

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2026
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 5829 EAST 116TH STREET, CARMEL, , 46033			
(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 Intakes 470189, 469808 and 466360. Intake 470189-State deficiencies related to the allegations are cited at R36. Intake 469808-No deficiencies related to the allegations are cited. Intake 466360-No deficiencies related to the allegations are cited. Survey dates: August 6 and 7, 2026. Facility number: 013217 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed	R 0000			

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	on August 13, 2026.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure the physician was notified of the need to alter treatment, and an order was obtained before the use of a seatbelt for 1 of 1 resident reviewed for notification. (Resident C) Findings include: The clinical record for Resident C was reviewed on 8/6/26 at 10:50 a.m. The diagnoses included, but was not limited to Parkinson's disease, dementia, and glaucoma. A facility event note, created on	R 0036	Once Divisional Director of Health & Wellness noted the intervention on resident's chart, the then Health & Wellness Director was suspended pending investigation. During investigation, it was noted that resident's spouse applied seatbelt. The resident was constantly taking it off and the wife stopped reapplying it. Resident was checked upon frequently. There was no adverse effect on the resident as a result of this finding as he was able to remove the seatbelt as needed. The Health & Wellness Director was terminated on 06/30/2026 for failing to obtain physician's order for the seatbelt. TheDivisional Director of Health & Wellness educated the Executive Director, Health & Wellness Coordinator and all branch leaders during the Higher Path Council Meeting on 06/24/2026 on Restraint and the requirement to obtain physician order for seatbelt. On 08/11/2026, theDivisional	09/03/2026

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5/26/26, indicated Resident C stood up from his wheelchair and fell on his bottom in the dining room. A Velcro seatbelt was placed on the wheelchair for a fall intervention.

A family communication note, created on 6/2/26, indicated the facility spoke with Resident C's wife related to the need for 1:1 monitoring due to his risk of falls. Resident C's wife indicated she could not afford to pay for a 1:1. The Health and Wellness Director discussed a wheelchair seatbelt with Resident C's wife. The wife thought it was a good idea and ordered one. The Health and Wellness Director would reach out to the physician.

Licensed Practical Nurse (LPN) 4, updated the note 2 months ago, which indicated the resident's seat belt clip continuously came detached from the strap. The Health and Wellness Director was notified of the issue with the seatbelt, and communication with the spouse.

LPN 4 updated the note 1 month ago, which indicated Resident C's spouse asked about the seatbelt for the resident. The Velcro seatbelt provided by the resident spouse was on the wheelchair currently. The spouse asked about the old

Director of Health & Wellness educated the new Health & Wellness Director on Restraint and the requirement to obtain physician order for seatbelt.

The Divisional Director of Health & Wellness will review all residents' chart and documentation to ensure compliance by 08/31/2026.

The Divisional Director of Health & Wellness or designee will continue to review all residents' chart and documentation weekly until 09/30/2026 and as needed afterwards.

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seatbelt and was advised that the discussion regarding the seatbelt would need to be held with the Health and Wellness Director as the nurse had not received an order for the seatbelt at this time. The issue was discussed with hospice, on 6/10/26, related to the availability/status of the seat belt order and was advised the was no order currently.

There was no documentation, the facility contacted the physician, or a physician's order was obtained for a seatbelt.

There was no assessment documented in the medical record for the use of a seatbelt.

During an interview, on 8/6/26 at 11:50 a.m., the Regional Nursing officer and the Executive Director (ED) indicated this incident happened with the prior Health and Wellness Director. She had been terminated. She never obtained an order for the use of the seatbelt. There was no assessment documented prior to the seatbelt being placed on the wheelchair. There was communication with hospice when it was applied but still no order was obtained. The facility should document an assessment, and an assessment was not documented. The facility should

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	contact the physician to ensure it was not a restraint and obtain a physician's order prior to use. During an interview, on 8/7/26 at 11:30 a.m., the ED indicated the previous Health and Wellness Director was terminated related to this incident. The facility did not have a restraint policy but was supposed to obtain an order and document an assessment prior to placing a seatbelt on a wheelchair. The facility followed all state regulations. This citation relates to intake number 470189.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect, when a	R 0052	The resident was safely returned to the facility. He was assessed by the Executive Director, RN and no physical injuries were observed. Health & Wellness Director updated Resident's care summary and added a nursing task for wander guard checks. All other residents with risk of elopement were reviewed and wander guard is to be applied by 08/30/2026	09/03/2026

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	resident with a diagnosis of dementia and a high risk for elopement wandered away from the facility for an undetermined amount of time for 1 of 1 resident reviewed for neglect. (Resident 6) This deficient practice resulted in Resident 6 exiting the facility without initiating an alarm and without staff knowledge, ambulating away from the facility, where he was found lying on the ground, 911 was called, and the resident sustained abrasions to his right hand and right knee. Findings include: During an interview, on 8/6/26 at 11:32 a.m., Resident 6's brother indicated the facility had called on 8/5/26 around 10:30 p.m., to let him know Resident 6 had been found outside the facility after falling by the local Emergency Medical Technicians (EMT). He indicated Resident 6 was a lifelong runner and used to run every day. He was worried Resident 6 could have gotten lost since getting lost was one of the first signs of Resident 6's dementia. He did not know how far the resident had gone or any of the details regarding the incident. The clinical record for Resident 6 was reviewed on 8/6/26 at 10:55 a.m. The diagnoses included, but were not limited to		The Executive Director submitted the state incident report for the elopement on 08/07/26 at 1404. The Divisional Director of Health & Wellness (DDHW) re-educated the Executive Director (ED) and Health & Wellness Director (HWD) on elopement prevention, incident reporting, and investigations. The HWD and ED re-educated all branch staff on wander guard checks and elopement protocols during mandatory staff meeting on 08/10/2026. The Maintenance Coordinator and ED completed a check of all resident monitoring systems and exit doors to ensure proper functioning on 08/10/2026.	
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dementia, Alzheimer's disease, delusions, generalized anxiety, hallucinations, and hypertension.

A facility "Getting to Know You" document, undated, indicated the resident was a life-long runner and had even completed in a marathon.

A mini-mental state examination, dated 7/29/25, indicated Resident 6 showed severe cognitive impairment.

A global deterioration scale, dated 3/9/26, indicated Resident 6 had a moderately severe cognitive decline. A resident with moderately severe cognitive decline could no longer survive without assistance with activities of daily living, often could not remember their address, was frequently disoriented to time or place, and could experience late day fatigue as evidenced by increased confusion or agitation.

A resident assessment, dated 5/29/26 at 1:10 p.m., indicated the resident was a high fall risk due to a history of falls, cognition, and medication use. His cognitive needs required frequent help due to disorientation, memory loss, poor safety awareness, poor judgment, disoriented to time and place, difficulty completing tasks, and was a moderate

The Divisional Director of Health & Wellness will be meeting with the branch leaders weekly to review elopement compliance and audits performed. The Divisional Director of Health & Wellness will audit documentation of residents monitoring weekly until 09/30/2026 and as needed afterwards.

elopement risk.

A psychiatric progress note, dated 6/26/26, indicated the resident was very confused, had a very disorganized thought process, poor short-term and long-term memory, severe impairment in judgement and insight, and an illogical thought process. The resident had progressing Alzheimer's disease with significant cognitive impairment consistent with advanced Alzheimer's disease.

A service plan, signed 6/26/26, indicated the resident was a high fall risk, wandered throughout the facility, required a wander guard device (an electronic safety monitoring device used in facilities to prevent elopement), frequent help due to disorientation, memory loss, and extensive interventions and care coordination to support dementia conditions.

A facility care log, dated June through August, indicated Resident 6 needed a wander guard. The care log did not indicate the placement or function of the wander guard was checked on any date or shift.

The physician orders for Resident 6 were reviewed and did not include an order for a wander guard device,

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	placement and function checks of the wander guard, or for safety checks before or after Resident 6's elopement. An elopement incident note, dated 8/5/26 at 10:44 p.m., indicated Resident 6 was transported back to the facility by EMTs, around 8:21 p.m., after an outside witness watched the resident fall while running and called 911. The Executive Director (ED), physician, and family were notified. The ED instructed the Qualified Medication Aide (QMA) to place a new wander guard device on the resident and to conduct safety checks for the next 24 hours. The resident had abrasions to his right hand and right knee. The weather, on 8/5/26 around 8:00 p.m., was partly cloudy and humid with temperatures between 80 and 85 degrees F (Fahrenheit). The resident was found on 116th St. (a 4-lane road with a speed limit of 40 miles per hour). He had passed 2 roundabout intersections with another 4-lane road and then a 2-lane road and was approximately 1 mile away from the facility. A nursing progress note, dated 8/5/26 at 10:47 p.m., indicated QMA 6 spoke with the ED and			
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received instructions to keep Resident 6 safe, place a new wander guard, and perform safety checks every hour for 24 hours.

During an observation, on 8/6/26 at 12:02 p.m., Resident 6 was in the dining room wearing mismatched shoes, one bright yellow shoe with a wander guard attached and one black shoe. He was oriented to person and unable to answer simple questions regarding his lunch.

During an observation, on 8/6/26 at 2:05 p.m., Resident 6 was wandering up and down the hallway between his apartment and the dining room.

During an observation, on 8/7/26 at 9:43 a.m., Resident 6 was finishing breakfast in the dining room and wearing one yellow shoe with a wander guard on it and one black shoe.

During an interview, on 8/6/26 at 2:15 p.m., the Executive Director (ED) indicated Resident 6 had refused to wear a wander guard after the elopement, so staff had placed it on his shoe. The QMA on duty had called her and told her about the elopement. She instructed the QMA to make sure the resident was safe, place a new wander guard on the resident, and perform safety checks for the next 24 hours. She did not

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return to the facility that evening to assess the resident, initiate an investigation of the incident, or report the elopement.

During an interview, on 8/6/26 at 3:08 p.m., CNA 10 indicated she did not see the resident elope because she was helping another resident take a shower. She did not hear any door alarms. QMA 6 told her the resident had been brought back to the facility by EMTs after a bystander called 911 when the resident had fallen. She indicated the resident was agitated and combative when he got back, so they gave him some space until he calmed down. They were then able to place a wander guard on one of his favorite shoes, but he does not wear shoes at bedtime. The resident would not let them place a wander guard on his ankle.

During an interview, on 8/6/26 at 3:30 p.m., the ED indicated Resident 6 had been able to break the wander guard off in the past. He had not liked it on his leg because he had some leg edema, so sometimes they had to place it on his shoe. She indicated she did not know how Resident 6 was able to get outside, but she suspected he did not have his wander guard on.

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During an interview, on 8/7/26 at 12:20 p.m., the ED indicated she did not report the elopement and did not have any further investigation information to provide.

A current facility policy, titled "Abuse and Neglect (IN)," dated 2/2025 and provided by the ED on entrance, indicated "...Executive Directors...who have reasonable cause to believe that a Resident is being, or has been...neglected...shall report the information immediately to the State licensure authority...."

A current facility policy, titled "Incident and Accident Report (IN)(HER)," dated 12/2024 and provided by the ED on 8/7/26 at 10:35 a.m., indicated "...Incidents...can include...resident elopements...."

A current facility policy, titled "Resident Monitoring Systems," undated and provided by the ED on 8/7/26 at 10:35 a.m., indicated "...Because safety is such a critical issue...it is important to remember the following: All equipment/device batteries are appropriately charged for each shift...Equipment is functioning and in working order...Ensure residents...are wearing...appropriate

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	equipment...."			
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	R 0090	This incident was reported to the state surveyors by the Executive Director verbally on 08/06/2026 while they were onsite and reported in the system on 08/07/2026 at 1404. On 08/10/2026, the Divisional Director of Health & Wellness re-educated the Executive Director and Health & Wellness Director on incident reporting and state agency notification. The Divisional Director of Health & Wellness will be reviewing significant incidents with branch leaders and ensure proper reporting to state agency is done.	08/31/2026

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	resident or resident's legal representative. (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 interview and record review, the facility failed to ensure an unusual occurrence was reported to the State agency for 1 of 1 resident reviewed for elopement. (Resident 6)			
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	Findings include: The clinical record for Resident 6 was reviewed on 8/6/26 at 10:55 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, delusions, generalized anxiety, hallucinations, and hypertension. A facility elopement incident note, dated 8/5/26 at 10:44 p.m., indicated the resident was transported back to the facility by EMTs (Emergency Medical Technicians), around 8:21 p.m., after an outside witness had called 911 after watching the resident fall while running. The resident had abrasions to his right hand and right knee. During an interview, on 8/6/26 at 2:15 p.m., the Executive Director (ED) indicated she had not started an investigation or reported the incident yet since. During an interview, on 8/6/26 at 3:30 p.m., the ED indicated she did not know how the resident was able to get outside, but she suspected he did not have his wander guard device on.			
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	During an interview, on 8/7/26 at 12:20 p.m., the ED indicated she did not have her login information at home, so she was unable to login to report the elopement. She had not reported the incident. A current facility policy, titled "Abuse and Neglect (IN)," dated 2/2025 and provided by the ED on entrance, indicated "...Executive Directors...shall report the information immediately to the State licensure authority...Reporting procedure will be for Executive Director to notify, within 24 hours...The State licensure authority and State Ombudsman within 24 hours...." A current facility policy, titled "Incident and Accident Report (IN)(HER)," dated 12/2024 and provided by the ED on 8/7/26 at 10:35 a.m., indicated "...Incidents...can include...resident elopements...Resident Incidents will be reported as required by State Licensing Agency...."			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in	R 0092	The Fire Department was notified on 08/19/2026 of our Fire Drill schedule and invited to participate. The responded stating they will be at the branch on 09/16/2026.	08/31/2026

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cases of emergency as follows:

(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on interview and record review, the facility failed to ensure documentation was provided to show the local fire department had been invited to participate in a fire/disaster drill at least every six (6) months.

Findings include:

The fire drill logs were reviewed on 8/6/26. The facility was unable to provide documentation to show the local fire department had been invited

The Executive Director re-educated the Maintenance Coordinator to invite the Fire Department to participate in Fire/Disaster Drill at least every 6 months.

The Executive Director will conduct audit every 6 months to ensure Fire department is invited at least every 6 months. This audits will be done going forward with no end date.

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	to attend or had attended a fire and disaster drill between 7/2025 to 7/2026. During an interview, on 8/6/26 at 3:03 p.m., Maintenance 2 indicated he had no documentation to show the fire department had been invited to observe/participate in a fire/disaster drill every six months. During an interview, on 8/7/26 at 11:34 a.m., the Executive Director indicated the facility did not have a policy which addressed fire department invitations for fire/disaster drills and the facility followed the State of Indiana regulations.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable.	R 0123	The Executive Director will complete job-specific orientation checklists and competency validations for CNA 8 and QMA 9 by 09/04/26. Divisional Director of Operations re-educated the Executive Director on the orientation checklist requirements on 08/14/26; Executive Director re-educated all branch leaders on completing job-specific orientation checklists with and validation by 09/04/26. Executive Director to complete a review	09/15/2026

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(5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure job specific orientation documentation was completed for 2 of 5 employees reviewed for employee records. (CNA 8 and QMA 9) Findings include: The employee records were reviewed on 8/7/26 at 10:30 a.m. CNA (Certified Nursing Assistant) 8 was hired on 3/3/26. There was no documentation to indicate job specific orientation had been completed. QMA (Qualified Medication Aide) 9 was hired on 6/16/26.		of all current employee files to ensure completed orientation checklists are present by 09/15/26. Executive Director will review all new hire files weekly for orientation checklists. Divisional Director of Operations will be meeting with the branch leaders weekly to review orientation compliance and audits performed until 09/15/26 and as needed afterwards.	
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	There was no documentation to indicate job specific orientation had been completed. During an interview, on 8/7/26 at 10:20 a.m., the ED (Executive Director) indicated when a nurse, QMA, or CNA was hired, they already had a certification and/or license so the facility would not need to re-train the employee for job specific skills. During an interview, on 8/7/26 at 11:06 a.m., an anonymous staff member indicated they did not get checked off on job specific skills once hired and prior to working on the floor without a preceptor or trainer. During an interview, on 8/7/26 at 11:45 a.m., the ED indicated the facility did not have a policy related to job specific orientation.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes	R 0246	The residents were checked upon by a licensed nurse and the as needed (PRN) administration was reviewed. There was no adverse effect on the residents as a result of the as needed (PRN) medication administered. On 08/19/2026 the Qualified Medication Aides (QMAs) were re-educated by the Health &	09/03/2026

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indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure a Qualified Medication Aide (QMA) obtained authorization prior to administering as needed (PRN) medications for 2 of 7 residents reviewed for medication administration. (Resident 4 and 6) Findings include: 1. The clinical record for Resident 4 was reviewed on 8/6/26 at 1:24 p.m. The diagnoses included, but were not limited to, bladder cancer and dementia. a. A physician's order, dated 12/16/24, indicated to administer acetaminophen (a pain-relieving medication) 500 milligrams (mg), 2 tablets, three times a day as needed (prn). On 5/2/26 at 8:16 p.m., two tablets of acetaminophen 500 mg were charted on the Medication Administration Record (MAR) as administered by QMA 6. There was no note in the clinical record or the MAR to indicate the nurse, or physician, had given authorization to administer the medication. On 5/12/26 at 9:50 p.m., two	Wellness Director and Executive Director on requirement to obtain authorization prior to administering as needed (PRN) medications. The Health & Wellness Director and/or designee will be auditing the medication administration record 2-3 days a week to ensure that if administration of as needed medications was done by QMAs, authorization was obtained prior to administration. The Divisional Director of Health & Wellness will be meeting with the Health & Wellness Director weekly to review the medication administration and ensure that Qualified Medication Aides (QMAs) obtain authorization prior to administering as needed (PRN) medications. This will be done through 09/30/2026 and monthly thereafter.	
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	tablets of acetaminophen 500 mg were charted on the Medication Administration Record as administered by QMA 6. There was no note in the clinical record or the MAR to indicate the nurse, or physician, had given authorization to administer the medication. b. A physician's order, dated 5/16/26, indicated to administer lorazepam (an antianxiety medication) 0.5 mg every four hours as needed for anxiety. On 6/3/26 at 9:50 a.m., 0.5 mg tablet of lorazepam was charted on the MAR as administered by QMA 7. There was no note in the clinical record or the MAR to indicate the nurse, or physician, had given authorization to administer the medication. 2. The clinical record for Resident 6 was reviewed on 8/6/26 at 10:55 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, delusions, generalized anxiety, hallucinations, and hypertension. A physician's order, dated 6/1/26, indicated to administer hydroxyzine 20 mg (milligrams) three times a day as needed for anxiety. The Medication Administration Record, dated July 2026,			
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	indicated a QMA administered Resident 6 an as needed (prn) hydroxyzine for restlessness or anxiety and assessed the effectiveness on 7/10/26 at 3:16 p.m., on 7/11/26 at 6:28 p.m., on 7/25/26 at 7:56 p.m., and on 7/28/26 at 7:28 p.m. There was no note in the clinical record or the MAR to indicate the nurse, or physician, had given authorization to administer the medication. During an interview, on 8/6/26 at 1:56 p.m., LPN 1 indicated if a resident required an as needed (prn) medication, the QMA was to inform the nurse so the nurse could assess the resident. The nurse would then inform the QMA whether to administer the medication. The QMA would note in the clinical record when the nurse authorized the medication administration. During an interview, on 8/6/26 at 1:56 p.m., QMA 3 indicated prior to administering an as needed (prn) medication, the nurse would be notified, assess the resident, and then authorize the medication administration. She would then document in the clinical record related to the administration. During an interview, on 8/7/26 at 12:15 p.m., the ED (Executive Director) indicated the QMA was supposed to document the			
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	nurse's assessment and approval in the MAR or EMR when an as needed medication was administered. A job description, titled "Medication Technician Job Description," not dated and provided by the ED on 8/7/26 at 9:45 a.m., indicated "...Administer medications to residents following established protocols...document medication administration...maintain accurate and up-to-date records of medication administration...adhere to state regulations, facility policies, and established medication administration guidelines...." A current facility policy, titled "Medication Management," not dated and provided by the ED on 8/7/26 at 11:35 a.m., indicated "...PRN medications...follow your state guidelines...."			
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	R 0273	All the residents were assessed by Health and Wellness Directors (including 2 Health and Wellness Directors from Ohio) from 08/16/2026 through 08/19/2026. There was no resident identified with food borne illness or gastrointestinal concerns as a result of this finding.	08/31/2026

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	interview, the facility failed to ensure the kitchen was maintained in a safe and sanitary manner in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 45 of 45 residents who received food from the kitchen. Findings include: During an initial kitchen tour, on 8/6/26 at 9:50 a.m., there was frozen cookie dough on a freezer thermometer, frozen ice cream stuck at the bottom of the freezer and a frozen "Core" water bottle in the freezer which was unlabeled and undated. In the reach in refrigerator, there was meat thawing at the bottom of the refrigerator which was not on a designated rack for thaw. The meat was sitting on top of unknown liquid/juices and puddles of liquid which was unknown. Cook 5 indicated the thermometer should not have frozen cookie dough on it and the frozen ice cream at the bottom of the freezer should have been cleaned. The meat should be thawing on a designated rack and not thawing in a puddle of unknown juices. During an initial kitchen tour, on 8/6/26 at 9:59 a.m., the sanitizer bucket was requested to be tested for concentration. Cook 5 indicated he did not have any		The Breadbasket Manager cleaned the freezer thermometer and floor, discarded the unlabeled water bottle, moved thawing meat to a designated rack, cleaned the refrigerator, and removed personal items on August 10, 2026. The Divisional Director of Operations re-educated the Executive Director and Breadbasket Manager on kitchen sanitation standards on 08/10/2026. The Breadbasket Manager during an in-service re-educated all dining staff on proper food storage, thawing, sanitizer testing, and personal item restrictions on 08/19/2026. The Breadbasket Manager will audit kitchen sanitation, food storage and labelling 2-3 days a week. The Executive Director will audit the kitchen weekly for sanitation, food storage and labelling until 09/30/2026 and every other week thereafter. DDO will be meeting with the branch leaders weekly to review	
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	test strips to test the solution, but he would look. During an interview, on 8/6/26 at 10:04 a.m., Cook 5 indicated he did not have any test strips to test the solution concentration. They should have test strips to test the solution. During a kitchen revisit, on 8/6/26 at 12:23 p.m., there were staff purses, keys, and jackets on top of a food preparation area. Cook 5 indicated staff should not have personal items in the food preparation areas. He told the staff who had a frozen water bottle in the freezer to remove it. During an interview, on 8/7/26 at 11:30 a.m., the Executive Director (ED) indicated the facility followed all state regulations. The facility did not have a policy for maintaining a sanitary kitchen.		kitchen sanitation compliance and audits performed until 09/30/2026.	
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.	R 0410	The resident received first step of tuberculosis testing on 08/11/2026 at 11:15AM and was read on 08/13/2026 at 3:25 PM. with a negative result. The Health and Wellness Director will perform audits of all residents' charts by 08/26/2026 to ensure two steps tuberculosis	08/31/2026

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OMB NO. 0938-0391

(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

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

Based on interview and record review, the facility failed to ensure tuberculosis skin tests were completed prior to, or upon, admission for 1 of 7 residents reviewed for tuberculosis testing. (Resident 19)

Findings include:

The clinical record for Resident 19 was reviewed on 8/6/26 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and hallucinations.

test was performed on all other residents.

The Divisional Director of Health & Wellness re-educated the Health and Wellness Director and the Executive Director on facility policy on tuberculosis testing on 08/11/2026.

The Divisional Director of Health & Wellness and/or designee will be auditing all new residents' charts to ensure tuberculosis testing is done upon admission.

A physician's admission order document, dated 6/25/25, indicated Resident 19's tuberculosis test had not been administered and would be completed by the facility.

Resident 19 was admitted to the facility on 7/31/25.

The Medication Administration Record (MAR), dated July and August 2025, did not include an order, administration, or results of an admission tuberculosis test.

During an interview, on 8/6/26 at 11:29 a.m., the Executive Director (ED) indicated a resident's tuberculosis test would be documented in the physician's admission orders, uploaded to the documents tab of the electronic health record, or kept in a binder. The ED could not find Resident 19's step 1 or step 2 tuberculosis test in the binder or in the electronic health record and indicated the tuberculosis test had not been completed.

A current facility policy, titled "Tuberculosis Screening-Resident (IL, IN, OH)", dated 04/2025 and received from the ED on 8/7/26 at 10:57 a.m., indicated "...Tuberculosis (TB) screening will be done at the time of move-in on all new Residents...Upon move-in, all

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Resident must undergo a two-step Mantoux Purified Protein Derivate (PPD) testing to ensure that they are not infected with tuberculosis...."			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREDalton Opole Owah	TITLEDivisional Director of Health & Wellness	(X6) DATE08/25/2026
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