

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 06/05/2025	
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: June 4 and 5, 2025 Facility number: 013946 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 17, 2025.	R 0000					
R 0054	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(x) (x) Residents have the right to confidentiality of all personal and clinical records. Information from these sources shall not be released without the resident ' s consent, except when the resident is transferred to another health facility, when required by law, or under a third party payment	R 0054	Nursing staff was educated on the importance of confidentiality of records. Staff was also educated on locking computer when not actively using it. The medication pass computers were also updated so that they go in sleep mode if not actively being used.			06/25/2025	

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contract. The resident ' s records shall be made immediately available to the resident for inspection, and the resident may receive a copy within five (5) working days, at the resident ' s expense.

Based on observation, interview, and record review, the facility failed to ensure a resident's personal information was maintained in a safe and secure manner for 1 of 1 random observation of a medication cart, (Resident 13).

Findings include:

During a continuous random observation, on 6/4/25 from 2:05 p.m., to 2:16 p.m., a medication cart was sitting at the end of the hallway leading into the dining room area. The lid on the medication cart computer was open and Resident 13's medication information was exposed. Several facility staff and a contractor, who was working on equipment in the dining room, were observed walking around and next to the area of the medication cart.

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On 6/4/25 at 2:16 p.m., the Executive Director (ED) came to the area and observed that the record was exposed. The ED indicated the record should have been minimized or the lid to the computer closed when the nurse was away from the cart.

During an interview, on 6/5/25 at 9:10 a.m., Qualified Medication Aide (QMA) 7 indicated she had not realized that she had not closed the resident's record when she walked away from her medication cart. The expectation was that the resident's records were to be kept secure and she should have closed or covered the computer screen when she walked away from the cart.

On 6/5/25 at 8:33 a.m., the ED provided a document, with a revision date of 4/15/20, titled, "Resident Files," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures: ...1...r. The resident file will be accessible on a need-to-know basis in order to provide the best service and care. s. Resident files will be secured...."

Based on observation, interview, and record review, the facility failed to ensure a resident's personal information was maintained in a safe and secure manner for 1 of 1

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random observation of a medication cart, (Resident 13).

Findings include:

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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. 5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25. Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure). The most recent resident evaluation/service plan review was dated 7/23/24. The record	R 0216	Facility had records of semi-annual assessments for the residents that surveyors had concerns about. The new wellness director was unable to locate them in a timely manner for the surveyors. The electronic health records system that the community uses gives us reminders for semi-annual assessments so that they are not missed. The service plans that were in question have been attached.	06/05/2025
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lacked documentation a semi-annual evaluation was completed.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The most recent resident evaluation/service plan review was dated 6/13/24. The record lacked documentation a semi-annual evaluation was completed.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they had not been doing semi-annual resident evaluations, and residents were evaluated annually and as needed if there was a significant change. They should have followed the state rules and guidelines for evaluating residents.

On 6/4/25 at 12:40 p.m., the Executive Director (ED) provided a document titled, "Physician's Certification," last revised on 3/26/19, and indicated it was the policy currently being used by the facility. The policy indicated,

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"...4. At the time of admission, the physician's certification must reflect the resident's current condition. Physician certification must be re-evaluated: a. At least annually, once a resident has moved into the Community, a comprehensive certification shall be completed by the physician. b. Upon identification of a significant change in the resident's condition...8. Community's may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's certification. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's certification...."

4. Resident 52's record was reviewed on 6/4/25 at 11:50 a.m. The record indicated the resident had been admitted to the facility on 1/29/23, for the diagnoses which included, but were not limited to, unspecified anxiety disorder (anxiety or fears that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive) and unspecified dementia (a group of symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning without a

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specific diagnosis).

A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

During an interview, on 6/4/25 at 2:24 p.m. the Wellness Director indicated they had not been doing semi-annual evaluations. They do an annual evaluation when they do the annual service plan, and would only complete another evaluation as needed, if there was a change in condition of the resident. The facility would follow the state guidelines regarding semi-annual evaluations.

Based on record review and interview the facility failed to ensure semi-annual assessments were completed for 6 of 7 residents reviewed for semi-annual assessments. (Residents 4, 13, 61, 52, 62, and 34).

Findings include:

1. On 6/4/25 reviewed the medical record of Resident 04. The resident was admitted to the assisted living facility on 1/2/24. atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery

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walls that can cause arteries to narrow, blocking blood flow), congestive heart disease ((a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

Upon admission an assessment was completed and signed by the resident. The record lacked documentation of a semi-annual evaluation being completed.

On 6/4/25 at 2:24 p.m. DON (Director of Nurses) indicated they had not been doing semi-annual evaluations. They did an annual evaluation when they did the annual service plan and only did another evaluation as needed (PRN) if there was something that changed or they needed something else. They did follow the state rules regarding assessments. There was an issue with the policy because of this being the corporation's only Indiana facility.

2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris unspecified (chest pain or discomfort that occurs when a part of your hear doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system

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that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a semi-annual evaluation was completed on Resident 13.

The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

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3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a semi-annual evaluation was completed on Resident 61.

The record indicated a resident screen/service plan was conducted on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a service plan for 2024.

The record indicated a physician assessment form was completed on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a physician assessment for 2024.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated they had not been completing semi annual evaluations. They had been

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completing annual evaluations when they did the service plans, and they only completed an additional evaluation when there was a significant change in condition with the residents. She indicated the company policy did not reflect that semi-annuals evaluations should be completed but she was aware they needed to follow state regulations regarding the semi-annual evaluations.

5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

The most recent resident evaluation/service plan review was dated 7/23/24. The record lacked documentation a semi-annual evaluation was completed.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not

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limited to, right transient ischemic deafness (hearing loss).

The most recent resident evaluation/service plan review was dated 6/13/24. The record lacked documentation a semi-annual evaluation was completed.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they had not been doing semi-annual resident evaluations, and residents were evaluated annually and as needed if there was a significant change. They should have followed the state rules and guidelines for evaluating residents.

On 6/4/25 at 12:40 p.m., the Executive Director (ED) provided a document titled, "Physician's Certification," last revised on 3/26/19, and indicated it was the policy currently being used by the facility. The policy indicated, "...4. At the time of admission, the physician's certification must reflect the resident's current condition. Physician certification must be re-evaluated: a. At least annually, once a resident has moved into the Community, a comprehensive certification shall be completed by the physician. b. Upon identification of a significant change in the resident's condition...8.

Community's may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's certification. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's certification...."

4. Resident 52's record was reviewed on 6/4/25 at 11:50 a.m. The record indicated the resident had been admitted to the facility on 1/29/23, for the diagnoses which included, but were not limited to, unspecified anxiety disorder (anxiety or fears that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive) and unspecified dementia (a group of symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning without a specific diagnosis).

A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

During an interview, on 6/4/25 at

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Based on record review and interview the facility failed to ensure semi-annual assessments were completed for 6 of 7 residents reviewed for semi-annual assessments. (Residents 4, 13, 61, 52, 62, and 34).

Findings include:

1. On 6/4/25 reviewed the medical record of Resident 04. The resident was admitted to the assisted living facility on 1/2/24. atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease ((a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

Upon admission an assessment was completed and signed by

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	the resident. The record lacked documentation of a semi-annual evaluation being completed. On 6/4/25 at 2:24 p.m. DON (Director of Nurses) indicated they had not been doing semi-annual evaluations. They did an annual evaluation when they did the annual service plan and only did another evaluation as needed (PRN) if there was something that changed or they needed something else. They did follow the state rules regarding assessments. There was an issue with the policy because of this being the corporation's only Indiana facility. 2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris unspecified (chest pain or discomfort that occurs when a part of your hear doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being). The census information			
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indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a semi-annual evaluation was completed on Resident 13.

The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

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5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart

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disease (clogged arteries) and essential primary hypertension (high blood pressure).

The most recent resident evaluation/service plan review was dated 7/23/24. The record lacked documentation a semi-annual evaluation was completed.

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The census information indicated that the resident was admitted to the facility on 4/4/23.

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A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

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The census information indicated that the resident was admitted to the facility on 4/4/23.

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The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a semi-annual evaluation was completed on Resident 61.

The record indicated a resident screen/service plan was conducted on 10/20/22, 11/2/23, and 4/1/25. The record lacked

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documentation of a service plan for 2024.

The record indicated a physician assessment form was completed on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a physician assessment for 2024.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated they had not been completing semi annual evaluations. They had been completing annual evaluations when they did the service plans, and they only completed an additional evaluation when there was a significant change in condition with the residents. She indicated the company policy did not reflect that semi-annuals evaluations should be completed but she was aware they needed to follow state regulations regarding the semi-annual evaluations.

5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

The most recent resident

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evaluation/service plan review was dated 7/23/24. The record lacked documentation a semi-annual evaluation was completed.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The most recent resident evaluation/service plan review was dated 6/13/24. The record lacked documentation a semi-annual evaluation was completed.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they had not been doing semi-annual resident evaluations, and residents were evaluated annually and as needed if there was a significant change. They should have followed the state rules and guidelines for evaluating residents.

On 6/4/25 at 12:40 p.m., the Executive Director (ED) provided a document titled, "Physician's Certification," last revised on 3/26/19, and indicated it was the policy

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currently being used by the facility. The policy indicated, "...4. At the time of admission, the physician's certification must reflect the resident's current condition. Physician certification must be re-evaluated: a. At least annually, once a resident has moved into the Community, a comprehensive certification shall be completed by the physician. b. Upon identification of a significant change in the resident's condition...8. Community's may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's certification. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's certification...."

4. Resident 52's record was reviewed on 6/4/25 at 11:50 a.m. The record indicated the resident had been admitted to the facility on 1/29/23, for the diagnoses which included, but were not limited to, unspecified anxiety disorder (anxiety or fears that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive) and unspecified dementia (a group of symptoms that negatively affect memory, thinking, and social abilities

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severely enough to interfere with daily functioning without a specific diagnosis).

A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

During an interview, on 6/4/25 at 2:24 p.m. the Wellness Director indicated they had not been doing semi-annual evaluations. They do an annual evaluation when they do the annual service plan, and would only complete another evaluation as needed, if there was a change in condition of the resident. The facility would follow the state guidelines regarding semi-annual evaluations.

Based on record review and interview the facility failed to ensure semi-annual assessments were completed for 6 of 7 residents reviewed for semi-annual assessments. (Residents 4, 13, 61, 52, 62, and 34).

Findings include:

1. On 6/4/25 reviewed the medical record of Resident 04. The resident was admitted to the assisted living facility on 1/2/24. atherosclerotic heart disease (the buildup of fats,

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cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease ((a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

Upon admission an assessment was completed and signed by the resident. The record lacked documentation of a semi-annual evaluation being completed.

On 6/4/25 at 2:24 p.m. DON (Director of Nurses) indicated they had not been doing semi-annual evaluations. They did an annual evaluation when they did the annual service plan and only did another evaluation as needed (PRN) if there was something that changed or they needed something else. They did follow the state rules regarding assessments. There was an issue with the policy because of this being the corporation's only Indiana facility.

2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris unspecified (chest pain or discomfort that occurs when a part of your hear doesn't get enough blood and oxygen),

Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a semi-annual evaluation was completed on Resident 13.

The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part

of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a semi-annual evaluation was completed on Resident 61.

The record indicated a resident screen/service plan was conducted on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a service plan for 2024.

The record indicated a physician assessment form was completed on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a physician assessment for 2024.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated they had not been completing semi annual evaluations. They had been completing annual evaluations when they did the service plans, and they only completed an additional evaluation when there was a significant change in condition with the residents. She indicated the company policy did not reflect that semi-annuals evaluations should be completed but she was aware they needed to follow state regulations regarding the

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semi-annual evaluations.

5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

The most recent resident evaluation/service plan review was dated 7/23/24. The record lacked documentation a semi-annual evaluation was completed.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The most recent resident evaluation/service plan review was dated 6/13/24. The record lacked documentation a semi-annual evaluation was completed.

During an interview, on 6/4/25 at

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	2:24 p.m., the Director of Nursing (DON) indicated they had not been doing semi-annual resident evaluations, and residents were evaluated annually and as needed if there was a significant change. They should have followed the state rules and guidelines for evaluating residents.			
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On 6/4/25 at 12:40 p.m., the Executive Director (ED) provided a document titled, "Physician's Certification," last revised on 3/26/19, and indicated it was the policy currently being used by the facility. The policy indicated, "...4. At the time of admission, the physician's certification must reflect the resident's current condition. Physician certification must be re-evaluated: a. At least annually, once a resident has moved into the Community, a comprehensive certification shall be completed by the physician. b. Upon identification of a significant change in the resident's condition...8. Community's may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's certification. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's certification...."

4. Resident 52's record was reviewed on 6/4/25 at 11:50 a.m. The record indicated the resident had been admitted to the facility on 1/29/23, for the diagnoses which included, but were not limited to, unspecified anxiety disorder (anxiety or fears that don't meet the exact criteria for any other anxiety

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disorders but are significant enough to be distressing and disruptive) and unspecified dementia (a group of symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning without a specific diagnosis).

A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

During an interview, on 6/4/25 at 2:24 p.m. the Wellness Director indicated they had not been doing semi-annual evaluations. They do an annual evaluation when they do the annual service plan, and would only complete another evaluation as needed, if there was a change in condition of the resident. The facility would follow the state guidelines regarding semi-annual evaluations.

Based on record review and interview the facility failed to ensure semi-annual assessments were completed for 6 of 7 residents reviewed for semi-annual assessments. (Residents 4, 13, 61, 52, 62, and 34).

Findings include:

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1. On 6/4/25 reviewed the medical record of Resident 04. The resident was admitted to the assisted living facility on 1/2/24. atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease ((a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

Upon admission an assessment was completed and signed by the resident. The record lacked documentation of a semi-annual evaluation being completed.

On 6/4/25 at 2:24 p.m. DON (Director of Nurses) indicated they had not been doing semi-annual evaluations. They did an annual evaluation when they did the annual service plan and only did another evaluation as needed (PRN) if there was something that changed or they needed something else. They did follow the state rules regarding assessments. There was an issue with the policy because of this being the corporation's only Indiana facility.

2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the

resident's diagnoses included but were not limited to, angina pectoris unspecified (chest pain or discomfort that occurs when a part of your heart doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood, thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a semi-annual evaluation was completed on Resident 13.

The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a

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progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a semi-annual evaluation was completed on Resident 61.

The record indicated a resident screen/service plan was conducted on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a service plan for 2024.

The record indicated a physician assessment form was completed on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a physician assessment for 2024.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated they had not been completing semi annual evaluations. They had been completing annual evaluations when they did the service plans, and they only completed an additional evaluation when there was a significant change in condition with the residents. She

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indicated the company policy did not reflect that semi-annuals evaluations should be completed but she was aware they needed to follow state regulations regarding the semi-annual evaluations.

5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

The most recent resident evaluation/service plan review was dated 7/23/24. The record lacked documentation a semi-annual evaluation was completed.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The most recent resident evaluation/service plan review

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was dated 6/13/24. The record lacked documentation a semi-annual evaluation was completed.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they had not been doing semi-annual resident evaluations, and residents were evaluated annually and as needed if there was a significant change. They should have followed the state rules and guidelines for evaluating residents.

On 6/4/25 at 12:40 p.m., the Executive Director (ED) provided a document titled, "Physician's Certification," last revised on 3/26/19, and indicated it was the policy currently being used by the facility. The policy indicated, "...4. At the time of admission, the physician's certification must reflect the resident's current condition. Physician certification must be re-evaluated: a. At least annually, once a resident has moved into the Community, a comprehensive certification shall be completed by the physician. b. Upon identification of a significant change in the resident's condition...8. Community's may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's certification.

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Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's certification...."

4. Resident 52's record was reviewed on 6/4/25 at 11:50 a.m. The record indicated the resident had been admitted to the facility on 1/29/23, for the diagnoses which included, but were not limited to, unspecified anxiety disorder (anxiety or fears that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive) and unspecified dementia (a group of symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning without a specific diagnosis).

A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

During an interview, on 6/4/25 at 2:24 p.m. the Wellness Director indicated they had not been doing semi-annual evaluations. They do an annual evaluation when they do the annual service plan, and would only complete

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another evaluation as needed, if there was a change in condition of the resident. The facility would follow the state guidelines regarding semi-annual evaluations.

Based on record review and interview the facility failed to ensure semi-annual assessments were completed for 6 of 7 residents reviewed for semi-annual assessments. (Residents 4, 13, 61, 52, 62, and 34).

Findings include:

1. On 6/4/25 reviewed the medical record of Resident 04. The resident was admitted to the assisted living facility on 1/2/24. atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease ((a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

Upon admission an assessment was completed and signed by the resident. The record lacked documentation of a semi-annual evaluation being completed.

On 6/4/25 at 2:24 p.m. DON (Director of Nurses) indicated they had not been doing

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semi-annual evaluations. They did an annual evaluation when they did the annual service plan and only did another evaluation as needed (PRN) if there was something that changed or they needed something else. They did follow the state rules regarding assessments. There was an issue with the policy because of this being the corporation's only Indiana facility.

2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris unspecified (chest pain or discomfort that occurs when a part of your heart doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a semi-annual evaluation was completed on

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Resident 13.

The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a semi-annual evaluation was completed on Resident 61.

The record indicated a resident screen/service plan was conducted on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a service plan for 2024.

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The record indicated a physician assessment form was completed on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a physician assessment for 2024.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated they had not been completing semi annual evaluations. They had been completing annual evaluations when they did the service plans, and they only completed an additional evaluation when there was a significant change in condition with the residents. She indicated the company policy did not reflect that semi-annuals evaluations should be completed but she was aware they needed to follow state regulations regarding the semi-annual evaluations.

5. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

The most recent resident evaluation/service plan review was dated 7/23/24. The record

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lacked documentation a semi-annual evaluation was completed.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The most recent resident evaluation/service plan review was dated 6/13/24. The record lacked documentation a semi-annual evaluation was completed.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they had not been doing semi-annual resident evaluations, and residents were evaluated annually and as needed if there was a significant change. They should have followed the state rules and guidelines for evaluating residents.

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"...4. At the time of admission, the physician's certification must reflect the resident's current condition. Physician certification must be re-evaluated: a. At least annually, once a resident has moved into the Community, a comprehensive certification shall be completed by the physician. b. Upon identification of a significant change in the resident's condition...8. Community's may develop their own tools for evaluating their residents; however, the establishment evaluation does not replace the requirement for a physician's certification. Documentation of evaluations and re-evaluations may be in any form that is accurate, that addresses the resident's condition, and that incorporates the physician's certification...."

4. Resident 52's record was reviewed on 6/4/25 at 11:50 a.m. The record indicated the resident had been admitted to the facility on 1/29/23, for the diagnoses which included, but were not limited to, unspecified anxiety disorder (anxiety or fears that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive) and unspecified dementia (a group of symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning without a

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specific diagnosis).

A signed annual service plan (plan of care) had been completed on 9/17/24.

The record lacked documentation that a semi-annual evaluation had been completed for the resident.

During an interview, on 6/4/25 at 2:24 p.m. the Wellness Director indicated they had not been doing semi-annual evaluations. They do an annual evaluation when they do the annual service plan, and would only complete another evaluation as needed, if there was a change in condition of the resident. The facility would follow the state guidelines regarding semi-annual evaluations.

Based on record review and interview the facility failed to ensure semi-annual assessments were completed for 6 of 7 residents reviewed for semi-annual assessments. (Residents 4, 13, 61, 52, 62, and 34).

Findings include:

1. On 6/4/25 reviewed the medical record of Resident 04. The resident was admitted to the assisted living facility on 1/2/24. atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery

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walls that can cause arteries to narrow, blocking blood flow), congestive heart disease ((a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

Upon admission an assessment was completed and signed by the resident. The record lacked documentation of a semi-annual evaluation being completed.

On 6/4/25 at 2:24 p.m. DON (Director of Nurses) indicated they had not been doing semi-annual evaluations. They did an annual evaluation when they did the annual service plan and only did another evaluation as needed (PRN) if there was something that changed or they needed something else. They did follow the state rules regarding assessments. There was an issue with the policy because of this being the corporation's only Indiana facility.

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that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a semi-annual evaluation was completed on Resident 13.

The record indicated a resident screen/service plan was conducted on 8/21/23 and 8/30/24.

The record indicated a physician assessment form was completed on 8/21/23, 8/30/24, and 5/15/25.

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3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a semi-annual evaluation was completed on Resident 61.

The record indicated a resident screen/service plan was conducted on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a service plan for 2024.

The record indicated a physician assessment form was completed on 10/20/22, 11/2/23, and 4/1/25. The record lacked documentation of a physician assessment for 2024.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated they had not been completing semi annual evaluations. They had been

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	completing annual evaluations when they did the service plans, and they only completed an additional evaluation when there was a significant change in condition with the residents. She indicated the company policy did not reflect that semi-annuals evaluations should be completed but she was aware they needed to follow state regulations regarding the semi-annual evaluations.			
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 observations, interview, and record review, the facility failed to ensure the kitchen was maintained in a clean and sanitary environment and failed to ensure food stored in the refrigerators and freezer had a date received and date opened label for 3 of 3 kitchen observations. Findings include: On 6/4/25 at 10:00 a.m., during initial kitchen observation with the Dietary Manager. Observed the walk in refrigerator noted to	R 0273	The dietary staff were educated regarding the importance of kitchen sanitation as well as labeling of food items. The dietary manager has been given a list of items to audit daily to assure that these concerns are continuously being addressed.	06/25/2025

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have a large, uncovered silver bowl with brown liquid substance within. Observed open boxes containing cabbage with dark brown leaves and celery that were uncovered and not dated.

An observation of the walk in freezer indicated several bags of frozen vegetables that were undated. Two frozen cream pies were not dated.

An observation of the stand-alone refrigerator indicated a large covered deep dish pan containing cucumbers and onions was not dated. Several containers of salad dressing were not dated.

An observation of the stove and fryer area indicated the metal shelf over the top of the stove was soiled with dust and brown debris. The wheels on the fryer were coated with dust and debris. Oil was on the floor next to the fryer with brown debris in the oil.

The vents above the stove were soiled with dust and debris. The shelf over the stove was covered in dust and brown debris.

On 6/4/25 at 10:20 a.m., during an interview the Dietary Manager indicated the kitchen was scheduled for a deep clean on 6/4/25. She acknowledged all food storage in refrigerator

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and freezer must be covered and dated when delivered and when opened.

On 6/4/25 at 11:45 a.m., during a random kitchen area observation, noted a pan of uncovered rolls had been placed on top of the range hood which was soiled with dust and brown debris.

On 6/5/25 at 10:00 a.m., during random kitchen observation observed soiled debris and dust covering a metal shelf above the stove. The stove vents were soiled with dirt and debris. The wheels on the fryer were covered in debris and brown substance.

On 6/5/2025 at 10:37 a.m., the Administrator provided a document titled, "Kitchen sanitation ," dated 9/1/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures ...4. The Dietary Director or designee will ensure a cleaning schedule is followed in a satisfactory manner ...11. Food contact surfaces of grills, griddles, stove tops, etc. should be cleaned daily and as needed throughout the day"

On 6/5/2025 at 10:37 a.m., the Administrator provided a document titled, "Food Storage," dated 9/1/2016, and indicated it was the policy currently being

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used by the facility. The policy indicated, "...Refrigerator Storage ...6. Foods must be covered to prevent contamination ...7. All opened food and food placed in secondary containers must be labeled and dated with the date opened ...10. Leftovers must be labeled, dated, and kept no longer than three days (or as permitted by state regulations)"

Based on observations, interview, and record review, the facility failed to ensure the kitchen was maintained in a clean and sanitary environment and failed to ensure food stored in the refrigerators and freezer had a date received and date opened label for 3 of 3 kitchen observations.

Findings include:

On 6/4/25 at 10:00 a.m., during initial kitchen observation with the Dietary Manager. Observed the walk in refrigerator noted to have a large, uncovered silver bowl with brown liquid substance within. Observed open boxes containing cabbage with dark brown leaves and celery that were uncovered and not dated.

An observation of the walk in freezer indicated several bags of frozen vegetables that were undated. Two frozen cream pies

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were not dated.

An observation of the stand-alone refrigerator indicated a large covered deep dish pan containing cucumbers and onions was not dated. Several containers of salad dressing were not dated.

An observation of the stove and fryer area indicated the metal shelf over the top of the stove was soiled with dust and brown debris. The wheels on the fryer were coated with dust and debris. Oil was on the floor next to the fryer with brown debris in the oil.

The vents above the stove were soiled with dust and debris. The shelf over the stove was covered in dust and brown debris.

On 6/4/25 at 10:20 a.m., during an interview the Dietary Manager indicated the kitchen was scheduled for a deep clean on 6/4/25. She acknowledged all food storage in refrigerator and freezer must be covered and dated when delivered and when opened.

On 6/4/25 at 11:45 a.m., during a random kitchen area observation, noted a pan of uncovered rolls had been placed on top of the range hood which was soiled with dust and brown debris.

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On 6/5/25 at 10:00 a.m., during random kitchen observation observed soiled debris and dust covering a metal shelf above the stove. The stove vents were soiled with dirt and debris. The wheels on the fryer were covered in debris and brown substance.

On 6/5/2025 at 10:37 a.m., the Administrator provided a document titled, "Kitchen sanitation ," dated 9/1/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures ...4. The Dietary Director or designee will ensure a cleaning schedule is followed in a satisfactory manner ...11. Food contact surfaces of grills, griddles, stove tops, etc. should be cleaned daily and as needed throughout the day"

On 6/5/2025 at 10:37 a.m., the Administrator provided a document titled, "Food Storage," dated 9/1/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "...Refrigerator Storage ...6. Foods must be covered to prevent contamination ...7. All opened food and food placed in secondary containers must be labeled and dated with the date opened ...10. Leftovers must be labeled, dated, and kept no longer than three days (or as permitted by state regulations)

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	"			
R 0275	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(h) (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. 2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris, unspecified (chest pain or discomfort that occurs when a part of your hear doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being). The census information indicated that the resident was admitted to the facility on 4/4/23. The record lacked documentation a diet order was obtained from physician for the resident.	R 0275	The physician assessment tool that is used by the community has been edited to assure that diet orders are obtained during each assessment.	06/27/2025

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a diet order was obtained from physician for the resident.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated the facility only obtained a diet order from the physician when a resident needed a specialized diet. She was not aware of the facility having a specific policy regarding diet orders.

4. Resident 62's record was reviewed on 6/5/25 at 9:30 a.m. The resident's profile indicated the resident was admitted to the facility on 10/21/23 and expired on 5/11/25.

Diagnoses on the resident's

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profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

The resident's record lacked documentation a diet order was obtained from the physician.

5. Resident 45's record was reviewed on 6/4/25 at 12:05 p.m. The resident's profile indicated the resident was admitted to the facility on 8/19/22.

Diagnosis on the resident's profile included, but were not limited to, unspecified dementia (general term for a group of brain disorders that cause a decline in mental ability, affecting thinking, memory, and reasoning).

The resident's record lacked documentation a diet order was obtained from the physician.

6. Resident 34's record was reviewed on 6/4/25 at 11:20 a.m. The resident's profile indicated the resident was admitted to the facility on 3/9/18.

Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The resident's record lacked

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documentation a diet order was obtained from the physician.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they only obtained a diet order from the physician if a specialized diet was required. Their facility policy did not indicate they were required to obtain a diet order for all residents, however, they should have followed the state rules and guidelines.

On 6/4/25 at 2:24 p.m., the DON provided a document titled, "Special Diets/Dietitian," last revised on 3/26/19, and indicated it was the policy currently being used by the facility. The policy indicated, "...1 Prior to admission, the resident's dietary needs should be assessed to ensure the Community can properly support and accommodate the resident's prescribed diet...6. The diet order must correspond to the physician's diet orders in the resident's medical chart...."

Based on record review and interview, the facility failed to ensure a diet order was obtained from the physician for 6 of 7 residents reviewed for diet orders (Residents 4, 13, 61, 62, 45, and 34).

Findings include:

1. On 6/4/25 the medical record of Resident 04 was reviewed.

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The resident was admitted to the assisted living facility on 1/2/24. Admitting diagnoses were atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease (a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

The record lacked documentation of physician order for diet.

On 6/4/25 at 2:24 p.m. DON (Director of Nursing) indicated she did not have a specific policy regarding orders, and they only got a diet order if they needed something specialized. They did not have a specific policy regarding diet orders, but they did follow the state rules.

2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris, unspecified (chest pain or discomfort that occurs when a part of your heart doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major

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depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a diet order was obtained from physician for the resident.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

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Diagnoses on the resident's profile included, but were not limited to, atherosclerotic heart disease (clogged arteries) and essential primary hypertension (high blood pressure).

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The resident's record lacked documentation a diet order was obtained from the physician.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they only obtained a diet order from the physician if a specialized diet was required. Their facility policy did not indicate they were required to obtain a diet order for all residents, however, they should have followed the state rules and guidelines.

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support and accommodate the resident's prescribed diet...6. The diet order must correspond to the physician's diet orders in the resident's medical chart...."

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Findings include:

1. On 6/4/25 the medical record of Resident 04 was reviewed. The resident was admitted to the assisted living facility on 1/2/24. Admitting diagnoses were atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease (a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

The record lacked documentation of physician order for diet.

On 6/4/25 at 2:24 p.m. DON (Director of Nursing) indicated she did not have a specific policy regarding orders, and they only got a diet order if they needed something specialized.

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They did not have a specific policy regarding diet orders, but they did follow the state rules.

2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris, unspecified (chest pain or discomfort that occurs when a part of your heart doesn't get enough blood and oxygen), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest, and a range of other symptoms affecting mood thoughts, and physical well-being).

The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a diet order was obtained from physician for the resident.

3. Resident 61's record was reviewed on 6/5/25 at 9:00 a.m. The profile indicated the resident's diagnoses included but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other

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important mental functions), hypertension (high blood pressure), and urinary tract infection (an illness in any part of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

The record lacked documentation a diet order was obtained from physician for the resident.

During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated the facility only obtained a diet order from the physician when a resident needed a specialized diet. She was not aware of the facility having a specific policy regarding diet orders.

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The resident's record lacked documentation a diet order was obtained from the physician.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they only obtained a diet order from the physician if a specialized

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diet was required. Their facility policy did not indicate they were required to obtain a diet order for all residents, however, they should have followed the state rules and guidelines.

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Findings include:

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walls that can cause arteries to narrow, blocking blood flow), congestive heart disease (a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

The record lacked documentation of physician order for diet.

On 6/4/25 at 2:24 p.m. DON (Director of Nursing) indicated she did not have a specific policy regarding orders, and they only got a diet order if they needed something specialized. They did not have a specific policy regarding diet orders, but they did follow the state rules.

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The census information indicated that the resident was admitted to the facility on 4/4/23.

The record lacked documentation a diet order was obtained from physician for the resident.

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of the urinary tract, the system of organs that make urine).

The census information indicated that the resident was admitted to the facility on 9/3/21.

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During an interview on 6/4/25 at 2:24 p.m., the Wellness Director indicated the facility only obtained a diet order from the physician when a resident needed a specialized diet. She was not aware of the facility having a specific policy regarding diet orders.

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Diagnosis on the resident's profile included, but were not limited to, unspecified dementia (general term for a group of brain disorders that cause a decline in mental ability, affecting thinking, memory, and reasoning).

The resident's record lacked documentation a diet order was obtained from the physician.

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Diagnosis on the resident's profile included, but were not limited to, right transient ischemic deafness (hearing loss).

The resident's record lacked documentation a diet order was obtained from the physician.

During an interview, on 6/4/25 at 2:24 p.m., the Director of Nursing (DON) indicated they only obtained a diet order from the physician if a specialized diet was required. Their facility policy did not indicate they were required to obtain a diet order for all residents, however, they

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should have followed the state rules and guidelines.

On 6/4/25 at 2:24 p.m., the DON provided a document titled, "Special Diets/Dietitian," last revised on 3/26/19, and indicated it was the policy currently being used by the facility. The policy indicated, "...1 Prior to admission, the resident's dietary needs should be assessed to ensure the Community can properly support and accommodate the resident's prescribed diet...6. The diet order must correspond to the physician's diet orders in the resident's medical chart...."

Based on record review and interview, the facility failed to ensure a diet order was obtained from the physician for 6 of 7 residents reviewed for diet orders (Residents 4, 13, 61, 62, 45, and 34).

Findings include:

1. On 6/4/25 the medical record of Resident 04 was reviewed. The resident was admitted to the assisted living facility on 1/2/24. Admitting diagnoses were atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease (a condition that develops when

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your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure).

The record lacked documentation of physician order for diet.

On 6/4/25 at 2:24 p.m. DON (Director of Nursing) indicated she did not have a specific policy regarding orders, and they only got a diet order if they needed something specialized. They did not have a specific policy regarding diet orders, but they did follow the state rules.

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The census information indicated that the resident was admitted to the facility on

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4/4/23.

The record lacked documentation a diet order was obtained from physician for the resident.

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Based on record review and interview, the facility failed to ensure a diet order was obtained from the physician for

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	6 of 7 residents reviewed for diet orders (Residents 4, 13, 61, 62, 45, and 34). Findings include: 1. On 6/4/25 the medical record of Resident 04 was reviewed. The resident was admitted to the assisted living facility on 1/2/24. Admitting diagnoses were atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), congestive heart disease (a condition that develops when your heart doesn't pump enough blood for your body's needs), and hypertension (high blood pressure). The record lacked documentation of physician order for diet. On 6/4/25 at 2:24 p.m. DON (Director of Nursing) indicated she did not have a specific policy regarding orders, and they only got a diet order if they needed something specialized. They did not have a specific policy regarding diet orders, but they did follow the state rules. 2. Resident 13's record was reviewed on 6/4/25 at 10:45 a.m. The profile indicated the resident's diagnoses included but were not limited to, angina pectoris, unspecified (chest pain			
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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 tuberculin solution (used for tuberculosis screening) was dated when opened during an observation of 1 of 1 medication rooms. Findings include: On 6/5/25 at 11:35 a.m., the medication room in the memory care unit was observed with Licensed Practical Nurse (LPN) 5. One box contained a vial of	R 0300	The community has acquired labels to be used for medications/solutions, etc. These labels will allow the nursing staff to note when the item was last used and when to discard.	06/26/2025

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opened tuberculin solution. Neither the vial, nor the box, were dated with an opened date. The vial's label indicated it was filled by the pharmacy on 2/19/25 and had an expiration date of 2/19/26. At the same time, LPN 5 indicated the staff normally put an opened date on the box, but this one must have been missed.

On 6/5/25 at 11:45 a.m., Executive Director (ED) provided a document titled, "Medication Program," last revised on 4/15/20, and indicated it was the policy currently being used by the facility. The policy indicated, "...Storage...4. A refrigerator will be available for medication and additional products requiring refrigeration...."

Based on observation, record review, and interview, the facility failed to ensure tuberculin solution (used for tuberculosis screening) was dated when opened during an observation of 1 of 1 medication rooms.

Findings include:

On 6/5/25 at 11:35 a.m., the medication room in the memory care unit was observed with Licensed Practical Nurse (LPN) 5. One box contained a vial of opened tuberculin solution. Neither the vial, nor the box, were dated with an opened

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	date. The vial's label indicated it was filled by the pharmacy on 2/19/25 and had an expiration date of 2/19/26. At the same time, LPN 5 indicated the staff normally put an opened date on the box, but this one must have been missed. On 6/5/25 at 11:45 a.m., Executive Director (ED) provided a document titled, "Medication Program," last revised on 4/15/20, and indicated it was the policy currently being used by the facility. The policy indicated, "...Storage...4. A refrigerator will be available for medication and additional products requiring refrigeration...."			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure hand washing was completed in a safe and sanitary manner during 1 of 1 meal service observation. Findings include: An observation of the Memory Care Unit lunch meal was	R 0414	Due to the surveyor having concerns regarding the way staff would dry their hands with paper towel, the community purchased paper towel dispensers. These paper towel dispensers have been mounted by each hand washing station in the community. This should allow the employees to wash and dry their hands in a safe and sanitary manner.	06/09/2025

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completed on 6/4/25 at 12:28 p.m.

On 6/4/25 at 12:40 p.m., License Practical Nurse (LPN 5) was observed washing her hands. She proceeded to turn off the faucet and dry her hands using paper towels which were held on the counter in an open container. The paper towel roll had visible wet marks, resembling wet finger marks, on the towels she used to turn off the faucet and dry her hands. No individual towel dispenser was observed. At the same time, the LPN indicated the paper towels had been like that for as long as she could remember. She had also previously witnessed staff remove the roll and take them into resident rooms to use, and bring it back and place it back on the counter.

During an interview, on 6/4/25 at 12:41 p.m., LPN 6 indicated the paper towels dispenser had been like that for a long time. The staff on the Memory Care Unit had discussed the wet towels in the past.

During an interview, on 6/5/25 at 8:30 a.m., the Executive Director (ED) indicated he had gone to the Memory Care Unit and saw the paper towels sitting on the counter. He understood the concern with everyone touching the towels when they

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used them.

On 6/5/25 at 8:33 a.m., the ED provided a document, with a revision date of 7/8/20, titled, "Personal Care Infection Control Procedures," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures: ...Hand Hygiene: ...5. Dry hands using an clean towel...."

Based on observation, interview, and record review, the facility failed to ensure hand washing was completed in a safe and sanitary manner during 1 of 1 meal service observation.

Findings include:

An observation of the Memory Care Unit lunch meal was completed on 6/4/25 at 12:28 p.m.

On 6/4/25 at 12:40 p.m., License Practical Nurse (LPN 5) was observed washing her hands. She proceeded to turn off the faucet and dry her hands using paper towels which were held on the counter in an open container. The paper towel roll had visible wet marks, resembling wet finger marks, on the towels she used to turn off the faucet and dry her hands. No individual towel dispenser was observed. At the same time, the LPN indicated the paper towels had been like that for as long as she could

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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
SIGNATURE

TITLE

(X6) DATE