STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF GATEWAY PARK	6338 WEST QUIET ROAD, GREENFIELD, , 46140

(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: 10/17/2025 and 10/20/2025 Facility number: 015521 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 23, 2025.	R 0000	R091 – Abuse Prevention / QMA Certification Verification Deficiency: Facility failed to follow abuse prevention policy; QMA with abuse finding remained employed. Correction: • QMA 5 suspended and terminated upon confirmation of abuse finding, termed on 10/24/25. • IPLA registry re-checked for all licensed staff; no other findings identified. Identification of Affected Individuals: • Health and Wellness Director completed assessment on all residents; no negative outcomes identified.Systemic Changes: • Hiring process updated to require documented IPLA verification at hire and quarterly. By the Health and Wellness Director. • Health and Wellness Director and Business Office Manager will co-sign License Verification Form prior to first shift. • Executive Director/Health and Wellness Director/ Business Office Manger signed up on Indiana website, to receive notification of any employee licensing issues. https://cloud.subscription.in.gov/signup?depid=546006748&prefCode=INSDH_921Monitoring: • Business Office Manager /designee will	

			complete quarterly audits of all licensed staff credentials. • Executive Director will review results for QA/QI for 12 months. R092 – Fire Drills on All Shifts Deficiency: Fire drills conducted only on day shift for three quarters. Correction: • 2nd shift drill completed by 11/7/2025 by the Maintenance Director documentation filed.Identification: • No residents were affected. Systemic Changes: • TELS Drill calendar ensures all shifts are covered quarterly, per policy and additional throughout the year. • Maintenance Director will review completion monthly and report any task out of compliance to Executive Director.Monitoring: • Maintenance Director submits quarterly logs to ED. • Executive Director will review logs during QA/QI for six consecutive quarters.R119 – Orientation Prior to Independent WorkDeficiency: CNA lacked documentation of completed orientation prior to working independently.Correction: • CNA 9 retrained on resident rights, dementia, abuse prevention, and job-specific skills; documentation filed. By the Health and Wellness Director.Identification: • All employee files reviewed by the Executive Director with no additional gaps found.Systemic Changes: • Orientation checklist revised by Health and Wellness Director; trainer and trainee signatures required before independent assignment. • Health and Wellness Director or verifies completion before scheduling. Monitoring: • Business Office Manager or audits 3 new-hire files/month for 6 months, then	

			quarterly.Executive Director will review audit at least quarterly during QA/QIR123 – Personnel Records ContentDeficiency: Multiple files lack training and job skill documentation.Correction: • Files for CNA 9, LPN 7, HHA 8 updated with orientation, job descriptions, and resident rights training by Business office Manager • Full personnel-file audit completed by 12/1/2025. Noncompliant items will be corrected by the Business Office Manager or .Systemic Changes: • Employee File Policy clarified with mandatory document list. • Business Office Manager or will conduct monthly file reviews of at least 10% of the personnel files. Monitoring: • Executive Director will review audit of 10% of files at least quarterly during QA/QI for 12 months.R154 – Kitchen Sanitation (Freezer Ice & Dishwasher) Deficiency: Ice accumulation in walk-in freezer; staff not trained dishwasher sanitization.Correction: • Freezer defrosted and inspected 10/21/2025, fixed on 11/5/2025. • Temperature/sanitization logs implemented on 10/27/2025. • Dietary staff educated on defrosting and chlorine test-strip use by 11/10/2025. By the Dining Services Director.Systemic Changes: • Dining Services Director verifies temperature and sanitization logs daily. • Maintenance inspects freezer weekly for ice build-up.Monitoring: • Dining Services Director or designee completes weekly log audits for 3 months, then monthly reports findings to EDThe Executive Director will review at least quarterly during QA/QI.R157	

			– Temperature Logs (Refrigerator/Freezer/Dish Machine)Deficiency: No temperature logs for 9 months. Correction: • AM/PM logs implemented for refrigerator, freezer, and dish machine on 10/27/2025. • Internal thermometers replaced and calibrated on 10/29/2025.Systemic Changes: • Policy updated to require twice-daily checks and documentation. • Dining Service Director or will be responsible for oversight and ensuring documentation completed weekly. Any blanks will be reported to the Executive Director.Monitoring: • Executive Director will review weekly for 3 months; monthly audits for 12 months.R412 – TB ScreeningDeficiency: Resident 4 lacked annual TB screening/risk assessment.Correction: • TB risk assessment completed 10/21/2025; no symptoms identified. • All resident charts reviewed by (insert job title) for TB compliance; no additional issues. Systemic Changes: • Move-in checklist includes TB due-date tracking. • Monthly review added to HWD Quality Audit Tool. Monitoring:• Executive Director will review 5 random charts for TB compliance at least quarterly during QA/QI review.	
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and	R 0091	R091 – Abuse Prevention / QMA Certification Verification Deficiency: Facility failed to follow abuse prevention policy; QMA with abuse finding remained employed. Correction: • QMA 5 suspended and terminated upon confirmation	10/27/2025

	facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to follow their abuse prevention policy pertaining to a staff member's qualified medication aide (QMA) certification for 1 of 5 employee files reviewed. (QMA 5) Findings include: Review of the employee files, on 10/20/2025 11:30 a.m., indicated QMA 5 was hired on 4/8/2025. Review of the professional licensing agency registry indicated QMA had a finding of abuse on her certification, dated 8/8/2025. During an interview on 10/20/2025 at 12:45 p.m., the Director of Health and Wellness indicated she was not aware of the finding on QMA 5's certification, that it was the expectation of the facility staff to report findings on their license immediately, and it was part of		of abuse finding, termed on 10/24/25. • IPLA registry re-checked for all licensed staff; no other findings identified. Identification of Affected Individuals: • Health and Wellness Director completed assessment on all residents; no negative outcomes identified.Systemic Changes: • Hiring process updated to require documented IPLA verification at hire and quarterly. By the Health and Wellness Director. • Health and Wellness Director and Business Office Manager will co-sign License Verification Form prior to first shift. • Executive Director/Health and Wellness Director/ Business Office Manger signed up on Indiana website, to receive notification of any employee licensing issues. https://cloud.subscription.in.gov/signup?depid=546006748&prefCode=INSDH_921Monitoring: • Business Office Manager /designee will complete quarterly audits of all licensed staff credentials. • Executive Director will review results for QA/QI for 12 months.	

	the facility's policy to not employ staff with findings of abuse. During an interview on 10/20/2025 at 3:45 p.m., the Director of Health and Wellness indicated when she spoke to QMA 5, on 10/20/2025, to inform QMA 5 of a suspension pending an investigation, QMA 5 reported that the finding was from November 2024. QMA 5 indicated the pending finding was not reported because QMA 5 was " ... awaiting paperwork ..." A policy entitled "Abuse, Neglect, Exploitation Prevention" was provided by the Director of Health and Wellness on 10/20/2025 at 3:51 p.m. The policy indicated all employees should be screened to ensure, " ...no active pending against his/her certificate ..." Based on interview and record review, the facility failed to follow their abuse prevention policy pertaining to a staff member's qualified medication aide (QMA) certification for 1 of 5 employee files reviewed. (QMA 5) Findings include: Review of the employee files, on 10/20/2025 11:30 a.m., indicated QMA 5 was hired on 4/8/2025. Review of the professional licensing agency registry indicated QMA had a			

	finding of abuse on her certification, dated 8/8/2025. During an interview on 10/20/2025 at 12:45 p.m., the Director of Health and Wellness indicated she was not aware of the finding on QMA 5's certification, that it was the expectation of the facility staff to report findings on their license immediately, and it was part of the facility's policy to not employ staff with findings of abuse. During an interview on 10/20/2025 at 3:45 p.m., the Director of Health and Wellness indicated when she spoke to QMA 5, on 10/20/2025, to inform QMA 5 of a suspension pending an investigation, QMA 5 reported that the finding was from November 2024. QMA 5 indicated the pending finding was not reported because QMA 5 was " ... awaiting paperwork ..." A policy entitled "Abuse, Neglect, Exploitation Prevention" was provided by the Director of Health and Wellness on 10/20/2025 at 3:51 p.m. The policy indicated all employees should be screened to ensure, " ...no active pending against his/her certificate ..."			
R 0092	Administration and Management - Noncompliance	R 0092	R092 – Fire Drills on All Shifts Deficiency: Fire drills conducted	10/27/2025

	410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to have fire drills conducted quarterly on each shift for 3 of 4 quarters reviewed for fire drills. Findings include: The fire drill handbook was provided by the Executive		only on day shift for three quarters. Correction: • 2nd shift drill completed by 11/7/2025 by the Maintenance Director documentation filed.Identification: • No residents were affected. Systemic Changes: • TELS Drill calendar ensures all shifts are covered quarterly, per policy and additional throughout the year. • Maintenance Director will review completion monthly and report any task out of compliance to Executive Director.Monitoring: • Maintenance Director submits quarterly logs to ED. • Executive Director will review logs during QA/QI for six consecutive quarters.	

	Director (ED) on 10/20/25 at 11:00 a.m. The fire drill handbook indicated fire drills were conducted during first shift only from January 2025 to September 2025. During an interview with the ED on 10/20/25 at 11:30 a.m., they indicated fire drills were conducted on day and night shift for their 4th fiscal quarter (October 2024 and December 2024), and for all of the other three fiscal quarters (January 2025 to September 2025) fire drills were conducted on day shift only. The ED indicated it was maintenance who was responsible to ensure fire drills were completed at least quarterly and on different shifts. The Fire Safety and Emergency Plan policy was provided by the ED on 10/20/25 at 2:05 p.m. It indicated "...7. The administrator and/or Environmental Services Director will be responsible for ensuring simulations and drills are conducted as required by State law..." Based on interview and record review, the facility failed to have fire drills conducted quarterly on each shift for 3 of 4 quarters reviewed for fire drills. Findings include: The fire drill handbook was provided by the Executive Director (ED) on 10/20/25 at			

	11:00 a.m. The fire drill handbook indicated fire drills were conducted during first shift only from January 2025 to September 2025. During an interview with the ED on 10/20/25 at 11:30 a.m., they indicated fire drills were conducted on day and night shift for their 4th fiscal quarter (October 2024 and December 2024), and for all of the other three fiscal quarters (January 2025 to September 2025) fire drills were conducted on day shift only. The ED indicated it was maintenance who was responsible to ensure fire drills were completed at least quarterly and on different shifts. The Fire Safety and Emergency Plan policy was provided by the ED on 10/20/25 at 2:05 p.m. It indicated "...7. The administrator and/or Environmental Services Director will be responsible for ensuring simulations and drills are conducted as required by State law..."			
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	R 0119	R119 – Orientation Prior to Independent Work Deficiency: CNA lacked documentation of completed orientation prior to working independently.Correction: • CNA 9 retrained on resident rights, dementia, abuse prevention, and job-specific skills; documentation filed. By the Health and Wellness	10/27/2025

	all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (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		Director.Identification: • All employee files reviewed by the Executive Director with no additional gaps found.Systemic Changes: • Orientation checklist revised by Health and Wellness Director; trainer and trainee signatures required before independent assignment. • Health and Wellness Director or verifies completion before scheduling. Monitoring: • Business Office Manager or audits 3 new-hire files/month for 6 months, then quarterly.Executive Director will review audit at least quarterly during QA/QI	

personnel record by the person supervising the orientation.

Based on interview and record review, the facility failed to ensure each staff member received orientation training to the facility pertaining to his/her department, prior to the employee working independently. (Certified Nurse Aide 9)

Findings include:

The employee record for Certified Nurse Aide (CNA) 9 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-25-25. The facility's personnel record for CNA 9 failed to have documented training records to reflect any education for dementia, resident rights, abuse and abuse prohibition education, or specific job-related tasks sign-off to indicate what required tasks he/she was capable of conducting.

In an interview with the Executive Director on 10-20-25 at 3:45 p.m., he indicated he was unable to locate the missing information in CNA 9's employee file. In a written statement on 10-21-25 at 12:04 p.m., the Executive Director indicated the Business Office Manager was responsible for ensuring "all employee files are current and inclusive...all

	orientation and education is received and captured int he [sic] files." In an interview with the Director of Nursing on 10-20-25 at 1:30 p.m., she indicated the facility was currently without a Business Office Manager related to the management staff discovering some of the employee files were missing some documentation of trainings. On 10-20-25 at 12:04 p.m., the Executive Director provided a copy of the facility's policy entitled, "Employee File Policy," with a revision date of 9/2023. This policy indicated, "The employee files are to be created and maintained by the Business Office Manager (BOM) in each community." It indicated the following information is to be included in each employee file: "Reference Checks...Signed Job Description, Licensure (C.N.A., Nursing, CPR, etc.), Verification letters for nurses if applicable...Background Check and Results...OIG Check and Results (if not part of the background check), Employee Orientation Documentation, On The Job Mentoring and Training Documentation, [and] All Ongoing Training and in-services (including Relias [electronic health education training program])..."			

	Based on interview and record review, the facility failed to ensure each staff member received orientation training to the facility pertaining to his/her department, prior to the employee working independently. (Certified Nurse Aide 9) Findings include: The employee record for Certified Nurse Aide (CNA) 9 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-25-25. The facility's personnel record for CNA 9 failed to have documented training records to reflect any education for dementia, resident rights, abuse and abuse prohibition education, or specific job-related tasks sign-off to indicate what required tasks he/she was capable of conducting.			

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	applicable...Background Check and Results...OIG Check and Results (if not part of the background check), Employee Orientation Documentation, On The Job Mentoring and Training Documentation, [and] All Ongoing Training and in-services (including Relias [electronic health education training program])..."			
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 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.	R 0123	R123 – Personnel Records Content Deficiency: Multiple files lack training and job skill documentation.Correction: • Files for CNA 9, LPN 7, HHA 8 updated with orientation, job descriptions, and resident rights training by Business office Manager • Full personnel-file audit completed by 12/1/2025. Noncompliant items will be corrected by the Business Office Manager or .Systemic Changes: • Employee File Policy clarified with mandatory document list. • Business Office Manager or will conduct monthly file reviews of at least 10% of the personnel files. Monitoring: • Executive Director will review audit of 10% of files at least quarterly during QA/QI for 12 months.	10/27/2025

	(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 each employee's personnel file included information related to specific job skills, documented education related to resident rights, including abuse and abuse prohibition education, and information pertinent to past employment and experience. (CNA 9, LPN 7 and HHA 8) Findings include: 1. The employee record for Certified Nurse Aide (CNA) 9 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-25-25. The facility's personnel record for CNA 9 failed to have documented training records to reflect any education for dementia, resident rights, including abuse and abuse prohibition education, or specific job skills. 2. The employee record for Licensed Practical Nurse (LPN) 7 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-26-25. The facility's personnel record			

	for LPN 7 failed to have documented training records to reflect any education for dementia, resident rights, abuse, or specific job skills. 3. The employee record for Home Health Aide (HHA) 8 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-25-25. The facility's personnel record for HHA 8 failed to have documented training records to reflect any education for dementia, resident rights, abuse, or specific job skills. On 10-20-25 at 12:04 p.m., the Executive Director provided a copy of the facility's policy entitled, "Employee File Policy," with a revision date of 9/2023. This policy indicated, "The employee files are to be created and maintained by the Business Office Manager (BOM) in each community." It indicated the following information was to be included in each employee file: "Reference Checks...Signed Job Description, Licensure (C.N.A., Nursing, CPR, etc.), Verification letters for nurses if applicable...Background Check and Results...OIG Check and Results (if not part of the background check), Employee Orientation Documentation, On The Job Mentoring and Training Documentation, [and] All Ongoing Training and in-services (including Relias			

	[electronic health education training program])..." On 10-20-25 at 3:31 p.m., the Director of Nursing provided a copy of a policy entitled, "Abuse, Neglect, Exploitation Prevention," with a revision date of 10/2021. This policy indicated, "It is the policy of Charter Senior Living to maintain the right of all residents to be free from abuse, neglect, exploitation, and mistreatment...Hiring Process Procedures: Send Criminal Background Check requests for all staff prior to, or upon hire, as per State regulations and/or State employee disqualification list/registry requirements. Do not offer a job to any applicant who declares a criminal history, which per State regulations would preclude his/her employment...Screen all Licensed Nurses to ensure he/she has a current, active license, there is no action pending against his/her license, and there has been no abuse reported on his/her license. Screen all potential Certified Nursing Assistants or uncertified caregivers to ensure he/she has a current, active certificate, there is no action pending against his/her certificate and there has been no abuse reported on it. Do not extend a job offer to anyone with a history of abuse, neglect, or exploitation on any resident in			

	an adult care home or who has an alleged abuse investigation pending. Training & Education Procedures: During orientation, and prior to Resident contact, inservice all employees about Resident Rights, how to diffuse aggressive and/or catastrophic actions of Residents in a manner that preserves dignity and is non-abusive, and what to do if they witness or suspect abuse, neglect, or exploitation and how to report it. Review the Abuse, Neglect and Exploitation Prevention Policy. Give the employee a copy and retain a copy for his/her personnel file. Annually, or more frequently if mandated by State regulation, present a mandatory in-service for all staff on Resident Rights, prohibition of abuse, how to prevent abuse, how to diffuse aggressive and/or catastrophic actions of Residents in a manner that preserves dignity and is non abusive, and what to do if they witness or suspect abuse, including how to report abuse and how to recognize signs of burnout, frustration and stress that may lead to abuse..." Based on interview and record review, the facility failed to ensure each employee's personnel file included information related to specific job skills, documented education related to resident rights, including abuse and abuse prohibition education,			

	and information pertinent to past employment and experience. (CNA 9, LPN 7 and HHA 8) Findings include: 1. The employee record for Certified Nurse Aide (CNA) 9 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-25-25. The facility's personnel record for CNA 9 failed to have documented training records to reflect any education for dementia, resident rights, including abuse and abuse prohibition education, or specific job skills. 2. The employee record for Licensed Practical Nurse (LPN) 7 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-26-25. The facility's personnel record for LPN 7 failed to have documented training records to reflect any education for dementia, resident rights, abuse, or specific job skills. 3. The employee record for Home Health Aide (HHA) 8 was reviewed on 10-20-25 at 10:45 a.m. It indicated she began employment on 7-25-25. The facility's personnel record for HHA 8 failed to have documented training records to reflect any education for dementia, resident rights, abuse, or specific job skills.			

	On 10-20-25 at 12:04 p.m., the Executive Director provided a copy of the facility's policy entitled, "Employee File Policy," with a revision date of 9/2023. This policy indicated, "The employee files are to be created and maintained by the Business Office Manager (BOM) in each community." It indicated the following information was to be included in each employee file: "Reference Checks...Signed Job Description, Licensure (C.N.A., Nursing, CPR, etc.), Verification letters for nurses if applicable...Background Check and Results...OIG Check and Results (if not part of the background check), Employee Orientation Documentation, On The Job Mentoring and Training Documentation, [and] All Ongoing Training and in-services (including Relias [electronic health education training program])..." On 10-20-25 at 3:31 p.m., the Director of Nursing provided a copy of a policy entitled, "Abuse, Neglect, Exploitation Prevention," with a revision date of 10/2021. This policy indicated, "It is the policy of Charter Senior Living to maintain the right of all residents to be free from abuse, neglect, exploitation, and mistreatment...Hiring Process Procedures: Send Criminal Background Check requests for all staff prior to, or upon hire, as			

	per State regulations and/or State employee disqualification list/registry requirements. Do not offer a job to any applicant who declares a criminal history, which per State regulations would preclude his/her employment...Screen all Licensed Nurses to ensure he/she has a current, active license, there is no action pending against his/her license, and there has been no abuse reported on his/her license. Screen all potential Certified Nursing Assistants or uncertified caregivers to ensure he/she has a current, active certificate, there is no action pending against his/her certificate and there has been no abuse reported on it. Do not extend a job offer to anyone with a history of abuse, neglect, or exploitation on any resident in an adult care home or who has an alleged abuse investigation pending. Training & Education Procedures: During orientation, and prior to Resident contact, inservice all employees about Resident Rights, how to diffuse aggressive and/or catastrophic actions of Residents in a manner that preserves dignity and is non-abusive, and what to do if they witness or suspect abuse, neglect, or exploitation and how to report it. Review the Abuse, Neglect and Exploitation Prevention Policy. Give the employee a copy and retain a copy for his/her personnel file.			

	Annually, or more frequently if mandated by State regulation, present a mandatory in-service for all staff on Resident Rights, prohibition of abuse, how to prevent abuse, how to diffuse aggressive and/or catastrophic actions of Residents in a manner that preserves dignity and is non abusive, and what to do if they witness or suspect abuse, including how to report abuse and how to recognize signs of burnout, frustration and stress that may lead to abuse..."			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to properly maintain a walk-in freezer resulting in built up ice inside of the freezer for 1 of 1 freezer observed and failed to have proper knowledge on use and sanitization of the chemical dishwasher. This had the potential to affect 46 of 46 residents that reside in the facility.	R 0154	R154 – Kitchen Sanitation (Freezer Ice & Dishwasher) Deficiency: Ice accumulation in walk-in freezer; staff not trained dishwasher sanitization.Correction: • Freezer defrosted and inspected 10/21/2025, fixed on 11/5/2025. • Temperature/sanitization logs implemented on 10/27/2025. • Dietary staff educated on defrosting and chlorine test-strip use by 11/10/2025. By the Dining Services Director.Systemic Changes: • Dining Services Director verifies temperature and sanitization logs daily. • Maintenance inspects freezer weekly for ice build-up.Monitoring: • Dining Services Director or designee completes weekly log audits for 3 months, then monthly reports findings to EDThe Executive Director will review at least quarterly during QA/QI.	10/27/2025

	Findings include: 1. During a tour of the kitchen with Cook 2 on 10/20/25 at 11:40 a.m., the walk-in freezer had a temperature reading on the outside of the door recording -7 degrees Fahrenheit. Cook 2 indicated she did not know where the internal thermometer was. Thick ice covered both fans in the freezer and the floor was covered in a thick layer of ice. During an interview with the Dietary Service Director (DSD) on 10/20/25 at 12:35 p.m., she indicated the buildup of ice has been in the walk-in freezer since she started working for the facility in August 2025. The DSD indicated she had not defrosted the freezer since she noticed the buildup in August 2025. The DSD indicated last week she had Cook 4 clean out the freezer and she assumed the ice was taken care of and he got it all then. The DSD indicated they did not have any measures in place to prevent ice buildup in the walk-in freezer.			

	During an interview with Cook 4 on 10/20/25 at 11:50 a.m., they indicated last week they spent hours in the walk-in freezer chipping away thick ice built up on the fans, floor, and boxes throughout the freezer but there was too much to get it all cleared out. The Food Storage policy was provided by the Executive Director (ED) on 10/20/25 at 2:05 p.m. It indicated "...8. The Dining Services Director, or his/her designee, will check refrigerators and freezers daily for proper temperatures..." 2. During the tour of the kitchen with Cook 2 on 10/20/25 at 11:40 a.m., they indicated they were not sure what kind of dishwasher the facility had (high temperature or chemical sanitization). Cook 2 indicated she had been shown how to run dishes through the dishwasher but had never been educated on how to check the dishwasher for daily sanitization. Cook 3 indicated she did not know whether or not the dishwasher was high temperature or chemical and had not been educated on how to properly check for daily sanitization. Cook 4 indicated they had never seen the dishwasher being tested for sanitization purposes. Cook 4 indicated they knew the facility had test strips somewhere, but he did not know			

	where they were kept. Cook 4 also indicated they had not been educated on how to check the dishwasher for sanitization purposes. During an interview with the DSD on 10/20/25 at 12:35 p.m., they indicated the facility used a chemical dishwasher. The DSD indicated they did not have any logs for recording chemical or temperature results for sanitization of the dishwasher. The DSD indicated it was the DSD who was responsible to ensure staff were properly educated and trained on the dishwasher and temperature/sanitization logs were completed. The DSD indicated they have not been able to ensure sanitization of the dishes due to not checking daily sanitization levels. The DSD indicated she was not aware that they needed to check the dishwasher. She indicated they look at the dials on top of the machine to make sure it is hitting the appropriate temperature ranges which were recorded on the front of the machine, but they do not check the chemical ranges. The Installation and Operation Manual for Low and High Temperature Model EST44 dish machine was provided by the ED on 10/20/25 at 2:32 p.m. It indicated "...3.3 Regular Service and Maintenance Checklist:			

	Check Wash-Tank Temperature 150 degrees Fahrenheit Minimum; Check Power-Rinse Tank Temperature 160 degrees Fahrenheit Minimum; Check Final-Rinse Temperature 180 to 195 degrees Fahrenheit (High-Temp) (140 degrees Fahrenheit for Low Temp); Check Final Rinse Pressure 20 psi..." A Dish Machine Temperature policy was provided by the Health and Wellness Director on 10/20/25 at 2:25 p.m. It indicated "...5. Rinse cycle must reach minimum safe ranges for low and high temperature machines...6. For low temperature machines, a test strip must be taken and recorded. The chlorination parts per million (PPM) must meet manufacturer specification..." Based on observation, interview, and record review, the facility failed to properly maintain a walk-in freezer resulting in built up ice inside of the freezer for 1 of 1 freezer observed and failed to have proper knowledge on use and sanitization of the chemical dishwasher. This had the potential to affect 46 of 46 residents that reside in the facility. Findings include: 1. During a tour of the kitchen			

	with Cook 2 on 10/20/25 at 11:40 a.m., the walk-in freezer had a temperature reading on the outside of the door recording -7 degrees Fahrenheit. Cook 2 indicated she did not know where the internal thermometer was. Thick ice covered both fans in the freezer and the floor was covered in a thick layer of ice. During an interview with the Dietary Service Director (DSD) on 10/20/25 at 12:35 p.m., she indicated the buildup of ice has been in the walk-in freezer since she started working for the facility in August 2025. The DSD indicated she had not defrosted the freezer since she noticed the buildup in August 2025. The DSD indicated last week she had Cook 4 clean out the freezer and she assumed the ice was taken care of and he got it all then. The DSD indicated they did not have any measures in place to prevent ice buildup in the walk-in freezer. During an interview with Cook 4 on 10/20/25 at 11:50 a.m., they indicated last week they spent hours in the walk-in freezer chipping away thick ice built up on the fans, floor, and boxes throughout the freezer but there was too much to get it all cleared out. The Food Storage policy was provided by the Executive			

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	A Dish Machine Temperature policy was provided by the Health and Wellness Director on 10/20/25 at 2:25 p.m. It indicated "...5. Rinse cycle must reach minimum safe ranges for low and high temperature machines...6. For low temperature machines, a test strip must be taken and recorded. The chlorination parts per million (PPM) must meet manufacturer specification..."			
R 0157	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(n) n) The facility shall develop, adopt, and implement written policies and procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area. Based on interview and record review, the facility failed to properly maintain temperature logs for the walk-in refrigerator, freezer, and dish machine for 9 of 9 months reviewed. This had the potential to affect 46 of 46 residents that reside in the facility. During a tour of the kitchen with Cook 2 on 10/20/25 at 11:40 a.m., the walk-in refrigerator, the walk-in freezer, and the dish machine were all missing temperature logs. The	R 0157	R157 – Temperature Logs (Refrigerator/Freezer/Dish Machine) Deficiency: No temperature logs for 9 months.Correction: • AM/PM logs implemented for refrigerator, freezer, and dish machine on 10/27/2025. • Internal thermometers replaced and calibrated on 10/29/2025.Systemic Changes: • Policy updated to require twice-daily checks and documentation. • Dining Service Director or will be responsible for oversight and ensuring documentation completed weekly. Any blanks will be reported to the Executive Director.Monitoring: • Executive Director will review weekly for 3 months; monthly audits for 12 months.	10/27/2025

	thermometer recording from the outside thermometer for the refrigerator recorded 33 degrees Fahrenheit and the freezer recorded -7 degrees Fahrenheit. Inside thermometers were not available in either the walk-in refrigerator or freezer. The walk-in freezer had a buildup of ice coating both fans and the floor throughout the freezer. Cook 2 indicated they had never seen temperature logs kept for the refrigerator, freezer, or the dishwasher. Cook 4 indicated there were no temperature logs for the dishwasher. During an interview with the Dietary Service Director (DSD) on 10/20/25 at 12:35 p.m., they indicated the kitchen does have thermometers kept inside of the walk-in refrigerator and freezer, but they must have fallen behind something or been misplaced. The DSD indicated she had not been keeping log temperatures for the walk-in refrigerator, walk-in freezer, and dishwasher. She indicated temperature logs were not being completed when she started working at the facility in August 2025, and she had not gotten around to doing them yet. The DSD indicated it was the Dietary Service Director who was responsible to ensure temperature logs were kept up to date and completed twice a day by herself or dietary staff.			

	The Food Storage policy was provided by the Executive Director (ED) on 10/20/25 at 2:05 p.m. It indicated "...8. The Dining Services Director, or his/her designee, will check refrigerators and freezers daily for proper temperatures..." The Dish Machine Temperature policy was provided by the Health and Wellness Director on 10/20/25 at 2:25 p.m. It indicated "...1. A log will be maintained for all dish room equipment daily. Temperatures for wash cycle, rinse cycle, and sanitation solution PPM for Low temperature machines will be recorded daily..." Based on interview and record review, the facility failed to properly maintain temperature logs for the walk-in refrigerator, freezer, and dish machine for 9 of 9 months reviewed. This had the potential to affect 46 of 46 residents that reside in the facility. During a tour of the kitchen with Cook 2 on 10/20/25 at 11:40 a.m., the walk-in refrigerator, the walk-in freezer, and the dish machine were all missing temperature logs. The thermometer recording from the outside thermometer for the refrigerator recorded 33 degrees Fahrenheit and the freezer recorded -7 degrees Fahrenheit. Inside thermometers were not			

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R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i) (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to provide tuberculosis (TB) screening for 1 of 5 residents reviewed for infection control measures. (Resident 4)	R 0412	R412 – TB Screening Deficiency: Resident 4 lacked annual TB screening/risk assessment.Correction: • TB risk assessment completed 10/21/2025; no symptoms identified. • All resident charts reviewed by (insert job title) for TB compliance; no additional issues. Systemic Changes: • Move-in checklist includes TB due-date tracking. • Monthly review added to HWD Quality Audit Tool. Monitoring:• Executive Director will review 5 random charts for TB compliance at least quarterly during QA/QI review.	10/27/2025

Findings include:

The clinical record for Resident 4 was reviewed on 10/20/2025 at 1:10 p.m. The medical diagnosis included Alzheimer's disease and depression.

Review of the clinical record indicated Resident 4 had a move-in date of 10/11/2024. No documentation of an annual TB screen was present on the medical record.

A chest x-ray, dated 10/1/2024, did not indicate signs of active tuberculosis.

During an interview on 10/20/2025 at 1:20 p.m., the Director of Health and Wellness indicated Resident 4 did not have an annual TB screening or test.

A Long-term Care Division Program Letter, entitled Tuberculosis Prevention -Requirement for Residential Care Nursing Facilities, dated 8/12/2021, indicated " ...these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis ..."

Based on interview and record review, the facility failed to provide tuberculosis (TB) screening for 1 of 5 residents reviewed for infection control measures. (Resident 4)

Findings include:

The clinical record for Resident 4 was reviewed on 10/20/2025 at 1:10 p.m. The medical diagnosis included Alzheimer's disease and depression.

Review of the clinical record indicated Resident 4 had a move-in date of 10/11/2024. No documentation of an annual TB screen was present on the medical record.

A chest x-ray, dated 10/1/2024, did not indicate signs of active tuberculosis.

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A Long-term Care Division Program Letter, entitled Tuberculosis Prevention -Requirement for Residential Care Nursing Facilities, dated 8/12/2021, indicated " ...these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis ..."

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 SIGNATUREDeasra Brush	TITLERN HWD	(X6) DATE11/05/2025