STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET, MISHAWAKA, , 46544

(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 the Investigation of Complaints IN00457341, IN00459840, IN00460059 and IN00463236. Complaint IN00457341 - State deficiencies related to the allegations are cited at R0239 and R0247. Complaint IN00459840 - State deficiencies related to the allegations are cited at R0217. Complaint IN00460059 - State deficiencies related to the allegations are cited at R0217. Complaint IN00463236 - State deficiencies related to the allegations are cited at R0144 and R0273. Survey date: July 14, 15 and 16, 2025 Facility number: 014224 Residential Census: 116 These State Residential	R 0000		

	Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/24/2025			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure walls, doors, light fixtures and flooring was clean and in good repair related in common areas, hallways and in two resident bathrooms.. (All common areas, Residents D and F) Findings include: 1. During a general observation of the facility on 7/14/2025 at 11:45 A.M. with the Environmental Service Director (ESD) the following concerns with maintenance and cleanliness of the facility were noted: -the doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333 and 334 had black scuff marks and missing paint.	R 0144	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case no residents were affected. 3. Resident doors will be cleaned/re-painted for 001, 117, 214, 224, 303, 329, 330, 331, 333 and 334. Stained carpet in all the hallways has been deep cleaned. Debris and dead bugs were removed throughout the hallways. Meeting to be held with all housekeeping staff on 8/15/25 to review policy on notifying MD on issues with resident rooms including, refusals, stains, and any repairs needed. 4. Maintenance Director/Designee will monitor for cleanliness during rounds daily 5 times per week. Any areas found to be deficient will logged on our work	08/22/2025

	-the door to the southwest stairway/exit door on the 1st floor had black scuff marks. -the hallway carpet outside of rooms 003, 108, 112, 117, 119, 122, 127, and in front of both elevators and all floors had black stains. -the light fixtures at the end of the 301 hall and outside room 202 had dead bugs in them. -the light fixture near the southwest stairway/exit door had dead bugs in it. During an observation of the lower level on 7/14/2025 at 12:33 P.M., the Environmental Services Director's office door frame was missing paint and trim. During an interview, on 7/15/2025 at 1:26 P.M., the Maintenance Director and the ED indicated the carpets and doors should have been cleaned and repaired and the light fixtures should have been free of bugs. 2. During an interview on 7/14/2025 at 10:28 A.M., Resident D indicated there was a hole from leaking water in the bathroom above the shower and it had been there for several weeks. He did not know why it had not been fixed. Observation of Resident D's		ticket system and corrected promptly. This will continue on-going.	

	bathroom, on 7/14/2025 at 10:34 A.M., indicated there was a large, square hole in the ceiling above the shower. A 5-gallon bucket filled with standing water was noted directly under the hole in the ceiling. During an interview on 3/14/2025 at 1:30 P.M., the Maintenance Director indicated the hole in the ceiling was due to a leak in the shower in room 214, the apartment directly above Room 114. The repair had been completed, two weeks ago and they were waiting for the repairs to "dry out" before repairing the hole in room 114's bathroom. He indiated his assistant had checked the repair work last week and it was still too damp, but he had not reported that there was a bucket of water in the shower. During an interview on 1/14/2025 at 1:50 P.M. the Maintenance Assistant indicated he had not been in the room in at least 2 weeks and it had not been dry enough the last time he had checked. The 5-gallon bucket was not there when he was last in the room. He indicated he received a list of things to be done from the Maintenance Director and his main job was to paint and repair empty apartments for new residents and the Maintenance Director usually completed the			

work orders.

During an interview on 7/14/2025 at 1:59 P.M., the Maintenance Director indicated staff were to have filled out a work orders to inform him of needed repairs. He indicated residents reported issues to staff member and the staff member was to fill out the work orders for them.

3. During an interview on 7/15/2025 at 10:40 A.M., Resident F indicated the facility had not been doing a very good job cleaning her apartment. Resident F indicated the housekeeper never cleaned her shower and her shower had mold. She indicated she had spoken to the housekeeper several times about the moldy shower, but nothing had been done about it.

During an observation of Resident F's apartment bathroom on 7/15/2025 at 2:18 P.M., the shower had two bath mats with a black colored substance resembling mold on the shower floor. The shower seat, floor and walls were dirty and also had a black substance resembling mold around the area where the bath mats had been.

During an interview on 7/15/2025 at 2:19 P.M., the Maintenance Director (MD)

	indicated he was responsible for housekeeping and Resident F's shower should not be dirty or have "mold" in it. He indicated resident's apartments were cleaned weekly and cleaning the shower was part of the weekly apartment cleaning. On 7/16/2025 at 8:20 A.M., the MD provided the task list for cleaning resident apartments titled, "Daily Cleaning Tasks for Rooms" and identified it as the task list currently used by the facility. The list indicated, "...Bathroom...Clean walls of shower, shower seat, faucets and grabs bars, scrub shower floors especially under shower seat...." were tasks that should have been performed by Housekeeping while cleaning resident's apartments. A current policy dated March 2021 and titled, "Resident Unit Cleaning" was provided on 7/16/2025 at 8:40 A.M. by the ED. The policy indicated, " ...Housekeeping services are typically provided on a weekly basis to residents. The standard service typically includes: Weekly cleaning of the bathroom (fixtures, floor) ...." A current policy dated March 2021 and titled, "Common Area Cleaning" was provided on 7/16/2025 at 8:40 A.M. by the ED. The policy indicated, " ...Extraction cleaning of			

	common area carpets is done every six months or more often if needed ..." and " ...Spot clean and sanitize walls, doors and doorknobs ...." This citation relates to complaint IN00463236. Based on observation and interview, the facility failed to ensure walls, doors, light fixtures and flooring was clean and in good repair related in common areas, hallways and in two resident bathrooms.. (All common areas, Residents D and F) Findings include: 1. During a general observation of the facility on 7/14/2025 at 11:45 A.M. with the Environmental Service Director (ESD) the following concerns with maintenance and cleanliness of the facility were noted: -the doors to rooms 001, 117, 214, 224, 303, 329, 330, 331, 333 and 334 had black scuff marks and missing paint. -the door to the southwest stairway/exit door on the 1st floor had black scuff marks.			

-the hallway carpet outside of rooms 003, 108, 112, 117, 119, 122, 127, and in front of both elevators and all floors had black stains.

-the light fixtures at the end of the 301 hall and outside room 202 had dead bugs in them.

-the light fixture near the southwest stairway/exit door had dead bugs in it.

During an observation of the lower level on 7/14/2025 at 12:33 P.M., the Environmental Services Director's office door frame was missing paint and trim.

During an interview, on 7/15/2025 at 1:26 P.M., the Maintenance Director and the ED indicated the carpets and doors should have been cleaned and repaired and the light fixtures should have been free of bugs.

2. During an interview on 7/14/2025 at 10:28 A.M., Resident D indicated there was a hole from leaking water in the bathroom above the shower and it had been there for several weeks. He did not know why it had not been fixed.

Observation of Resident D's bathroom, on 7/14/2025 at 10:34 A.M., indicated there was a large, square hole in the ceiling above the shower. A

	5-gallon bucket filled with standing water was noted directly under the hole in the ceiling. During an interview on 3/14/2025 at 1:30 P.M., the Maintenance Director indicated the hole in the ceiling was due to a leak in the shower in room 214, the apartment directly above Room 114. The repair had been completed, two weeks ago and they were waiting for the repairs to "dry out" before repairing the hole in room 114's bathroom. He indiated his assistant had checked the repair work last week and it was still too damp, but he had not reported that there was a bucket of water in the shower. During an interview on 1/14/2025 at 1:50 P.M. the Maintenance Assistant indicated he had not been in the room in at least 2 weeks and it had not been dry enough the last time he had checked. The 5-gallon bucket was not there when he was last in the room. He indicated he received a list of things to be done from the Maintenance Director and his main job was to paint and repair empty apartments for new residents and the Maintenance Director usually completed the work orders. During an interview on 7/14/2025 at 1:59 P.M., the			

	Maintenance Director indicated staff were to have filled out a work orders to inform him of needed repairs. He indicated residents reported issues to staff member and the staff member was to fill out the work orders for them. 3. During an interview on 7/15/2025 at 10:40 A.M., Resident F indicated the facility had not been doing a very good job cleaning her apartment. Resident F indicated the housekeeper never cleaned her shower and her shower had mold. She indicated she had spoken to the housekeeper several times about the moldy shower, but nothing had been done about it. During an observation of Resident F's apartment bathroom on 7/15/2025 at 2:18 P.M., the shower had two bath mats with a black colored substance resembling mold on the shower floor. The shower seat, floor and walls were dirty and also had a black substance resembling mold around the area where the bath mats had been. During an interview on 7/15/2025 at 2:19 P.M., the Maintenance Director (MD) indicated he was responsible for housekeeping and Resident F's shower should not be dirty or have "mold" in it. He indicated			

	resident's apartments were cleaned weekly and cleaning the shower was part of the weekly apartment cleaning. On 7/16/2025 at 8:20 A.M., the MD provided the task list for cleaning resident apartments titled, "Daily Cleaning Tasks for Rooms" and identified it as the task list currently used by the facility. The list indicated, "...Bathroom...Clean walls of shower, shower seat, faucets and grabs bars, scrub shower floors especially under shower seat...." were tasks that should have been performed by Housekeeping while cleaning resident's apartments. A current policy dated March 2021 and titled, "Resident Unit Cleaning" was provided on 7/16/2025 at 8:40 A.M. by the ED. The policy indicated, " ...Housekeeping services are typically provided on a weekly basis to residents. The standard service typically includes: Weekly cleaning of the bathroom (fixtures, floor) ...." A current policy dated March 2021 and titled, "Common Area Cleaning" was provided on 7/16/2025 at 8:40 A.M. by the ED. The policy indicated, " ...Extraction cleaning of common area carpets is done every six months or more often if needed ..." and " ...Spot clean and sanitize walls, doors and			

	doorknobs ...." This citation relates to complaint IN00463236.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services	R 0217	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Audit to be completed to ensure services plans are up date per resident's current plan of care. Upon returning to community DON/Designee to to meet with resident to ensure care plan up to date to meet resident's current needs. 4. DON/Designee will continue audit to ensure procedure completed per policy for all Current Residents' care plans. Results of audits will be brought to managers meeting monthly for review and/or recommendations.5. Audit to continue for six month or month if issues persist.	08/22/2025

provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on interview and record review, the facility failed to update the Service Plan to reflect the resident's current needs after a hospitalization for 1 of 3 residents reviewed for Service Plans. (Resident B)

Finding includes:

During an interview on 7/14/2025 at 9:39 A.M., Resident B indicated that she had been hospitalized in May for a fractured pelvis. She had been discharged from the hospital to a rehabilitation facility but after a couple of days was readmitted to the hospital with gastrointestinal issues. The hospital then discharged her back to the assisted living facility on 5/18/2025 per her request, as she felt it was her home. She indicated she was unable to do much for herself when she was readmitted to the facility, but a good friend (another resident of the facility) had stayed with her for a few days to help her. She indicated

	the ADON had checked in on her and had offered assistance, but the Resident B indicated she told the ADON she was fine. She indicated she had not asked the staff for help because she had her friend there for the first few days, which she preferred.. She indicated staff had brought her meals to her room until she was able to go to the dining room. She had also asked for help with her shower on one occasion and the staff had helped her. A record review completed on 7/15/2025 at 9:56 A.M., indicated Resident B's diagnoses included, but were not limited to, epilepsy. An assessment of her mental status indicated her cognition was intact. The Service Plan, last updated on 8/29/2024, indicated she needed assistance with transferring in and out of the shower, bathing and shampooing and drying her hair. The record lacked documentation that the resident had returned to the facility and that an assessment had been completed upon her return and an update to the Service Plan to reflect the Resident B's condition at the time were made. During an interview on 7/14/2025 at 2:27 P.M., the ADON indicated when the resident had returned from the			

	hospital, the QMA (Qualified Medication Aide) should have documented her return. She indicated she had checked in with the resident to see if she needed anything and had read the hospital discharge paperwork. She further indicated the Service Plan should have been updated to reflect the resident's current condition. During an interview on 7/15/2025 at 8:15 A.M., the ED indicated staff should have documented the resident return from the hospital and the Service Plan should have been updated to reflect the resident's needs after she had returned from the hospital. A current policy dated 9/30/2022 and titled, "Resident Service Plans" was provided on 7/16/2025 at 8:40 A.M. by the ED. The policy indicated, " ...The service plan is completed upon admission, 30 days following admission, reviewed and revised semiannually or following a change in condition ...." This citation relates to Complaint IN00460059 and IN00459840. Based on interview and record review, the facility failed to update the Service Plan to reflect the resident's current			

	needs after a hospitalization for 1 of 3 residents reviewed for Service Plans. (Resident B) Finding includes: During an interview on 7/14/2025 at 9:39 A.M., Resident B indicated that she had been hospitalized in May for a fractured pelvis. She had been discharged from the hospital to a rehabilitation facility but after a couple of days was readmitted to the hospital with gastrointestinal issues. The hospital then discharged her back to the assisted living facility on 5/18/2025 per her request, as she felt it was her home. She indicated she was unable to do much for herself when she was readmitted to the facility, but a good friend (another resident of the facility) had stayed with her for a few days to help her. She indicated the ADON had checked in on her and had offered assistance, but the Resident B indicated she told the ADON she was fine. She indicated she had not asked the staff for help because she had her friend there for the first few days, which she preferred.. She indicated staff had brought her meals to her room until she was able to go to the dining room. She had also asked for help with her shower on one occasion and the staff had helped her.			

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R 0239	Health Services - Nonconformance 410 IAC 16.2-5-4(c) (c) Each facility shall choose whether or not it administers medication or provides residential nursing care, or both. These policies shall be delineated in the facility policy manual and clearly stated in the admission agreement. Based on record review and interview, the facility failed to ensure physician ordered medications and treatments were administered for 1 of 3 residents whose medications were reviewed. (Resident C)	R 0239	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Inservice to be held on 8/15/25 to review Medication administration policies. Audit to then be completed to ensure medications are given per orders. All diabetic medications to be given by licensed nurse ordered to be given on Thursdays while multiple licensed nurses in the facility. Residents notified of orders. 4. DON/Designee will continue audit to ensure procedure	08/22/2025

	Finding includes: During an interview, on 7/15/2025 at 9:40 A.M., Resident C indicated the nursing staff had not administered her Ozempic (an injectable prescription medicine primarily used for adults with diabetes to improve blood sugar control along with diet and exercise) injection on July 3rd, 2025. The record for Resident C was reviewed on 7/15/2025 at 12:45 P.M. Diagnoses, included but were not limited to: rheumatoid arthritis, diabetes mellitus, anxiety, depression and urinary tract infection. A review of the May 2025 Medication Administration Record (MAR) indicated Resident C had not received his weekly dose of Ozempic on May 22nd. A review of the May 2025 MAR indicated the resident had not had her Freestyle Libre 2 Sensor (is a small, wearable device that continuously monitors glucose levels in people with diabetes) replaced. A review of the June 2025 MAR indicated Resident C had not had her Freestyle Libre 2 Sensor replaced. A review of the July 2025 MAR indicated Resident C had not		completed per policy for all Current Residents. Results of audits will be brought to managers meeting monthly for review and/or recommendations.5. Audit to continue for six month or month if issues persist.	

	received her weekly dose of Ozempic on July 3rd. There was no documentation that Resident C's had refused any of her medications or blood glucose checks. During an interview, on 7/15/2025 at 2:15 P.M., the Assistant Director of Nursing (ADON) indicated Resident C had not administered her own Ozempic or changed her own Continuous Glucose Monitor (CGM). The ADON indicated the nursing staff had been responsible for completing the treatment and administering the medication. The ADON indicated she should have documented the CGM changes in May and June and should have administered the Ozempic as ordered. On 7/16/2025 at 8:45 A.M., the Administrator provided a policy titled, "Medication Administration," dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...The administration of medications shall be as ordered by the resident's physician...3. Medications ordered to be given per subcutaneous will be administered by licensed nurses in accordance with the physician's orders..."			

This citation relates to complaint IN00457341.

Based on record review and interview, the facility failed to ensure physician ordered medications and treatments were administered for 1 of 3 residents whose medications were reviewed. (Resident C)

Finding includes:

During an interview, on 7/15/2025 at 9:40 A.M., Resident C indicated the nursing staff had not administered her Ozempic (an injectable prescription medicine primarily used for adults with diabetes to improve blood sugar control along with diet and exercise) injection on July 3rd, 2025.

The record for Resident C was reviewed on 7/15/2025 at 12:45 P.M. Diagnoses, included but were not limited to: rheumatoid arthritis, diabetes mellitus, anxiety, depression and urinary tract infection.

A review of the May 2025 Medication Administration Record (MAR) indicated Resident C had not received his weekly dose of Ozempic on May 22nd.

A review of the May 2025 MAR indicated the resident had not had her Freestyle Libre 2 Sensor (is a small, wearable

device that continuously monitors glucose levels in people with diabetes) replaced.

A review of the June 2025 MAR indicated Resident C had not had her Freestyle Libre 2 Sensor replaced.

A review of the July 2025 MAR indicated Resident C had not received her weekly dose of Ozempic on July 3rd.

There was no documentation that Resident C's had refused any of her medications or blood glucose checks.

During an interview, on 7/15/2025 at 2:15 P.M., the Assistant Director of Nursing (ADON) indicated Resident C had not administered her own Ozempic or changed her own Continuous Glucose Monitor (CGM). The ADON indicated the nursing staff had been responsible for completing the treatment and administering the medication. The ADON indicated she should have documented the CGM changes in May and June and should have administered the Ozempic as ordered.

On 7/16/2025 at 8:45 A.M., the Administrator provided a policy titled, "Medication Administration," dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy

	indicated "...The administration of medications shall be as ordered by the resident's physician...3. Medications ordered to be given per subcutaneous will be administered by licensed nurses in accordance with the physician's orders..." This citation relates to complaint IN00457341.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure the physician was notified of errors in medication administration for 1 of 3 residents reviewed for pharmaceutical services. (Resident C) Finding includes: During an interview, on 7/15/2025 at 9:40 A.M., Resident C indicated the nursing staff had not administered her Ozempic (an injectable prescription medicine primarily used for adults with	R 0247	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Physician notified of missed diabetic medication. Inservice to be held on 8/15/25 to review Medication administration policies and notification. Audit to then be completed to then be completed to ensure if medications are unable to be given per orders notification is completed per policy. 4. DON/Designee will continue audit to ensure procedure completed per policy for all Current Residents. Results of audits will be brought to managers meeting monthly for review and/or recommendations.5. Audit to continue for six month or month if issues persist.	08/22/2025

	diabetes to improve blood sugar control along with diet and exercise) injection on July 3rd, 2025. The record for Resident C was reviewed on 7/15/2025 at 12:45 P.M. Diagnoses, included but were not limited to: rheumatoid arthritis, diabetes mellitus, anxiety, depression and urinary tract infection. A Service Plan Report, signed on 11/29/2024, indicated Resident C required assistance for weekly Ozempic injections. A review of the May 2025 Medication Administration Record (MAR) indicated Resident C had not received her weekly dose of Ozempic on May 22nd. A review of the July 2025 MAR indicated Resident C had not received her weekly dose of Ozempic on July 3rd. Resident C's clinical record failed to evidence physician notification for the missed doses of Ozempic on May 22nd and July 3rd, 2025.			

During an interview, on 7/15/2025 at 2:15 P.M., the Assistant Director of Nursing (ADON) indicated Resident C's physician had not been notified that the resident had missed doses of Ozempic on May 22nd and on July 3rd, 2025.

On 7/16/2025 at 10:06 A.M., the Administrator provided a policy titled, "Medication Errors," dated 9/1/2021 and indicated the policy was the one currently used by the facility. The policy indicated "Medication not administered is considered a medication error...Procedure...2. The resident's prescribing physician is immediately notified of the medication error..."

This citation relates to complaint IN00457341.

Based on record review and interview, the facility failed to ensure the physician was notified of errors in medication administration for 1 of 3 residents reviewed for pharmaceutical services. (Resident C)

Finding includes:

During an interview, on 7/15/2025 at 9:40 A.M., Resident C indicated the nursing staff had not administered her Ozempic (an injectable prescription medicine primarily used for adults with diabetes to improve blood sugar

	control along with diet and exercise) injection on July 3rd, 2025. The record for Resident C was reviewed on 7/15/2025 at 12:45 P.M. Diagnoses, included but were not limited to: rheumatoid arthritis, diabetes mellitus, anxiety, depression and urinary tract infection. A Service Plan Report, signed on 11/29/2024, indicated Resident C required assistance for weekly Ozempic injections. A review of the May 2025 Medication Administration Record (MAR) indicated Resident C had not received her weekly dose of Ozempic on May 22nd. A review of the July 2025 MAR indicated Resident C had not received her weekly dose of Ozempic on July 3rd. Resident C's clinical record failed to evidence physician notification for the missed doses of Ozempic on May 22nd and July 3rd, 2025. During an interview, on 7/15/2025 at 2:15 P.M., the Assistant Director of Nursing (ADON) indicated Resident C's physician had not been notified that the resident had missed doses of Ozempic on May 22nd and on July 3rd, 2025.			

	On 7/16/2025 at 10:06 A.M., the Administrator provided a policy titled, "Medication Errors," dated 9/1/2021 and indicated the policy was the one currently used by the facility. The policy indicated "Medication not administered is considered a medication error...Procedure...2. The resident's prescribing physician is immediately notified of the medication error..." This citation relates to complaint IN00457341.			
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 store food in a safe and sanitary manner in the walk-in freezer in 1 of 1 kitchen that was observed. This had the potential to affect 116 of the 116 residents who received food from the kitchen. Finding includes: During a tour of the kitchen, with the Director of Dining (DOD) on 7/14/2025 at 11:45 A.M., the	R 0273	1. Corrections of previous timeframes cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. Box of food moved and stored appropriately. Inservice held on 7/30/25 to review proper food storage policies with all kitchen staff. 4. Dietary Manager/Designee will then monitor for proper food storgage 3x weekly to ensure procedure completed per policy. Results of will be brought to managers meeting monthly for review and/or recommendations.5. This is to continue for six month or month if issues persist.	08/08/2025

walk in freezer had a box of pork chops and two containers of orange juice stored directly on the floor.

During an interview, on 7/14/2025 at 11:46 A.M., the DOD indicated the truck had just delivered food supplies less than an hour before the observation and it was the facility's policy to have all the food put away within one hour of the delivery. The DOD indicated if the staff had had the full hour, all food would have been stored correctly and there would not have been food stored on the freezer floor.

However, during an interview on 7/14/2025 at 2:12 P.M., Dietary Aide (DA) 3 indicated the facility had had a problem in the past with storing food on the floor of the freezer, but she had not seen food on the freezer floor in about a month. She had not noticed the food on the floor in the freezer that day and was not able to recall what time the food delivery had been.

During an interview on 7/14/2025 at 2:20 P.M., DA 4 indicated there had been pork chops and orange juice stored on the freezer floor earlier that morning when had arrived to work. DA 4 indicated the facility received three deliveries a week and there had not been enough room in the freezer to store the

food correctly. DA 4 indicated the food delivery had been received before 8:00 A.M. that morning.

During an interview on 7/14/2025 at 2:30 P.M., DA 6 indicated she had seen food stored on the freezer floor that morning when she had entered the freezer. DA 6 believed the food had been delivered around 8:00 A.M. but could not be certain.

During an interview on 7/14/2025 at 2:50 P.M., the Food Vendor Customer Service Representative for the food vendor company that the facility had used indicated the food delivery to the facility had been completed by 7:49 A.M. on 7/14/2025.

On 7/16/2025 at 10:05 A.M., the Executive Director provided an undated policy titled, "Our Food: Food Safety", and identified it as the one the facility currently used. The policy indicated, "...Foods and supplies shall be stored properly in designated storage areas. Store all products six-inches away from floors and walls...."

This citation relates to complaint IN00463236.

Based on observation, interview and record review, the facility failed to store food in a safe and sanitary manner in the walk-in

freezer in 1 of 1 kitchen that was observed. This had the potential to affect 116 of the 116 residents who received food from the kitchen.

Finding includes:

During a tour of the kitchen, with the Director of Dining (DOD) on 7/14/2025 at 11:45 A.M., the walk in freezer had a box of pork chops and two containers of orange juice stored directly on the floor.

During an interview, on 7/14/2025 at 11:46 A.M., the DOD indicated the truck had just delivered food supplies less than an hour before the observation and it was the facility's policy to have all the food put away within one hour of the delivery. The DOD indicated if the staff had had the full hour, all food would have been stored correctly and there would not have been food stored on the freezer floor.

However, during an interview on 7/14/2025 at 2:12 P.M., Dietary Aide (DA) 3 indicated the facility had had a problem in the past with storing food on the floor of the freezer, but she had not seen food on the freezer floor in about a month. She had not noticed the food on the floor in the freezer that day and was not able to recall what time the food delivery had been.

During an interview on 7/14/2025 at 2:20 P.M., DA 4 indicated there had been pork chops and orange juice stored on the freezer floor earlier that morning when had arrived to work. DA 4 indicated the facility received three deliveries a week and there had not been enough room in the freezer to store the food correctly. DA 4 indicated the food delivery had been received before 8:00 A.M. that morning.

During an interview on 7/14/2025 at 2:30 P.M., DA 6 indicated she had seen food stored on the freezer floor that morning when she had entered the freezer. DA 6 believed the food had been delivered around 8:00 A.M. but could not be certain.

During an interview on 7/14/2025 at 2:50 P.M., the Food Vendor Customer Service Representative for the food vendor company that the facility had used indicated the food delivery to the facility had been completed by 7:49 A.M. on 7/14/2025.

On 7/16/2025 at 10:05 A.M., the Executive Director provided an undated policy titled, "Our Food: Food Safety", and identified it as the one the facility currently used. The policy indicated, "...Foods and supplies shall be stored properly in designated

	storage areas. Store all products six-inches away from floors and walls...." This citation relates to complaint IN00463236.			

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