| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 04/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LEGACY LIVING LEASING JASPER, LLC | 1850 WEST STATE ROAD 56, JASPER, , 47546 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey.<br><br>Survey dates: April 20 & 21, 2026<br><br>Facility number: 014383<br><br>Residential Census: 94<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on April 27, 2026 | R 0000 | This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request desk review in lieu of a post survey visit. | |
| R 0121 | Personnel - Noncompliance<br><br>410 IAC 16.2-5-1.4(f)(1-4)<br><br>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The | R 0121 | No residents have been affected by this deficient practice.<br><br>All residents have the potential to be affected by the same deficient practice.<br><br>The systemic change made to ensure this deficient practice will not recur is education provided | 05/01/2026 |

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| | result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:<br><br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br><br>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br><br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.<br><br>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work | | to leadership team to ensure no new hires begin with resident care prior to receiving documentation of the new hire's initial tb skin test.<br><br>The Business Office Manager or designee will monitor these changes for each new hire moving forward until facility has reached compliance with 10 newly hired employees.<br><br>This systemic change will be completed Friday 5/1/26. | |

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| | until tuberculosis is ruled out.<br><br>Based on interview and record review, the facility failed to ensure newly hired employees were properly screened for tuberculosis (TB) for 3 of 3 newly hired staff reviewed. Staff did not have TB screening prior to resident contact. (Licensed Practical Nurse 3, Home Health Aide 4, Qualified Medication Aide 5)<br><br>Findings include:<br><br>On 4/20/26 at 1:30 P.M., employee records were reviewed and indicated the following newly hired employees lacked TB screening prior to starting work and documentation of results lacked a measured millimeter (mm) of induration (raised, hardened bump indicating a possible positive result):<br><br>1. Licensed Practical Nurse (LPN) 3's hire date was 10/16/25. Her employee record indicated her first step TB screening was 12/8/25 and her second step TB screening was 12/23/25. The result of the 12/23/25 reading indicated a "neg" result.<br><br>2. Home Health Aide (HHA) 4's hire date was 12/9/25. Her employee record indicated her first step TB screening was | | | |

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| | 1/26/26 and her second step TB screening was 2/10/26. The result of the 2/10/26 reading indicated a "neg" result.<br><br>3. Qualified Medication aide (QMA) 5's hire date was 12/15/25. Her employee record indicated her first step TB screening was 1/9/26 and her second step TB screening was 1/27/26. The result of the 1/27/26 reading indicated a "neg" result.<br><br>During an interview on 4/21/26 at 9:20 A.M., the Director of nursing (DON) indicated the employee hire date was their start work date. Sometimes the employees got their first step TB screening but failed to get the second step so they would restart that series. At that time, she indicated they no longer had records of the initial TB screenings if they received one since the series of two had to be repeated.<br><br>On 4/21/26 at 9:49 A.M., the Administrator indicated there was not a policy to provide, but they would follow the state regulations. | | | |
| R 0155 | Sanitation and Safety Standards - Deficiency<br><br>410 IAC 16.2-5-1.5(l)<br><br>(l) The facility shall have an | R 0155 | No residents have been affected by this deficient practice.<br><br>No other residents have the | 05/01/2026 |

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| | effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items.<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary disposal of waste for 2 of 2 days of the survey. Trash was observed on the ground around dumpsters, and a dumpster was observed overflowing.<br><br>Finding includes:<br><br>On 4/20/26 at 10:00 A.M., 1 of 2 dumpsters (Dumpster A) behind the facility was observed with several items of trash scattered around it. The side door of the dumpster was observed open.<br><br>On 4/21/26 at 9:00 A.M., Dumpster A was observed with trash on the ground surrounding it. The other dumpster (Dumpster B) was observed with the lids up and overflowing with trash. Some of the trash was observed behind the dumpster on the ground. | | potential to be affected by the same deficient practice.<br><br>The systemic change made to ensure this deficient practice does not occur is routine rounding and cleaning of any excess debris around dumpsters every Monday Wednesday and Friday designated to a specific department.<br><br>The Maintenance Director or designee will monitor these changes to ensure the practice will not recur 3 times per week for the first 4 weeks, 2 times per week for the next 4 weeks and 1 time per week for the following 4 weeks.<br><br>This systemic change will be completed Friday 5/1/26. | |

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| | On 4/21/26 at 9:10 A.M., the Director of Nursing (DON) indicated each department was responsible for taking their trash out at the end of the shift and as needed.<br><br>On 4/21/26 at 9:20 A.M., the Maintenance Director indicated the dumpsters were emptied on Monday, Wednesday, and Friday each week. He further indicated any and all staff were responsible for picking up any trash that may be observed on the ground surrounding the dumpsters.<br><br>On 4/21/26 at 10:25 A.M., the DON indicated the trash had been picked up on 4/20/26 at 4:36 A.M., (5-6 hours prior to initial observation) and that during the pickup trash may have been dropped from the dumpster. She indicated the workers that picked up the trash did not clean items that were dropped during pickup.<br><br>On 4/21/26 at 9:49 A.M., the Administrator indicated there was not a policy for dumpster sanitation, but that the facility followed the state regulations. | | | |
| R 0273 | Food and Nutritional Services - Deficiency<br><br>410 IAC 16.2-5-5.1(f)<br><br>(f) All food preparation and serving | R 0273 | No residents have been affected by this deficient practice.<br><br>All residents have the potential | 05/08/2026 |

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| | 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.<br><br>On 4/20/26 at 11:08 A.M., during a dining observation, Kitchen Staff 2 along with two other kitchen staff were observed serving multiple residents drinks, salads with dressings and plates of food without sanitizing their hands. Home Health Aide (HHA) 6 was observed carrying three glass cups of ice cream, one in each hand and one against his body, from a freezer area to a counter where he sat them down and applied chocolate syrup. HHA 6 picked up the glass cups with one in each hand and one against his body and carried the ice cream to three different residents.<br><br>During an interview on 4/21/26 at 9:02 A.M., the Director of Nursing (DON) indicated staff should sanitize hands when passing food and drink. She was not sure but thought it was between every three residents. The DON indicated staff should not carry food against their body.<br><br>On 4/21/26 at 9:49 A.M., the Administrator provided an undated Handling of Food policy which indicated, "...7. Infection | | to be affected by the same deficient practice.<br><br>The systemic changes made to ensure this deficient practice does not occur is mandatory in-service of all kitchen staff related to proper labeling, dating, and storage of open food items, proper handwashing, sanitizing, and general infection control protocols while serving, and proper cleaning schedule education.<br><br>Following the in-service, the Executive Chef or designee will audit food storage areas, handwashing and infection control during server meal times, and sanitation and cleanliness of serving area 3 times per week for the first 4 weeks, 2 times per week for the next 4 weeks and 1 time per week for the following 4 weeks.<br><br>This in service will be completed Friday 5/8/26. | |

Control...b. Staff must sanitize hands every 3 residents served in the restaurant and hand wash if visibly soiled..."

Based on interview, observation, and record review, the facility failed to ensure food was stored and served in accordance with professional standards for 1 of 2 kitchen observations and 1 of 1 dining observations. Foods were not labeled properly, frozen food was open to air in the freezer, the drink machine had splattered dried juice, staff did not sanitize hands while passing food and drink, and staff carrying food against themselves and serving it to residents.

Findings include:

1. On 4/2/26 from 9:25 through 9:45 A.M., the following was observed in the kitchen:

Walk in freezer:

A clear bag of frozen biscuits was open to air.

Stand alone freezer had the following items open to air and not dated:

clear bag of sausage patties

clear bag of chicken breast

clear bag of chicken tenders

clear bag of chicken patties

clear bag of chicken chunks

cardboard box with a clear bag of pork patties

cardboard box with a clear bag of chicken patties.

Dining area of the kitchen:

The grate on the drink machine had paint peeled off throughout and a brown substance.

The juice machine had multiple dried juice areas splattered on it.

The chest freezer had a scoop of ice cream resting on the surface and four uncovered bowls of ice cream. One bowl had a spoon in it.

Live gnats were observed in the area.

During an interview on 4/20/26 at 9:38 A.M., the Dietary Manager indicated food items should not be open to air. Food should be in a bag that was closed, labeled, and dated with the expiration date.

During an interview on 4/20/26 at 9:40 A.M., Kitchen Staff 2 indicated the juice machine should be cleaned weekly

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| | otherwise it would get sticky and gnats. She further indicated that ice cream should be cleaned up immediately if it was dropped, and there should not be any bowls of ice cream in the chest freezer open to air. | | | |

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.)

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETheresa Wolf | TITLEExecutive Director | (X6) DATE05/04/2026 |