

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 09/02/2026	
NAME OF PROVIDER OR SUPPLIER VILLAS OF HOLLY BROOK INDIANA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1941 W US HIGHWAY 40, BRAZIL, , 47834					
(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. Survey dates: September 1 and 2, 2026 Facility number: 013946 Residential Census: 60 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 15, 2026.	R 0000					
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,	R 0216	Employees were in-serviced regarding monthly weights and vitals.		09/24/2026		

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 observation, record review, and interview, the facility failed to ensure a resident was weighed per his care plan and facility policy for 1 of 7 residents records reviewed (Resident 055).

Findings include:

During the initial observation, on 9/1/26 at 10:52 a.m., Resident 055 was observed in the therapy gym practicing using a handled device to put on his socks. His legs and feet were observed to be swollen. At the same time, he indicated he had gained so much weight when he was in the nursing home prior to his coming to the assisted living facility. His feet and lower legs had been swollen for quite some time. He believed it was due to his poor circulation and inability to walk like he once did.

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Resident 055's record was reviewed on 9/1/26 at 11:20 a.m. The profile indicated the resident had been admitted to the assisted living facility on 6/18/26, for diagnoses that included, but were not limited to, spinal stenosis of the lumbar region (the narrowing of the spinal canal in the lower back, which can squeeze the nerves and cause pain or numbness in the legs), spondylolisthesis (a spinal condition where one of the back bones [vertebrae] slips out of place and moves forward over the bone beneath it), and essential hypertension (high blood pressure).

An admission care plan indicated the resident would be weighed monthly. The record lacked documentation that the resident had been weighed since his admission on 6/18/26.

During an interview, on 9/1/26 at 12:07 p.m., the resident indicated he could not remember being weighed by any staff since he had been at the facility. He was not aware that his care plan indicated he was to be weighed monthly.

During an interview, on 9/1/26 at 2:00 p.m., the Resident Care Coordinator indicated she could not find any documentation to indicate that the resident had been weighed since his

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	admission. The expectation was that his weight should have been obtained monthly. The facility policy was that all residents would be weighed monthly. On 9/1/26 at 2:25 p.m., the Executive Director provided a document, with a revision date of 3/26/19, titled, "Vital Signs," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: Vital signs and weight will be taken on all residents on a monthly basis ...Results will be documented according to established procedures in electronic health record (EHR). Procedures: ...3. Monthly vital sign readings should be recorded in the electronic health record (EHR)"			
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, interview, and record review, the facility failed to ensure beard restraints were worn in the kitchen and dining room during	R 0273	The employees were in-serviced regarding proper hand-washing techniques and when to wear hair/beard restraints. Hand washing step by step signs were also placed at all hand-washing stations to assist staff. Hair and beard restraint holders have been added to help remind staff to wear them when they enter the kitchen. The holders are also clear so that the staff will know when the supply is	09/17/2026

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1 of 2 kitchen observations and 1 of 1 dining room observations. The facility failed to ensure proper handwashing procedure was conducted for 1 of 1 dining observations.

Findings include:

1. During an initial tour of the kitchen with the Dietary Manager on 09/1/26 at 9:34 a.m. the following was observed:

a. Dietary Aide 5 was observed going into the walk-in refrigerator with no beard restraint on.

b. Dietary Aide 5 was observed placing a cover over the baking sheet of blueberry cheesecake with no beard restraint on.

c. At 9:40 a.m. Dietary Aide 5 began washing dishes with the dishwasher machine and was not wearing a beard restraint.

2. During an observation in the main dining room on 09/1/26 at 10:00 a.m., the following was observed:

a. Dietary Aide 5 was removing leftover food from breakfast meal off the steam table and onto a cart, he was not wearing a beard restraint.

b. Dietary Aide 5 took the cart of food into the kitchen and was

getting low.

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not wearing a beard restraint.

c. Dietary Aide 5 re-entered the dining room from the kitchen was cleaning the steam table area and was not wearing a beard restraint.

During an interview on 9/1/26 at 10:18 a.m., the Dietary Manager indicated she was aware that the Dietary Aide should be wearing a beard restraint, but she had run out of them last Friday 8/28/26. She had ordered more and they should be on the delivery truck today 09/1/26. She indicated the Dietary Aide had been using a hair net for the beard restraint, but she didn't know why he didn't use one all morning. She would address it immediately.

On 9/1/26 at 11:19 a.m., the Executive Director provided a document with a revised date of 5/23/19, titled, "Food Preparation," and indicated it was the current policy being used by the facility. The policy indicated, " ...6. Food Handlers will wear hair restraints/nets during food preparation"

3. During the lunch meal dining observation, on 9/1/26 the following was observed:

a. At 12:25 p.m., Dietary Aide 5 washed his hands at the sink and turned off the water faucet handle with his bare hands and

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continued to assist residents at the steam table with their lunch meal.

b. At 12:27 p.m., Dietary Aide 6 was observed to wash her hands for 7 seconds and turned off the water faucet handle with her bare hands and continued to assist residents in the dining room.

c. At 12:31 p.m., Dietary Aide 5 washed his hands and turned off the water faucet handle with his bare hands and continued to assist in the dining room.

d. At 12:36 p.m., Dietary Aide 5 washed his hands and turned off the water faucet handle with his bare hands and left the dining room and entered the kitchen.

e. At 2:05 p.m., Dietary Aide 6 washed her hands for 5 seconds and turned off the water faucet handle with her bare hands and continued to take out silverware and add salt and pepper packets to the tables.

During an interview on 9/1/26 at 12:28 p.m., Dietary Aide 7 indicated staff should wash their hands after assisting three residents. She would sing the "ABC" song twice in her head while washing her hands, staff should not turn off the water with their bare hands but use a

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	paper towel. On 9/1/26 at 2:08 p.m., the Executive Director provided a document with a revised date of 7/8/20, titled, "Personal Care Infection Control Procedures," and indicated it was the current policy being used by the facility. The policy indicated, " ...All staff will follow proper procedures to prevent spread of infection ...2. Lather hands by rubbing them together with the soap. Lather the backs of hands, between fingers, and under your nails. 3. Scrub hands for at least 20 seconds. 4. Rinse hands well under clean, running water. 5. Dry hands using a clean towel or air dry them"			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation record review and interview the facility failed to ensure insulin was dated when opened for 1 of 2 medication storage observations	R 0300	The employees that assist in medication administration were in-serviced on medication administration and medication storage. This will assure that these employees are following proper procedures when disposing of medications, storing medications, and administering them.	09/17/2026

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(Resident 041), and failed to ensure Tubersol Tuberculin testing solution (a testing solution administered under the skin to test for tuberculosis [TB] infection) was administered prior to expiration date for 2 of 4 residents and 2 of 2 employees reviewed (Residents 04 and 035).

Findings include:

1. On 9/2/26 at 9:00 a.m., during an observation of medication administration cart on the memory care unit with Licensed Practical Nurse (LPN) 9. Observed an insulin pen (an injection device with a needle that delivers insulin into the subcutaneous tissue [the tissue between your skin and muscle] labeled, Glargine insulin 100 units. The prescription label indicated the medication was prescribed for Resident 041. The label lacked a date to indicate when it was opened. The LPN indicated he thought insulin pens would be discarded after 30 days once opened.

On 9/2/26 at 9:15 a.m., the medical record of Resident 41 was reviewed. The resident was admitted to the facility on 3/12/26. Admitted diagnosis included but was not limited to Type 2 Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high).

The medical record indicated a physician order, dated 7/2/26, to administer Insulin Glargine-U100 Pen, Inject 15 units subcutaneously daily. Review of the medication administration record indicated the medication was administered on 9/2/26 at 8:30 a.m.

On 9/2/26 at 9:48 a.m., during a phone interview LPN 4 indicated all insulin pens should be dated when opened. She indicated the insulin pens were destroyed after 30 days once opened.

The U.S. Food and Drug administration guidelines for insulin administration, dated 9/19/2017, indicated, "Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days."

2. On 9/2/26 at 9:30 a.m., during observation of the

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medication storage room with the Resident Care Coordinator. Observed 3 vials (a universal glass container designed to safely store a medication) of Tubersol Tuberculin testing solution. Vial 1 was dated as opened on 8/5/2026. Vial 2 date opened indicated 4/9/26. Vial 3 lacked a date opened. The Coordinator indicated the vials should be dated when opened and they should be discarded after 30 days, once opened.

On 9/2/26 at 9:48 a.m., during a phone interview LPN 4 indicated she did not recall what vial she administered the most recent TB test from, but she thought it was from the vial dated 8/5/26. She indicated she thought the vials should be destroyed after 30 days once opened. She indicated she had not been trained in the new computer system on medication destruction.

Review of the TB administration record from 4/9/26 to 9/2/26 indicated 4 residents and 2 employees were administered TB tests. Residents 04 and 035 were administered a TB test from vial 2, with date opened 4/9/26 on 8/7/26.

The manufacture guidelines for administration of Tubersol solution indicated, "A vial of TUBERSOL which has been entered (opened) and in use for

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30 days should be discarded.
Do not use after expiration
date."

On 9/2/26 at 10:30 a.m., the
Executive Director provided a
document, titled, "Medication
Program," with a revision date
of 11/17/23, and indicated it was
the policy currently being used
by the facility. The policy
indicated, "...Disposal of
Medications ...1. When a
Resident's medication is
changed, expired, discontinued,
or following a resident's transfer,
discharge, or death, all unused
medications will be recorded on
a medication release/disposal
log form and ideally returned to
the issuing pharmacy for
disposal"

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
SIGNATUREGaddis Baysinger

TITLEExecutive Director

(X6) DATE09/24/2026