, and home health services were arranged timely related for wound care for 1 of 7 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 11, 9, and 2)

Findings include:

1. On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The LPN placed one Preservision tablet (an eye vitamin) into the medication cup with the other pills the resident was going to receive and administered them to the resident.

The record for Resident 11 was reviewed on 7/8/25 at 10:30 a.m.

A Physician's Order, dated 6/9/25, indicated the resident was to receive Preservision AREDS 2, take two tablets every morning.

During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing indicated the resident should have received two Preservision tablets as ordered.

2. On 7/7/25 at 4:20 p.m., RN 1 was observed preparing Resident 9's medications, which included a Humalog insulin pen (insulin lispro, fast-acting insulin) and a Humalog 75-25 mix insulin pen (insulin lispro protamine/insulin lispro mix,

	intermediate-acting insulin/fast-acting insulin mix). RN 1 removed the resident's Humalog 75-25 insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 40 units, cleaned the resident's right arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. RN 1 removed the resident's Humalog insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 6 units, cleaned the resident's left arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. During an interview on 7/7/25 at 4:43 p.m., RN 1 indicated she had not primed the insulin pens prior to administering the injections. The insulin pens were primed when they were new and first opened. During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not primed the insulin pens prior to administering the insulin. The applicable policy			

was requested.

A policy titled, Injectable Medication Administration, received from the Director or Nursing as current, indicated "...Insulin Pen Technique...Prime [per manufacturers recommendation] prior to each injection..."

3. On 7/8/25 at 10:41 a.m., an undated dressing was observed to Resident 2's right lower leg. The resident indicated the bandage was covering a skin tear from when she fell prior to admission to the facility.

The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke.

The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment.

A 6/27/25 Physician's Order indicated home health services for right leg wound care.

The resident's record lacked a nursing assessment or documentation of a leg wound. The record lacked visit notes or any documentation of home health services provided.

During an interview on 7/7/25 at

4:40 p.m., the Director of Nursing (DON) indicated the resident's wound and wound care from home health services should have been included in the admission assessment and service plan. She did not know what kind of wound the resident had or if the home health nurse had been providing wound care. The DON indicated she could not find documentation of visits from the home health nurse.

Based on observation, record review, and interview the facility failed to ensure medications were administered as ordered, insulin pens were primed before use, and home health services were arranged timely related for wound care for 1 of 7 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 11, 9, and 2)

Findings include:

1. On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The LPN placed one Preservision tablet (an eye vitamin) into the medication cup with the other pills the resident was going to receive and administered them to the resident.

The record for Resident 11 was reviewed on 7/8/25 at 10:30 a.m.

A Physician's Order, dated

	6/9/25, indicated the resident was to receive Preservision AREDS 2, take two tablets every morning. During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing indicated the resident should have received two Preservision tablets as ordered. 2. On 7/7/25 at 4:20 p.m., RN 1 was observed preparing Resident 9's medications, which included a Humalog insulin pen (insulin lispro, fast-acting insulin) and a Humalog 75-25 mix insulin pen (insulin lispro protamine/insulin lispro mix, intermediate-acting insulin/fast-acting insulin mix). RN 1 removed the resident's Humalog 75-25 insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 40 units, cleaned the resident's right arm with an alcohol swab, and administered the injection. She had not primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer. RN 1 removed the resident's Humalog insulin pen from the medication drawer and put the needle on the pen. She donned gloves, dialed the pen to 6 units, cleaned the resident's left arm with an alcohol swab, and administered the injection. She had not			

primed the insulin pen prior to administering the injection. She removed her gloves and used hand sanitizer.

During an interview on 7/7/25 at 4:43 p.m., RN 1 indicated she had not primed the insulin pens prior to administering the injections. The insulin pens were primed when they were new and first opened.

During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not primed the insulin pens prior to administering the insulin. The applicable policy was requested.

A policy titled, Injectable Medication Administration, received from the Director or Nursing as current, indicated "...Insulin Pen Technique...Prime [per manufacturers recommendation] prior to each injection..."

3. On 7/8/25 at 10:41 a.m., an undated dressing was observed to Resident 2's right lower leg. The resident indicated the bandage was covering a skin tear from when she fell prior to admission to the facility.

The record for Resident 2 was reviewed on 7/7/25 at 10:40 a.m. Diagnoses included, but were not limited to, spinal stenosis, diabetes, and stroke.

	The 6/25/25 Admission Assessment indicated the resident required physical assistance with transfers and hygiene/dressing, and had mild cognitive impairment. A 6/27/25 Physician's Order indicated home health services for right leg wound care. The resident's record lacked a nursing assessment or documentation of a leg wound. The record lacked visit notes or any documentation of home health services provided. During an interview on 7/7/25 at 4:40 p.m., the Director of Nursing (DON) indicated the resident's wound and wound care from home health services should have been included in the admission assessment and service plan. She did not know what kind of wound the resident had or if the home health nurse had been providing wound care. The DON indicated she could not find documentation of visits from the home health nurse.			
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	R 0273	No residents were affected by these findings. The kitchen and food preparation areas were not included in this finding. In the walk-in freezer the frozen items noted were immediately removed and discarded.	07/28/2025

	standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to maintain proper food sanitation related to unlabeled, undated, and expired food, sticky and dirty stored food containers, and dirty floors. This had the potential to affect the 97 residents who received food from the kitchen. Findings include: On 7/7/25 at 9:05 a.m., during the initial tour of the kitchen with Cook 1, the following was observed: 1. In the walk-in freezer, there were opened and undated packages of meatballs, hash browns, and vegetables. A box of frozen corn was open, uncovered, and undated. Several loose hush puppies were observed on a shelf. 2. In the dry storage area, there were opened and undated boxes of pasta, powdered mashed potatoes, snack cakes, and crackers. On a bottom shelf, there were 6 large plastic jugs of sauces coated in a brown sticky residue. There was an opened plastic jug of soy sauce with a manufacturer's expiration date of July 2020. There was an opened plastic jug of red cooking wine with a manufacturer's expiration date		The dry storage area was cleaned and open items were discarded. The flour was within its expiration date but the bin was not dated. The flour was discarded and replaced and dated. Staff inservices to be held addressing these findings. Kitchen Manager or Designee will monitor these areas of concern weekly for 30 days or until 100% compliance is achieved	

	of August 2022. The floor underneath the shelves was dirty with dark, sticky spillage. 3. In the cooking area, there was a large unlabeled and undated plastic bin filled with white powder. During an interview on 7/7/25 at 9:20 a.m., Cook 1 indicated food items should have been labeled when they were opened, and disposed of by the manufacturer's expiration date. He indicated the bin in the cooking area should have been labeled as containing flour and dated for when it was filled. During an interview on 7/7/25 at 12:05 p.m., the Kitchen Manager indicated all food items should be dated when they were brought in and when they were opened. All food should have been covered or contained. The floor needed to be cleaned and expired items disposed of. A policy titled, "Sanitation and Infection Control", received as current from the Administrator on 7/7/25 at 2:00 p.m., indicated, " ... The Culinary Department follows federal, state, and local regulations to ensure individuals are provided safe and sanitary food, which includes: ... Covering, labeling and dating all stored food items ... Using foods with expiration			

dates prior to the date on the package and leftovers within 72 hours ...".

Based on observation, record review, and interview, the facility failed to maintain proper food sanitation related to unlabeled, undated, and expired food, sticky and dirty stored food containers, and dirty floors. This had the potential to affect the 97 residents who received food from the kitchen.

Findings include:

On 7/7/25 at 9:05 a.m., during the initial tour of the kitchen with Cook 1, the following was observed:

1. In the walk-in freezer, there were opened and undated packages of meatballs, hash browns, and vegetables. A box of frozen corn was open, uncovered, and undated. Several loose hush puppies were observed on a shelf.

2. In the dry storage area, there were opened and undated boxes of pasta, powdered mashed potatoes, snack cakes, and crackers. On a bottom shelf, there were 6 large plastic jugs of sauces coated in a brown sticky residue. There was an opened plastic jug of soy sauce with a manufacturer's expiration date of July 2020. There was an opened plastic jug of red cooking wine with a

	manufacturer's expiration date of August 2022. The floor underneath the shelves was dirty with dark, sticky spillage. 3. In the cooking area, there was a large unlabeled and undated plastic bin filled with white powder. During an interview on 7/7/25 at 9:20 a.m., Cook 1 indicated food items should have been labeled when they were opened, and disposed of by the manufacturer's expiration date. He indicated the bin in the cooking area should have been labeled as containing flour and dated for when it was filled. During an interview on 7/7/25 at 12:05 p.m., the Kitchen Manager indicated all food items should be dated when they were brought in and when they were opened. All food should have been covered or contained. The floor needed to be cleaned and expired items disposed of. A policy titled, "Sanitation and Infection Control", received as current from the Administrator on 7/7/25 at 2:00 p.m., indicated, " ... The Culinary Department follows federal, state, and local regulations to ensure individuals are provided safe and sanitary food, which includes: ... Covering, labeling and dating all stored food items			

	... Using foods with expiration dates prior to the date on the package and leftovers within 72 hours ...".			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, record review, and interview, the facility failed to ensure over-the-counter (OTC) medications were labeled with the resident and physician names for 1 of 5 residents observed during medication administration. (Resident 11) Finding includes: On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The resident was going to receive Vitamin D, a probiotic, Preservision AREDS 2, and a calcium supplement. The medications were purchased	R 0302	The Licensed Nurse will continue to be responsible for ensuring all medications are labeled appropriately. An audit was completed, and no other residents were lacking medication labels. The Director of Nursing Designee will conduct in-services with nursing staff on completion of labeling all medications. Director of Nursing/Designee will review medication Drawers 3 days per week for the next or until 100% compliance is achieved	07/28/2025

over-the-counter by the resident's family. The bottles were not labeled with the resident's name or the physician's name.

During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing (DON) indicated the OTC bottles should have been labeled properly.

The facility policy titled, "Medication Labels", was provided by the DON and identified as current on 7/8/25 at 3:13 p.m. The policy indicated medications should be listed with the resident's name and room number and the prescriber's name.

Based on observation, record review, and interview, the facility failed to ensure over-the-counter (OTC) medications were labeled with the resident and physician names for 1 of 5 residents observed during medication administration. (Resident 11)

Finding includes:

On 7/8/25 at 9:30 a.m., LPN 1 was observed preparing Resident 11's medications. The resident was going to receive Vitamin D, a probiotic, Preservision AREDS 2, and a calcium supplement. The medications were purchased over-the-counter by the resident's family. The bottles

	were not labeled with the resident's name or the physician's name. During an interview on 7/8/25 at 11:30 a.m., the Director of Nursing (DON) indicated the OTC bottles should have been labeled properly. The facility policy titled, "Medication Labels", was provided by the DON and identified as current on 7/8/25 at 3:13 p.m. The policy indicated medications should be listed with the resident's name and room number and the prescriber's name.			

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 observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to lack of glove use with blood glucose monitoring for 1 of 5 residents observed during medication administration. (Resident 9) Finding includes: On 7/7/25 at 4:20 p.m., RN 1 was observed preparing to check Resident 9's blood glucose. She washed her hands and cleaned the resident's left ring finger with an alcohol swab. She put the strip in the glucometer then took the lancet	R 0407	Resident #9 was not affected by this citation. The Director of Nursing completed a random audit to observe nursing staff glove compliance. No other concerns were noted. The Licensed Nurse will continue to be responsible for ensuring infection control practices are met at all times. The Director of Nursing Designee will conduct in-services with nursing staff on infection control practices. Director of Nursing/Designee will randomly observe nursing staff 3 days per week for the next or until 100% compliance is achieved.	07/28/2025

and punctured the resident's finger. She applied the blood sample to the test strip and the blood glucose reading was 292. She disposed of the lancet and the test strip and used hand sanitizer. RN 1 had not worn gloves during the procedure.

During an interview on 7/7/25 at 4:25 p.m., RN 1 indicated she had not worn gloves because the resident did not like them.

During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not worn gloves when checking the resident's blood sugar. The applicable policy was requested.

A policy, titled Glucose Monitoring in LTC Facilities, received from the Director or Nursing as current, indicated "...When testing blood sugars as ordered, ensure the area is cleaned. Staff should be wearing gloves..."

Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to lack of glove use with blood glucose monitoring for 1 of 5 residents observed during medication administration. (Resident 9)

Finding includes:

On 7/7/25 at 4:20 p.m., RN 1

	was observed preparing to check Resident 9's blood glucose. She washed her hands and cleaned the resident's left ring finger with an alcohol swab. She put the strip in the glucometer then took the lancet and punctured the resident's finger. She applied the blood sample to the test strip and the blood glucose reading was 292. She disposed of the lancet and the test strip and used hand sanitizer. RN 1 had not worn gloves during the procedure. During an interview on 7/7/25 at 4:25 p.m., RN 1 indicated she had not worn gloves because the resident did not like them. During an interview on 7/7/25 at 5:16 p.m., the Director of Nursing was made aware that RN 1 had not worn gloves when checking the resident's blood sugar. The applicable policy was requested. A policy, titled Glucose Monitoring in LTC Facilities, received from the Director or Nursing as current, indicated "...When testing blood sugars as ordered, ensure the area is cleaned. Staff should be wearing gloves..."				

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

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

SIGNATURE		