STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN SENIOR LIVING LLC	1375 NICOLE DRIVE, FRANKLIN, , 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: June 15 and 16, 2026 Facility number: 015132 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 19, 2026.	R 0000	Franklin Senior Living LLC 1375 Nicole Drive Franklin, IN 46131 Dear Ms. Suzanne Kuzemka, On June 16, 2026, an annual survey (Event ID K1YT11) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of July13, 2026. Please feel free to call me with any further questions on 1 (317)	

			992-6335. Respectfully submitted, Lasha Miller (Executive Director) Franklin Senior Living LLC 1375 Nicole Drive Franklin, IN 46131	
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure pre-employment references were completed for 2 of 5 employee records reviewed. (CNA 15, Activities Assistant 17) Findings included: 1. On 6/16/26 at 10:33 a.m., the employee record for Certified Nursing Aide (CNA) 15 was reviewed. The record indicated the CNA was hired on 4/22/26	R 0116	R116 Personal Non-Compliance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1. Immediate Actions Taken for Those Residents Identified:** Reference checks were completed for CNA #15 and Activity Assistant #17. No	07/13/2026

	and was currently an employee of the facility. The employee record lacked pre-employment reference checks prior to employment. 2. On 6/16/26 at 10:45 a.m., the employee record for Activities Assistant 17 was reviewed. The record indicated the Activities Assistant was hired on 5/18/26 and was currently an employee of the facility. The employee record lacked pre-employment reference checks prior to employment. During an interview on 6/16/26 at 11:00 a.m., the Executive Director (ED) indicated new employees were to have reference checks prior to employment. On 6/16/26 at 11:15 a.m., the ED provided a policy titled Background Screening and Annual Verification, dated 5/1/23, and indicated it was the current policy being used by the facility. A review of the policy indicated "...new hire screenings...Prior employment verification (minimum of 2 written/verbal verifications."		residents were affected by this citation. **2. How the Facility Identified Other Residents:** Any resident residing in the facility had the potential to be affected. An audit was completed on all staff files to verify that reference checks were completed. HR was educated to ensure pre-employment reference checks are completed prior to hire. **3. Measures Put Into Place/System Changes:** The RSD/Designee will review all new hire files 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, and then weekly for 4 months to ensure compliance. **4. How the Corrective Actions Will Be Monitored:** The RSD/Designee will be responsible for implementing this Plan of Correction. Audit findings will be presented to the QAA Committee monthly for 6 months. The results of these audits will be reviewed during the Quality Assurance meetings monthly for 6 months or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns	

			and make recommendations to revise the Plan of Correction as indicated. **5. Date of Compliance:** July 13, 2026	
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 which they are trained to perform.	R 0117	R117 Personal Deficiency The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1. Immediate Actions Taken for Those Residents Identified:** All nursing staff will complete CPR and First Aid certification by July 12, 2026. **2. How the Facility Identified Other Residents:**	07/13/2026

	Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure all shifts had at least one staff member working who was First Aid certified for 6 of 21 shifts reviewed for First Aid certification. (CNA 13, CNA 15, QMA 14) Finding includes: On 6/16/26 at 8:10 a.m., the Executive Director provided a copy of the "as worked" staff schedule from 6/9/26 through 6/15/26. A review of the document indicated the following: - The work schedule identified 3 - eight-hour shifts per day. The "first shift" hours were from 7:00 a.m. to 3:00 p.m.; the "second shift" hours were from 3:00 p.m. to 11:00 p.m.; and the "third shift" hours were from 11:00 p.m. to 7:00 a.m. - The daily schedule identified each staff member who worked that particular shift and who was designated as the certified First Aid (training course that provides individuals with the knowledge and skills to respond to a medical emergency until more qualified help arrived) staff member for that shift.		Any resident residing in the facility had the potential to be affected. An audit was completed on all staff to verify expiration dates of CPR and First Aid certification cards. HR was educated to maintain a logbook with expiration dates for CPR and First Aid certifications and to notify staff to renew certifications prior to expiration. **3. Measures Put Into Place/System Changes:** The BOM/RSD/Designee will review the staffing schedule 7 days per week for 4 weeks, then 3 times weekly for 4 weeks, and then weekly for 4 months to ensure the facility has at least one staff member with current CPR and First Aid certification on all shifts. **4. How the Corrective Actions Will Be Monitored:** The RSD/Designee will be responsible for implementing this Plan of Correction. Audit findings will be presented to the QAA Committee monthly for 6 months. The results of these audits will be reviewed during the Quality Assurance meetings monthly for 6 months or until 100%	

	- Certified Nurse Aide (CNA) 13 was identified as having worked the "third shift" on 6/10/26, 6/12/26, and 6/15/26 and was identified as the designated certified First Aid staff member for those shifts. CNA 13's employee record lacked a First Aid certification. No other facility staff members working those shifts were certified for First Aid. - CNA 15 was identified as having worked the "second shift" on 6/11/26 and was identified as the designated certified First Aid staff member for that shift. CNA 15's employee record lacked a First Aid certification. No other facility staff members working that shift were certified for First Aid. - Qualified Medication Aide (QMA) 14 was identified as having worked the "third shift" on 6/13/26 and 6/14/26 and was identified as the designated certified First Aid staff member for those shifts. QMA 14's employee record lacked a First Aid certification. No other facility staff members working those shifts were certified for First Aid. The facility records lacked verification that CNA 13, CNA 15, and QMA 14 had a First Aid certification. During an interview on 6/16/26 at 12:20 p.m., the Resident Services Director indicated she		compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the Plan of Correction as indicated. **5. Date of Compliance: July 13, 2026**	

	was unable to provide verification that CNA 13, CNA 15, and QMA 14 were First Aid certified. During those six shifts covered by CNA 13, CNA 15 and QMA 14, no other staff members who worked those shifts were First Aid certified. During an interview on 6/16/26 at 12:50 p.m., the Resident Services Director indicated the facility was to follow the State regulations regarding the certified First Aid staffing requirements. The facility lacked at least one certified First Aid staff member for every shift. On 6/16/26 at 12:45 p.m., the Resident Services Director provided a copy of the Resident Services: Cardiopulmonary Resuscitation (CPR) policy, dated 2/29/24 and indicated it was the current policy in use by the facility. A review of the document indicated, "...validate nursing staff...annually or as dictated by state specific requirements..."			
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),	R 0121	R121 Personal Non-Compliance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of	07/13/2026

	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. (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,		this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1. Immediate Actions Taken for Those Residents Identified:** 2 step PPD were completed for CNA #16 and Activity Assistant #17. No residents were affected by this citation. **2. How the Facility Identified Other Residents:** Any resident residing in the facility had the potential to be affected. An audit was completed on all staff files to verify that 2 step PPD were completed. HR was educated to ensure 2 steps PPD are completed upon hire. **3. Measures Put Into Place/System Changes:** The RSD/Designee will review all new hire files 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, and then weekly for	

	fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure new employees had a pre-employment health screen and tuberculin skin test for 2 of 5 employee records reviewed. (Activities Assistant 17, CNA 16) Findings include: 1. On 6/16/26 at 10:30 a.m., the employee record for Activities Assistant 17 was reviewed. The record indicated Activities Assistant 17 was hired on 5/13/26 and was a current employee of the facility. Activities Assistant 17's record lacked a required pre-employment health screen. During an interview on 6/16/26 at 10:45 a.m., the Executive Director (ED) indicated all employees should have a pre-employment health screen prior to employment. On 6/16/26 at 11:26 a.m., the Resident Services Director provided a policy titled Back Ground Screening and Annual Verification, dated 6/24/25 and indicated it was the current policy being used by the facility. A review of the policy indicated "...new hire screenings...Appropriate health		4 months to ensure compliance. **4. How the Corrective Actions Will Be Monitored:** The RSD/Designee will be responsible for implementing this Plan of Correction. Audit findings will be presented to the QAA Committee monthly for 6 months. The results of these audits will be reviewed during the Quality Assurance meetings monthly for 6 months or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the Plan of Correction as indicated. **5. Date of Compliance:July 13, 2026**	

	screenings as defined by state regulatory statutes and community standards." 2. On 6/16/26 at 10:35 a.m., the employee record for Certified Nursing Aide (CNA) 16 was reviewed. The record indicated CNA 16 was hired on 5/4/26 and was a current employee of the facility. CNA 16's employee record lacked documentation that a first and second step mantoux skin test (tuberculosis screening) had been completed. During an interview on 6/16/26 at 10:45 a.m., the ED indicated new employees were to receive the required first and second step skin mantoux test. On 6/16/26 at 11:26 a.m., the Resident Services Director provided a policy titled TB-SNF Associate Screening, dated 9/1/23, and indicated it was the current policy being used by the facility. A review of the policy indicated "...1. Each newly hired Franciscan Advisory Services' associate must receive a TB 2-step intra-cutaneous (Mantoux) test..."			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h)	R 0151	**R151 Safety and sanitation standard non compliance.** The facility requests paper	07/13/2026

	(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed for 2 of 5 residents who housed pets in the facility. (Resident 821, Resident 836) Findings include: On 6/15/26 at 1:00 p.m., the Executive Director provided a list of residents who housed pets in the facility. A review of the document indicated that Resident 821 had a canine pet and Resident 836 had a feline pet who resided with the residents. 1. On 6/16/25 at 11:55 a.m., Resident 821's canine rabies vaccination and annual veterinary examination record was reviewed. The document titled Rabies Certificate, dated 3/29/25, indicated the canine's rabies vaccination was administered and the annual veterinary examination was conducted on 3/29/25. The next rabies vaccination and annual veterinary examination was due was due on 3/29/26. No other documentation was provided.		compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1. Immediate Actions Taken for Those Residents Identified:** Resident 821's and 836's canine rabies vaccination and annual examination will be completed by Jul,13, 2026.No residents were affected by this citation.	

	2. On 6/16/26 at 11:55 a.m., Resident 836's feline rabies vaccination and annual veterinary examination record was reviewed. The document titled Animal Hospital of Martinsville (AHOM) Vaccine Certificate, dated 9/8/22, indicated the feline's rabies vaccination was administered and the annual veterinary examination was conducted on 9/8/22. The next rabies vaccination and annual veterinary examination was due on 9/8/25. No other documentation was provided. The records lacked a current rabies vaccination certification and the annual veterinary examination of the canine and feline. During an interview on 6/16/26 at 11:58 p.m., the Executive Director indicated Resident 821 and Resident 836's rabies vaccination and annual veterinarian examination documentation should have been updated. On 6/16/26 at 11:35 a.m., the Executive Director provided a copy of the Pet Policy Number: RS-21, with a revision date of 6/1/21, and indicated it was the current policy in use by the facility. A review of the document indicated, "...4. Resident must provide initial		**2. How the Facility Identified Other Residents:** Any resident residing in the facility had the potential to be affected. An audit was completed on all with pets to ensure all pets have their rabies vaccination and examination annually. All pets in the facility were up to date with their vaccination and annual examination. **3. Measures Put Into Place/System Changes:** The ED/RSD will track all residents including new admissions with pets to ensure that rabies vaccination and annual exam is conducted timely. ED/RSD will conduct monthly audits x 6 months to ensure compliance. **4. How the Corrective Actions Will Be Monitored:** The RSD/Designee will be responsible for implementing this Plan of Correction. Audit findings will be presented to the QAA Committee monthly for 6 months. The results of these audits will be reviewed during the Quality Assurance meetings monthly for 6 months or until 100% compliance	

	proof of vaccination and freedom from fleas and ticks from a veterinarian to the Community and annually thereafter..." On 6/16/26 at 12:08 p.m., a review of the Rabies Vaccination Requirements located at 345 IAC 1-5-2 indicated, "...all dogs and cats...3 months of age and older must be vaccinated against rabies..."		is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the Plan of Correction as indicated. **5. Date of Compliance:July 13, 2026**	
R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between one hundred (100) degrees Fahrenheit and one hundred and twenty (120) degrees Fahrenheit for 6 of 14 resident apartments in the building reviewed for hot water temperatures. (Apartment 140, Apartment 143, Apartment 144,	R 0187	**R187 Physical Plant Standard Deficiency** The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1. Immediate Actions Taken for Those Residents**	07/13/2026

	Apartment 230, Apartment 228, Apartment 222) Findings include: During a facility tour with the Executive Director the following was observed: 1. On 6/16/26 at 8:13 a.m., Apartment 140's bathroom sink's hot water temperature was observed to be 128 degrees Fahrenheit (F). 2. On 6/16/26 at 8:21 a.m., Apartment 143's kitchen sink's hot water temperature was observed to be 125 degrees F. 3. On 6/16/26 at 8:22 a.m., Apartment 144's bathroom sink's hot water temperature was observed to be 125 degrees F. 4. On 6/16/26 at 8:46 a.m., Apartment 230's kitchen sink's hot water temperature was observed to be 126 degrees F. 5. On 6/16/26 at 8:51 a.m., Apartment 228's kitchen sink's hot water temperature was observed to be 92 degrees F. During an interview at that time, Resident 808 indicated that her hot water never got hot.		**Identified:** The Maintenance Director adjusted the water temperature to ensure it is maintained between 100°F and 120°F. Apartments 140, 143, 144, 230, 228, and 222 were rechecked after the temperature adjustment, and all apartment water temperatures were confirmed to be within the required range of 100°F–120°F. **2. How the Facility Identified Other Residents:** Any resident residing in the facility had the potential to be affected. No residents were found to be affected by this citation. **3. Measures Put Into Place/System Changes:** The Maintenance Director was educated by the Executive Director (ED) on maintaining appropriate water temperature and completing weekly water temperature checks throughout the building. The ED/Designee will audit 5 random apartments weekly for 4 weeks, then 3 apartments weekly for 4 weeks, and then 1 apartment weekly for 4 months to ensure ongoing compliance. **4. How the Corrective Actions**	

	6. On 6/16/26 at 9:03 a.m., Apartment 222's kitchen sink's hot water temperature was observed to be 122 degrees F. During an interview on 6/16/26 at 8:15 a.m., the Executive Director indicated that the water temperatures were to be between 100 and 120 degrees F. On 6/16/26 at 8:10 a.m., the Executive Director provided a copy of Franciscan Advisory Services System Policy section: Plant operations, Subject: Hot Water Standards with an effective date of 2/1/23 and indicated it was the current policy in use by the facility. A review of the policy indicated, Purpose: To ensure safety of residents exposed to hot water while maintaining temperature levels that meet effective sanitation requirements. "...1. Resident areas - Maximum temperature 110 F ..." degrees Fahrenheit.		**Will Be Monitored:** The RSD/Designee will be responsible for implementing this Plan of Correction. Audit findings will be presented to the QAA Committee monthly for 6 months. Results will be reviewed during Quality Assurance meetings monthly for 6 months or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the Plan of Correction as indicated. **5. Date of Compliance:July 13, 2026**	
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.	R 0273	**R273 Food and Nutritional Services** The facility requests paper compliance for this citation. This Plan of Correction is the center’s credible allegation of compliance. Preparation and/or execution of	07/13/2026

	Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 3 kitchen observations. Refrigerated foods were not covered and labeled and staff hair was not covered while in the kitchen food preparation area. (Server, 2, Server 3, Server 4, Server 5, Server 6, Server 7, Server 8, Dish Washer Aide 9, and Server 10) Findings include: 1. During the initial kitchen tour with Cook 12 on 6/15/26 from 8:42 a.m. to 9:00 a.m., the following was observed: - Inside the kitchen's walk-in refrigerator was observed. One large tray that held ten cooked chicken pieces with a label dated 6/12/26 was observed on a cart. The tray was observed to not be covered. - One large tray that held sliced pieces of cake was observed on a cart inside the walk-in refrigerator. The tray was observed to not be covered and it lacked a label for when the tray was placed into the refrigerator. During an interview at that time, Cook 12 indicated both food trays should have been covered and the cake		this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1. Immediate Actions Taken for Those Residents Identified:** All open food items without dates were immediately discarded. All kitchen staff were educated on proper labeling of food items with dates, covering food items, and properly securing hair using hair nets. No residents were affected by this citation. **2. How the Facility Identified Other Residents:** Any resident residing in the facility had the potential to be affected. No residents were affected by this citation. **3. Measures Put Into Place/System Changes:** The DSD/Designee will visually inspect the kitchen 3 times weekly for 4 weeks, then 2 times	

	should have been labeled and dated. Cook 12 indicated he was unsure how long the foods could be left in the refrigerator before they must be discarded. - Server 2 was observed walking through out the kitchen area and near the steamtable where the breakfast foods were held. Server 2's head was covered with hair that was approximately two and a half inches in length. The hair was observed to not be covered. **-** Server 3 was observed walking through out the kitchen area and near the steamtable where the breakfast foods were held. Server 3 was observed to have hair, approximately 24 inches in length, that hung below the shoulder area. The hair was observed to not be covered. - Server 4 was observed walking through out the kitchen area and near the steamtable where the breakfast foods were held. Server 4 was observed to have her hair pulled into a ponytail at the back of her head, approximately 10 inches in length, that hung below the shoulder area. The hair was observed to not be covered.		weekly for 4 weeks, and then 1 time weekly for 4 months to ensure food is properly labeled, covered, and hair nets are being utilized appropriately. Any concerns will be addressed immediately. **4. How the Corrective Actions Will Be Monitored:** The RSD/ED/Designee will be responsible for implementing this Plan of Correction. Audit findings will be presented to the QAA Committee monthly for 6 months. Results of these audits will be reviewed in Quality Assurance meetings monthly for 6 months or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the Plan of Correction as indicated. **5. Date of Compliance:July 13, 2026**	

2. During a follow-up kitchen observation on 6/15/26 from 11:13 a.m. to 11:35 a.m., the following was observed:

- Server 3 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 3 was observed to have hair, approximately 24 inches in length, that hung below the shoulder area. The hair was observed to not be covered.

- Server 4 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 4 was observed to have hair pulled into a ponytail to the back of her head, approximately 10 inches in length, that hung below the shoulder area. The hair was observed to not be covered.

- Server 5 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 5 was observed to have hair pulled into a ponytail in the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was observed to not be covered.

	- Server 6 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 6 was observed plating cookies for the residents' desserts. Server 6 was observed to have long braided hair that was pulled into a ponytail at the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was observed to not be covered. - Server 7 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 7 was observed to have long braided hair that was pulled into a ponytail in the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was observed to not be covered. - Server 8 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 8 was observed to have long braided hair that was pulled into two ponytails in the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was			

observed to not be covered.

- Dish Washer Aide 9 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Dish Washer 9 was observed wearing a ball cap. Below the Dish Washer 9's ball cap, hair was observed to be approximately 7 inches in length and near the should area. The hair below the cap was observed to not be covered.

- Server 10 was observed walking through out the kitchen area, near the steamtable which held the noon meal, and near where the food was being plated. Server 10 was observed to have curly hair that was approximately 8 inches in length. The hair was observed to not be covered.

3. During a follow-up kitchen observation on 6/15/26 from 12:55 p.m. to 1:05 p.m., the following was observed:

- Server 6 was observed walking through out the kitchen area, near the steamtable that held the noon meal, and near where the foods were being plated. Server 6 was observed filling cups with ice cream for the residents. Server 6 was observed to have long braided hair that was pulled into a

	ponytail at the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was observed to not be covered. - Server 8 was observed walking through out the kitchen area, near the steamtable that held the noon meal, and near where the foods were being plated. Server 8 was observed to have long braided hair that was pulled into two ponytails at the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was observed to not be covered. - Server 10 was observed walking through out the kitchen area, near the steamtable that held the noon meal, and near where the foods were being plated. Server 10 was observed to have curly hair that was approximately 8 inches in length. The hair was observed to not be covered. - Server 7 was observed walking through out the kitchen area, near the steamtable that held the noon meal, and near where the foods were being plated. Server 7 was observed to have long braided hair that was pulled into a ponytail in the back of her head, approximately 14 inches in length, that hung below the shoulder area. The hair was observed to not be			

covered.

During an interview on 6/15/26 at 8:40 a.m., Server 2 indicated he was unsure where the hairnets (hair restraints) were kept.

During an interview on 6/15/26 at 1:10 p.m., Cook 12 indicated "only the cooks" were required to wear hair nets while in the kitchen.

On 6/15/26 at 1:40 p.m., the Executive Director provided a copy of the Food Storage policy, dated 10/25/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...ensure all perishable, non-perishable...are stored safely and according to local and state requirements...if a product is removed from its original packaging, it should be tightly completely wrapped...with tight-fitting lid then label and dated..."

On 6/15/26 at 1:40 p.m., the Executive Director provided a copy of the Personnel Hygiene policy, dated 10/25/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...dietary associate's personnel hygiene is an essential part of food safety and preventing the spread of bacteria...hair must be

	appropriately restrained per local/state regulations...hair net or clean cap that completely covers all hair is required in any food production area..." During an interview at that time, the Executive Director indicated the staff hair was to be kept covered while in the kitchen and refrigerated foods were to be kept covered and labeled while in the refrigerator. On 6/15/26 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC (Indiana Administrative Code) 7-26, effective April 15, 2025, indicated, "... foods shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded...food shall be protected from contamination by storing the food...covered containers, or wrappings...wrap food tightly to prevent cross contamination...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."				

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 SIGNATURELasha	TITLEMiller	(X6) DATE07/01/2026