STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT ELKHART	1129 PARKWAY AVENUE, ELKHART, , 46516

(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: May 6, 7, and 8, 2026 Facility number: 14916 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Qua;ity review completed May 11, 2026.	R 0000		
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within	R 0090	Executive Director reported incident to the State Department of Health on 5/7/26. The alleged incident had the potential to affect 98 of 98 residents. The Executive Director/designee will report all qualifying incidents to the State Department of Health within 24 hours. The Regional Director of Operations in-serviced Executive Director	05/08/2026

	twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during		regarding the expectations and regulations pertaining to reportable events. The Executive Director/designee will review incidents with Regional team weekly to verify reportable events for a period of six months. Systemic changes will be completed by 5/8/26.	

	the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review the facility failed to ensure a fire involving fencing attached to the building and roof overhang soffit was reported to the Department of Health. 98 residents resided in the building. Findings include: In an interview, on 5/6/2026 at 9:55 AM, Cook 9 indicated staff had been cleaning up from two days prior. During an observation, on 5/6/26 at 11:46 AM, charred fencing and building supports were observed at the back of the building near the employee entrance to the facility kitchen. A document titled Core,			

	provided by the local Deputy Fire Marshall, on 5/7/26 at 10:50 AM, dated 5/4/2026 at 1:48 PM, indicated the Fire Department was summoned to a high risk, high rise, fire at the facility. The document indicated fire crews extinguished a fire in progress in the rear of the building and performed some minor soffit overhaul. The document indicated Fire Unit 11 reviewed security footage with facility staff and determined the source of the fire was an employee discarding a cigarette in a trash hopper. In an interview, Cook 9 indicated to Fire Unit 11, Cook 9 thought she had extinguished the cigarette with her shoe prior to discarding the butt in the trash hopper. In an interview on 5/7/26 at 10:33 AM, the Administrator indicated facility video surveillance included Cook 9 pulling up a chair in the area smoking a cigarette and later throwing the butt of the cigarette in the trash hopper. The Administrator indicated the fire destroyed two fence panels, charred 2 additional panels, burnt into the soffit of the roof overhang. The Administrator indicated one employee was sent to the hospital, treated in the emergency department and released for low blood oxygen saturation. The Administrator indicated she did not report the			

	incident to the Department of Health because she did not know she needed to. A current policy pertaining to reporting of facility unusual occurrences was not available for review at the time of facility exit.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for	R 0117	Business Office Manager(BOM) is no longer employed at community. Executive Director(ED)/designee will be educated regarding personnel file requirements by Regional Director of Operations. All RN/LPN/QMA staff will be trained by a qualified trainer for CPR/First Aide certification. The alleged incident had the potential to affect 98 of 98 residents. ED/designee will audit personnel files for completed CPR/First Aide certifications for all RN/LPN/QMA. Any staff identified as incomplete will be trained on CPR/First aid. ED/designee will review certifications for expiration dates upon hire and monthly for a minimum of 6 months to ensure compliance. Healthcare Director(HCD)/designee will review the schedule weekly for a minimum of 6 months to ensure there is at least one CPR/First Aide certified person on each shift for a minimum of 6 months. Systemic changes will	06/14/2026

	which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure staff certified in cardiopulmonary resuscitation (CPR) and first aid were present in 5 of 21 shifts reviewed. 98 of 98 residents resided in the facility. Findings include: During a record review conducted on 5/7/26 at 11:09 AM, staffing records from the period of 5/2/26 to 5/8/26 were reviewed. On 5/3/26, no first-aid certified staff member was present in the facility between 2:00 PM and 10:00 PM. On 5/5/26, no first-aid certified staff member was present in the facility between 2:00 PM and 10:00 PM. On 5/5/26, no first-aid certified staff member was present in the facility between 10:00 PM and 6:00 AM. On 5/6/26, no first-aid certified staff member was present in the facility between 10:00 PM and 6:00 AM. On 5/7/26, no CPR or first-aid certified staff member was		be completed by 6/14/26.	

	present in the facility between 10:00 PM and 6:00 AM. During an interview, on 5/8/26 at 11:12 AM, the Administrator indicated she had provided all available CPR and first aid certification records. The Administrator indicated a CPR and first aid certified staff member should be present in the facility at all times. A policy titled, Certified Nurse Aide (CNA) job description, undated, provided by the Administrator, on 5/8/26 at 9:18 AM, indicated CNA staff must be CPR and First Aide certified.			
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure all staff members	R 0118	BOM is no longer employed at community. Executive Director(ED)/designee will be provided education regarding requirements of certified/licensed staff by Regional Director of Operations. Staff #7 and #8 were removed from the schedule pending recertification. The alleged incident had the potential to affect 98 of 98 residents. A review of all certified/licensed staff was complete on 5/8/26, by Executive Director. ED/designee will review all certifications/licenses upon hire and monthly for a minimum of 6 months. Any staff member will be removed from schedule if license/certification is not	06/14/2026

	scheduled to work maintained current certifications for 2 of 33 Certified Nurse Aide (CNA) staff members employed by the facility (CNA 7 and CNA 8). Findings include: 1) During a record review, on 5/6/2026 at 10:32 AM, CNA 7's employee records were reviewed. Licence verification performed on the Indiana Professional Licensing Agency (IPLA) website indicated CNA 7's CNA certification had expired on 4/1/2026. A review of facility schedules, provided by the Administrator on 5/6/2026 at 1:56 PM, indicated CNA 7 was scheduled to work from 10:00 PM to 6:00 AM on 5/4/2026, 5/5/2026, and 5/6/2026. 2) During a record review, on 5/6/2026 at 10:32 AM, CNA 8's employee records were reviewed. Licence verification performed on the Indiana Professional Licensing Agency (IPLA) website indicated CNA 8's CNA certification had expired on 2/6/2026.		renewed 1 day prior to expiration. Systemic changes will be completed by 6/14/26.	

	A review of facility schedules, provided by the Administrator on 5/6/2026 at 1:56 PM, indicated CNA 8 was scheduled to work from 2:00 PM to 10:00 PM on 5/4/2026, 5/5/2026, 5/6/2026, and 5/7/2026. In an interview, on 5/7/2026 at 2:25 PM, the Administrator indicated all licensed and certified staff should maintain current licensure and certification. A current policy, titled Certified Nurse Aide Job description, provided by the Adminstrator on 5/8/2026 at 9:18 AM, indicated CNA staff should ensure current certification was maintained.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled;	R 0119	Department heads will be in-serviced on the requirements of job specific orientations by Executive Director (ED)/designee. Cook, LPN, and Housekeeper had job specific orientation completed upon notification. ED/designee will audit staff files for job specific orientations. Any staff without a job specific orientation will be given the orientation and the form will be completed and stored in the personnel file. The alleged incident had the potential to affect 98 of 98 residents. Executive Director/designee will audit employee files monthly for 6	06/14/2026

	(C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure job specific orientation was provided for 3 of 5 employee files reviewed (Cook		months to ensure compliance. Systemic changes will be completed by 6/14/26.	

	3, Licensed Practical Nurse 4, and Housekeeper 5). Findings include: 1. During a record review on 3/6/2026 at 11:25 AM, Cook 3's employee file was reviewed. Cook 3's employee file did not include a record of job specific orientation. 2. Licensed Practical Nurse (LPN) 4's employee file did not include a job specific orientation record. 3. Housekeeper 5's employee file did not include a job specific orientation record. In an interview, on 5/7/2026 at 2:25 PM, the Administrator indicated all employees should receive job specific orientation before being tasked with job responsibilities. She indicated a signed copy of job specific orientation should be maintained in the employee record. A current facility policy, titled Employee File Retention, dated 9/4/2019, provided by the Administrator on 5/8/2026 at 9:35 AM, indicated records of job specific orientation should be maintained in the employee record according to state guidelines..			

R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (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 result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (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. (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.	R 0121	Healthcare Director(HCD) will be educated on the policy related to health screens by Executive Director(ED). Cook, LPN, Housekeeper, QMA, and CNA have completed an updated health screening. ED/designee will audit files for health screenings. Any staff without a health screening will be given a health screening by an LPN at the community which will become part of their personnel file. The alleged incident had the potential to affect 98 of 98 residents. Executive Director/designee will audit employee files monthly for 6 months to ensure compliance. Systemic changes will be completed by 6/14/26.	06/14/2026

	(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (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 until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure an employee heath screening was provided for 5 of 5 employee files reviewed (Cook 3, Licensed Practical Nurse (LPN) 4, Housekeeper 5, Qualified Medicine Aide (QMA) 6, and Certified Nurse Aide (CNA) 10. Findings include: 1. During a record review on 3/6/2026 at 11:25 AM, Cook 3's employee file was reviewed. Cook 3's employee file did not include documentation of an employee health screening. 2. LPN 4's employee file did not include documentation of an employee health screen. 3. Housekeeper 5's employee file did not include documentation of an employee health screen.			

	4. QMA 6's employee file did not include documentation of an employee health screen. 5. CNA 10's employee file did not include documentation of an employee heath screen. In an interview, on 5/8/2026 at 11:12 PM, the Administrator indicated she had mistakenly believed health screening were being performed by a contracted vendor who provided other services for the facility. The Administrator indicated she did not have records of employee health screenings for the files reviewed. The Administrator indicated all employess should have a pre-employment physical on file. A current facility policy, titled Employee File Retention, dated 9/4/2019, provided by the Administrator on 5/8/2026 at 9:35 AM, indicated records of employee health screenings should be maintained in the employee record according to state guidelines..			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the	R 0123	BOM is no longer employed in the community. Executive Director (ED)/designee will be educated on requirements of signed job descriptions by Regional Director of Operations. LPN and Housekeeper signed a job description and this was	06/14/2026

	following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure employee records included a signed job desciption for 2 of 5 employee records reviewed (Licensed Practical Nurse 4 and Housekeeper 5). Findings include: 1. During a record review, on 3/6/2026 at 11:25 AM, Licensed		placed in personnel file. ED/designee will audit files for a current job description. Any staff identified without a current job description will be given one to review and sign which will became part of their employee file. The alleged incident had the potential to affect 98 of 98 residents. Executive Director/designee will audit personnel files monthly for at least 6 months to ensure compliance. Systemic changes will be completed by 6/14/26.	

	Practical Nurse (LPN) 4's employee file was reviewed. LPN 4's file indicated she was hired as Qualified Medicine Aide (QMA) and became licensed as an LPN on 12/3/2025. LPN 4's employee file did not include an LPN job description. 2. Housekeeper 5's employee file did not include a signed job description. In an interview, on 5/7/2026 at 2:35 PM, the Administrator indicated all employees should sign a job description during orientation, before being tasked with job responsibilities. A current facility policy, titled Employee File Rentention, dated 9/4/2019, provided by the Administrator, on 5/8/2026 at 9:35 AM, indicated a signed job description should be maintained in the employee file according to state rules.			
R 0147	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(d) (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on observation,	R 0147	All staff will receive an in-service on the communities smoking policy. The alleged incident had the potential to affect 98 of 98 residents. Executive Director/designee will train staff upon hire and annually regarding smoking safety. Executive Director/designee will walk the outside of the community to look for evidence of smoking in inappropriate	06/14/2026

	interview, and record review the facility failed to ensure smoking policies were followed resulting in a fire affecting the main structure of the building. 98 residents resided in the building. Findings include: In an interview, on 5/6/2026 at 9:55 AM, Cook 9 indicated staff had been cleaning up after a fire from two days prior. During an observation, on 5/6/26 at 11:46 AM, charred fencing and building supports were observed at the back of the building near the employee entrance to the facility kitchen. A metal structure with a fitted ashtray was adjacent to a section of charred fence. The ashtray was full of liquid with 23 floating cigarette butts. 29 cigarette butts were observed in the grass along the sidewalk near the staff entrance to the kitchen. A document titled Core, provided by the local Deputy Fire Marshall, on 5/7/26 at 10:50 AM, dated 5/4/2026 at 1:48 PM, indicated the Fire Department was summoned to a high risk, high rise, fire at the facility. The document indicated fire crews extinguished a fire in progress in the rear of the building and performed some minor soffit overhaul. The document indicated Fire Unit 11 reviewed		areas on a weekly basis for 6 months to ensure compliance. Systemic changes will be completed by 6/14/26.	

	security footage with facility staff and determined the source of the fire was an employee discarding a cigarette in a trash hopper. Fire Unit 11's interview with Cook 9 indicated Cook 9 had been smoking in the area and thought she had extinguished the cigarette with her shoe prior to discarding the butt in the trash hopper. In an interview on, 5/7/26 at 10:33 AM, the Administrator indicated one resident in the facility smoked in a designated area beyond the awning in the front of the building. The Administrator indicated staff could smoke in their personal vehicles in the parking lot only. The Administrator indicated cigarette butts found in the ash tray and grassy area outside the kitchen door were disposed of by employees who were not following the smoking policy. The Administrator indicated facility video surveillance included Cook 9 pulling up a chair in the area smoking a cigarette and later throwing the butt of the cigarette in the trash hopper. A current policy, titled Tobacco Free Workplace, undated, provided by the Administrator, on 5/6/26 at 1:09 PM, indicated staff could smoke during break times in designated areas.			

R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an 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. Based on observation, interview and record review, the facility failed to ensure dumpsters were kept clean and closed during 2 of 2 observations. Findings include: On 5/6/26 beginning at 9:40 AM, the dumpster area was toured with Cook 9. The outside dumpster area was observed to have 2 dumpsters, one dumpster for cardboard and 1 dumpster for trash. Both dumpster lids were observed to be open. The ground area surrounding the dumpster was observed to be littered with debris. The debris was observed to contain a white bag of trash, a black bag of trash, a soiled disposable brief, a wet, folded area rug, and 2 purple disposable gloves. On 5/7/26 at 9:30AM, the dumpster area was toured with	R 0155	Area surrounding dumpsters were cleaned and dumpster lids were closed by Maintenance Director. The alleged incident had the potential to affect 98 of 98 residents. All staff will be in-serviced to keep dumpster lids closed and to keep surrounding area free from litter at all times, by Maintenance Director/designee. Maintenance Director/designee will observe the area weekly for a minimum of 6 months to ensure compliance. Systemic changes will be completed by 6/14/26.	06/14/2026

	Cook 9. The outside dumpster area was observed. Both dumpster lids were observed to be open. The ground area surrounding the dumpster was observed to be littered with a white bag of trash, a black bag of trash, a soiled disposable brief, a wet, folded area rug, and 4 purple disposable gloves. In an interview, on 5/6/26 at 9:55 AM, Cook 9 indicated the dumpster lids should be closed, and the surrounding area should be free from litter. Cook 9 indicated they were not sure which department had the responsibility of keeping the dumpster area clean. A current facility policy, dated 2020, indicated all dumpsters would be covered and the surrounding area would be litter free.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review the facility failed to ensure medication administration was supervised according to the	R 0240	Residents/Families will be made aware of the medication administration/storage policy by Executive Director. Over the counter medications were removed from the resident's room on 5/7/26. The alleged incident had the potential to affect 98 of 98 residents. Staff will be in-serviced to the medication administration policy, by Healthcare Director. Healthcare Director/designee will train staff upon hire and	06/14/2026

	service plan for 2 of 7 of residents reviewed. (Resident 20 and Resident 100) Findings include: 1. During an observation, on 5/6/26 at 10:40 AM, Resident 20 had one bottle of Docusate Sodium 100 mg tablets and one container of chewable TUMS on the table next to her chair. Resident's hands were trembling during the conversation. A record review for Resident 20 began on 5/7/26 at 9:50 AM. Diagnoses included history of fall, hip fracture, weakness, constipation, tremors, depression, and anxiety. A review of Resident 20's current semiannual assessment and service plan, dated11/12/25, indicated Resident 20 was cognitively intact and had a mild vision impairment. The assessment and service plan indicated the resident was dependent on staff for all medication administration. Physician orders, dated 3/4/26, indicated to give Docusate sodium 100 mg once a day as needed.		annually regarding medication administration process. Healthcare Director/designee will audit 5 apartments per week for 6 months to ensure residents that do not have a self-administer order do not have medications in their apartment. Systemic changes will be completed by 6/14/26	

	No order for TUMS (calcium carbonate) was found. In an interview, on 5/7/26 at 11:54 AM, the Executive Director indicated Resident 20 did not have a self-administration of medication assessment. 2. During an observation on 5/7/26 at 11:33 AM, the following was observed: QMA 2 entered Resident 100's room to confirm the scheduled dose of carbidopa-levodopa. Multiple medication bottles were in view on the kitchen counter. QMA 2 exited Resident 100's room, prepared the scheduled dose of carbidopa-levodopa, returned to Resident 100's room, picked up a clear small medication cup with two tablets in the cup. QMA 2 indicated the tablets looked like Centrum Silver multivitamin and torsemide from this morning's medication pass. Resident 100 confirmed not taking the torsemide because of an outing Resident 100 had planned and did not want the diuretic effects during the outing. Bottles of Centrum Silver, Calcium Minis 40 mcg tablets, Vitamin C 500 mg tablets, Imodium tablets, and lactase enzyme tablets were also found in Resident 100's room. A small hammer was on the counter next to the			

	medication bottles. Resident 100 indicated the hammer was used to crush the Calcium Minis tablets. A record review for Resident 100 began on 5/7/26 at 12:13 PM. Diagnoses included Parkinson's Disease, hypertension, and heart failure. A review of Resident 100's current semiannual assessment and service plan, dated 5/4/26, indicated Resident 100 was cognitively intact. The assessment and service plan indicated the resident was dependent on staff for all medication administration. Physician orders, dated 2/19/26, indicated to give Carbidopa-Levodopa 25mg-100 mg, three times a day in ½ tablet to 1 tablet as indicated by Resident 100's preference, Certavite Senior Tablet 1 tablet every morning, Oyster Shell (calcium) 500 with Vitamin D 5 mg twice a day, and Torsemide 20 mg, once a day, in the morning. There were no orders for Vitamin C, Imodium, or Lactase Enzyme available for review. In an interview on, 5/7/26 at 11:40 AM, QMA 2 indicated she watched Resident 100 take her medication that morning and did not know if Resident 100 could			

	self-administer medications. QMA 2 indicated she did not know why a torsemide tablet and multivitamin was in her room at lunchtime medication pass. QMA 2 indicated she didn't know how to look in the electronic medical record to verify if Resident 100 could self-administer medications or keep them in her room. In an interview on, 5/7/26 at 11:54 AM, the Executive Director indicated Resident 100 did not have a self-administration of medication assessment. Staff administered all of Resident 100's medication. A current policy, dated 2/2026, provided by the Executive Director, indicated a periodic nursing assessment indicating a resident can safely administer his/her own medications must be completed. No medication should be at the resident's bedside unless they can self-administer. Residents should not be on a combination of some self-administered and some not self-administered medication.			
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	R 0273	Food at question was discarded for safety purposes. The kitchen will be deep cleaned, oil to fryer changed and all food will be labeled appropriately by 5/10/26. The alleged incident	06/14/2026

	' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure proper storage of open food items. 98 of 98 residents residing in the facility ate food prepared in the kitchen. Findings include: On 5/6/26 beginning at 9:40 AM, the kitchen was toured with Cook 9. In the walk-in cooler, a ¼ full clear plastic bin of coleslaw was observed to have no open date. A cheese sandwich in a clear plastic container did not have an open date. 2 clear plastic containers of cheese slices did not have an open date. A clear plastic bag of shredded cheese did not have an open date. A resealable clear plastic bag of salami did not have an open date. An open plastic bag of hot dogs inside a clear plastic bin did not have a cover. Plastic wrap was observed to be crumpled to one side of the plastic bin. Cook 9 removed the plastic wrap; the plastic wrap was dated 4/22/26. The walk-in freezer was observed to have 4 sealed clear plastic bags on a shelf. The bags contained frozen potatoes. The bags did not have labels or		had the potential to affect 98 of 98 residents. All dining staff will be in-serviced on the cleaning/labeling of food and proper storage including the maintenance of food appliance/food substance by the Dining Service Director/designee. The Dining Service Director(DSD)/designee will observe all requirements are complete weekly for a minimum of 6 months. Systemic changes will be completed by 6/14/26.	

	dates. Cook 9 indicated the potatoes had arrived at the facility in boxes with labels. Cook 9 indicated the bags had been removed from the labeled boxes to maximize storage space. A deep fryer was observed to contain dark brown grease. The grease contained dark brown and black debris floating on top of the grease. The wall behind the deep fryer had layers of a thick, cloudy substance. The floor under the deep fryer had layers of a thick, cloudy substance and debris. The debris consisted of partial French fries ranging from white to black in color. A gas stove grease trap was full of a thick, black substance and yellow and white chunks too numerous to count. The gas burners were littered with clumps of a white cloudy substance and debris of yellow and white chunks too numerous to count. Two trash barrels were observed to be uncovered. Cook 9 indicated they did not know if the trash barrels had lids. Cook 9 indicated she had been employed by the facility for 1 year. She indicated she had never seen lids for the trash barrels during the entire time. In an interview, on 5/6/26 at 9:55 AM, Cook 9 indicated all			

	open food items should be labeled with an open date. Cook 9 indicated the gas stove was not currently in use by the facility. Cook 9 were not sure how often the deep fryer was to be cleaned. Cook 9 indicated they were not sure how often the deep fryer grease was to be changed. Cook 9 indicated they were not sure of when the floors under the gas stove and deep fryer were to be cleaned. A current facility policy, dated 2020, indicated all open food items should be labeled with the open date and discarded within 72 hours. The policy indicated all leftovers should be covered tightly, labeled with the open date and discarded within 72 hours. The policy indicated indicated the kitchen floors were to be washed with hot water and soap daily and as needed. The policy indicated large appliances would be moved to clean the floors at least monthly. The policy indicated all trash receptacles would be provided with tight fitting lids. The policy indicated all trash containers would remain covered except during immediate use.			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear	R 0296	All staff administering medications will be in-serviced on infection control and proper use of PPE by Healthcare Director/designee. The alleged	06/14/2026

	written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview, and record review the facility failed to ensure staff competency regarding eye drop administration for 1 of 1 resident observed. (Resident 90) Findings include: During an observation, on 5/7/26 at 11:20 AM, the following was observed: QMA 2 administered eye drops to Resident 90 without using gloves. QMA 2's left hand held each eye lid open with her left thumb and index finger then administered one eye drop to each eye. QMA 2 left Resident 90's room and touched the laptop track pad with her left-hand fingers without using hand hygiene. A record review for Resident 90 began on 5/8/26 at 12:48 PM. Diagnoses included hypertension, hypothyroid, and dry eyes. A review of Resident 90's current semiannual assessment and service plan, dated 10/28/25, indicated Resident 90 was cognitively intact. The assessment and service plan		incident had the potential to affect 4 of 98 residents. Healthcare Director/designee will train staff upon hire and annually regarding infection control standards and PPE usage. Healthcare Director/designee will observe staff administering eye drops weekly for 1 month, then monthly for a minimum of 6 months to ensure compliance. Systemic changes will be completed by 6/14/26.	

	indicated the resident was dependent on staff to administer all of the resident's medications. A review of physician orders, dated 2/19/26, indicated Refresh Plus 0.5% eye drops were to be administered three times a day, 2 drops in one or both eyes for dry eye relief. In an interview, on 5/7/26 at 11:45 AM, QMA 2 indicated staff are supposed to wear gloves when administering eye drops and use a clean cotton ball to clean each eye. A thumb or two fingers were to be used to hold open the lower eye lid to instill eye drop medication. Staff were to remove gloves and wash hands after the administration was completed. A current policy dated 4/2026, provided by the Executive Director, indicated staff were required to wash hands and put on gloves before eye drop administration.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:	R 0349	All clinical staff that administer medications will be in-serviced on the Medication Administration policy by Healthcare Director/designee. The alleged incident had the potential to affect 98 of 98 residents. Healthcare Director/designee will train staff upon hire and annually	06/14/2026

	(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, interview, and record review the facility failed to ensure complete and accurate documentation of medication administration for 3 of 6 residents reviewed. (Resident 10, Resident 20, and Resident 30) 1. A record review for Resident 10 began on 5/6/26 at 2:30PM. Diagnoses included atrial fibrillation, cardiac pacemaker, hypertension, and atherosclerotic heart disease of a coronary artery. Physician orders, dated 2/27/26, indicated Amiodarone HCL 400mg, was to be given one time, every day. Atorvastatin 40 mg , was to be given one time, every day. Eliquis 5 mg, was to be given 2 times a day. Gabapentin 300mg, was to be given every evening at bedtime. A review of physician orders, dated 4/22/26, indicated Amoxicillin 875 mg was to be given every 12 hours for 7 days. A review of the Medication Administration Record (MAR)		regarding medication management standards. The Healthcare Director/designee will audit the EMAR for missing documentation five times weekly for a minimum of 6 moths to ensure compliance. Systemic changes will be completed by 6/14/26.	

	dated 4/7/2026 to 5/7/26 indicated documentation of medication administration was missing for Amiodarone HCL 400mg on 4/19/26, 4/24/26, 4/25/26, 4/26/26, 4/30/26, 5/1/26, 5/5/26. Documentation was missing for Eliquis 5 mg on 4/19/26 in the morning, 4/24/26 in the morning and evening, 4/25/26 in the morning, 4/26/26 in the morning and evening, 4/29/26 in the morning, 4/30/26 in the morning, 5/1/26 in the morning and evening, 5/4/26 in the evening, 5/5/26 in the morning. Documentation was missing for Gabapentin 300mg on 4/24/26, 4/26/26, 5/1/26, and 5/4/26. Documentation was missing for Amoxicillin 875 mg on 4/24/26 in the morning and evening, 4/25/26 in the morning, 4/26/26 in the morning and evening. A review of progress notes, dated 4/7/2026 to 5/7/26, indicated reasons for medication administration omissions were missing. 2. A record review for Resident 20 began on 5/7/26 at 9:50 AM. Diagnoses included history of fall, hip fracture, weakness, constipation, tremors, depression, and anxiety. A review of Resident 20's current semiannual assessment and service plan, dated			

	11/12/25, indicated Resident 20 was cognitively intact and had a mild vision impairment. The assessment and service plan indicated the resident was dependent on staff for all medication administration. Physician orders, dated 3/4/26, indicated Amlodipine 5 mg was to be given once a day at 9:00 AM. Propranolol 20 mg was to be given twice a day. Tramadol 50 mg was to be given twice a day. A review of the MAR dated 4/1/26 to 4/30/26 indicated documentation of medication administration was missing for Amlodipine 5 mg on 4/19/26, 4/24/26, 4/25/26, 4/26/26, and 4/30/26. Documentation was missing for Propranolol 20 mg on 4/16/26 at 8:00 AM, 4/19/26 at 8:00 AM, 4/24/26 at 8:00 AM and 8:00 PM, 4/25/26 at 8:00 AM, 4/26/26 at 8:00 AM and 8:00 PM, and 4/30/26 at 8:00 AM. Documentation was missing for Tramadol 50 mg on 4/8/26 at 8:00 AM, 4/10/26 at 8:00 PM, 4/19/26 at 8:00 AM, 4/24/26 at 8:00 AM and 8:00 PM, 4/25/26 at 8:00 AM, 4/26/26 at 8:00 AM and 8:00 PM, and 4/30/26 at 8:00 AM. 3. A record Review of Resident 30 began on 5/6/26 at 2:55 PM. Diagnoses included atrial fibrillation, dementia, amnesia,			

	and diabetes type 2. Physician orders, dated 3/4/26, indicated Eliquis 2.5 mg was to be given twice a day. Insulin Lispro 5 units was to be given three times a day before meals, and Acetaminophen 1,000 mg was to be given three times a day. A review of the Medication Administration Record (MAR) dated 4/1/2026 to 4/30/26 indicated Documentation of medication administration was missing for Eliquis 2.5 mg on 4/20/26 at 8:00 AM. Documentation was missing for Insulin Lispro 5 units on 4/3/26 at breakfast time, 4/9/26 at lunch time, 4/17/26 at lunch time, 4/20/26 at breakfast time and 4/26/26 at dinner time. Documentation was missing for Acetaminophen 1,000mg on 4/2/26 at 2:00 PM, 4/3/26 at 2:00 PM, 4/9/26 at 2:00 PM, 4/17/26 at 2:00 PM, 4/20/26 at 8:00 AM, and 4/29/26 at 2:00 PM. In an interview, on 5/8/26 at 11:12 AM, the Director of Nursing indicated staff administering medications should not leave missing documentation on the MAR. When the resident was out of the building or refused staff should have used the correct response to document .			

	A current policy dated 2/2026, provided by the Executive Director, indicated medications administered by staff must be documented immediately after resident administration or refusal.			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure complete documentation related to death for 1 of 1 resident reviewed (Resident 50). Findings include: On 5/7/26 at 9:50 AM, a review of a move-out report, dated 2/6/26 through 5/6/26, indicated Resident 50 had been given notice on 3/21/26 and had moved out on 3/30/26. The	R 0357	The community was provided the policy regarding the death of a resident by the corporate team. All QMA/LPN/RN will be in-serviced on the documentation policy related to a resident’s death by Healthcare Director/designee. The alleged incident had the potential to affect 98 of 98 residents. Healthcare Director/designee will train staff upon hire and as needed regarding standards around charting a resident’s death. The Healthcare Director/designee will review documentation following a death for a minimum of 6 months. Systemic changes will be completed by 6/14/26.	06/14/2026

	reason for the move out was listed as deceased. Resident 50's record was reviewed on 5/7/26 at 9:55 AM. Diagnoses included heart failure and chronic kidney disease. Resident 50's medical record did not contain any reference to his death. Resident 50's most recent progress note was dated 12/22/25. Resident 50's medical record was reviewed on 5/7/26 at 11:59 AM. The medical record did not include Resident 50's condition at the time of death, the disposition of their remains or the disposition of their medications and personal belongings. On 5/7/26 at 2:20 PM, Resident 50's burial transit permit was reviewed. Resident 50 passed away on 3/21/26 at 7:37 AM. On 5/8/26 at 12:15 PM, Resident 50's hospice notes for benefit period 1/27/26 through 4/26/26 were reviewed. The hospice notes indicated Resident 50's most recent hospice visit was on 3/20/26. The hospice notes did not indicate the resident's condition preceding death, vital signs, disposition of their remains or			

	disposition of their personal belongings and medications. Resident 50's vital sign record, dated 6/5/25 through 2/18/26, was provided by the facility on 5/8/26 at 12:50 PM. Resident 50's most recent vital sign assessment was on 2/18/26 at 2:14 PM. In an interview, on 5/8/26 at 12:45 PM, the Administrator indicated they did not have any other documentation related to the events of Resident 50's death. The Administrator indicated the facility did not have a policy specific to resident death. A current facility policy, titled Transfer/Discharge of a Resident, dated 4/2021, indicated move-out inspection was to be completed after the resident's personal belongings have been removed.			

R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure documentation of Annual Health Statements for 5 of 6 residents reviewed (Resident 20, Resident, 30, Resident 60, Resident 70, and Resident 80). Findings include: 1. Resident 20's Annual Health Statement, dated 7/31/24, had not been updated. Resident 20's diagnoses included hip fracture, weakness, depression, and anxiety. 2. Resident 30's Annual Health Statement, dated 2/25/25, had not been updated. Resident 30's diagnoses included diabetes, dementia, and amnesia. 3. Resident 60's Annual Health Statement, dated 1/10/23, had not been updated. Resident 60 diagnoses included dementia and stroke.	R 0409	Residents 20, 30, 60, 70 and 80 had their annual Health Statement updated and placed in chart. All resident charts will be audited for last dated annual health statement by Healthcare Director (HCD)/designee. The alleged incident had the potential to affect 98 of 98 residents. The Healthcare Director/designee will audit resident files monthly for a minimum of 6 months to ensure Health Statements are up to date. Any resident with a health statement with a date that exceeds one year will be updated by their physician and placed in chart by HCD/designee. The Healthcare Director/designee will ensure an annual health statement is completed prior to resident’s anniversary date. Systemic changes will be completed by 6/14/26.	06/14/2026

4. Resident 70's Annual Health Statement, dated 2/3/23, had not been updated. Diagnoses included dementia and heart failure.

5. Resident 80's Annual Health Statement, dated 4/25/25, had not been updated. Resident 80's diagnoses included dementia, obstructive sleep apnea, and diabetes.

In an interview on, 5/7/26 at 1:50 PM, the Administrator indicated they were unable to locate recent annual health statements for Resident 20, Resident 30, Resident 60, Resident 70, and Resident 80.

In an interview on, 5/8/26 at 11:15 AM, the Director Nursing (DON) indicated they were unaware of the requirement of an annual health statement for each resident.

A current facility policy, dated 4/2026, indicated each resident's medical history would include the most recent history and physical examination, admission tuberculosis (TB) screening, current TB screening, special care unit approval and mental health screening if applicable. The policy did not reference the requirement of an annual health statement.

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 SIGNATURETara Carney	TITLEExecutive Director	(X6) DATE05/28/2026