STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/15/2025

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 the Investigation of Intake IN00463227. Intake IN00463227 -- Residential deficiency related to the allegations is cited at R0027. Survey date; September 15, 2025 Facility number: 015521 Residential Census: 44 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-5. Quality review completed on September 16, 2025.	R 0000		
R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and	R 0027	**R0027 Resident Rights:**	09/30/2025

communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States.

Based on observation, interview, and record review, the facility failed to provide a dignified environment for 2 of 3 residents reviewed for dignity related to conducting a blood draw during a meal service and conducting an injection of medication in the common area of the Memory Care Unit (MCU), both events occurring with other residents in close proximity. (Residents B and C)

Findings include:

A. During an interview with the Director of Nursing (DON) on 9-15-25 at 12:32 p.m., she was shown two pictures of Resident B having a blood sample being obtained, while seated in the MCU's dining room at what appeared to be at the time of a meal, with plates of food and drink visible. The DON indicated the staff members present in the pictures were herself and Registered Nurse (RN) 3. She indicated, after verifying information from Resident B's clinical record, Resident B most recently had a blood sample obtained on 7-9-25. She indicated she thought this would

1. Corrective Action for Affected Residents

- Identify all residents impacted by the deficiency.
- Describe the immediate steps taken to correct the issue for those residents.
- Staff involved were retrained on resident rights policies. Affected residents received a formal apology and assurance of corrective measures being taken.

2. Systemic Changes to Prevent Recurrence

- Outline changes to facility procedures, policies, or staffing to prevent future violations.

	have been the correct date, as the facility had terminated a contract with a lab service company related to obtaining blood samples in the dining room and in the MCU's common areas at the end of June 2025, and facility staff now obtain any needed blood samples. The DON indicated facility staff were not to conduct blood draws in the dining room or common areas "to allow each resident privacy and follow resident rights....They [facility staff] know or should know [this] because I have talked to them about it, not to...draw blood in the common area or dining room. I have told them to use the charting room, the resident's room or other private area. That's just common practice [to allow privacy and dignity.]" She indicated, "I don't know why I would have done that or allowed that at the breakfast table." Resident B's clinical record was reviewed on 9-15-25 at 12:24 p.m. It indicated his diagnoses included, but were not limited to, dementia. It indicated he had been at the facility over three months, residing on the MCU of the facility. A nurse practitioner visit note, dated 6-23-25, indicated an order request to obtain multiple serum (blood) tests. Corresponding laboratory test results indicated the blood samples were obtained on		• Resident rights training will be added to monthly in-service education in RELIAS. Supervisors will conduct monthly audits on staff-resident interactions. **3. Monitoring and Quality Assurance** • Describe how the facility will monitor compliance going forward. • Resident satisfaction surveys will include questions on dignity and respect. Results will be reviewed monthly by the Quality Assurance Committee.	

	7-9-25 at 10:45 a.m. B. During a care observation with Resident C and Licensed Practical Nurse (LPN) 4 on 9-15-25 at 11:50 a.m., LPN 4 was observed to prepare Novolog insulin for administration after obtaining a blood glucose reading with a continuous glucose monitor. LPN 4 then walked to Resident C, was seated in her wheelchair in the common area of the MCU and administered the insulin via an injection. One (1) other resident was seated within 10 feet of Resident C, two (2) other peers were seated within 20 feet, and 12 other peers were located greater than 25 feet from Resident C at the time of receiving the injection. In an interview with LPN 4, immediately after the administration of the injection, on 9-15-25 at 11:55 a.m., she indicated she was not aware of any particular facility policies or procedures regarding where blood draws or injections can be conducted in the facility. In an interview with the DON on 9-15-25 at 12:32 p.m., she indicated facility staff were not to conduct injections in the dining room or common areas "to allow each resident privacy and follow resident rights....They [facility staff] know, or should know [this] because I have		**4. Responsible Party** • Name the title (not the individual) of the person responsible for implementing the POC. • Director of Nursing, Desara Brush, RN will oversee training and compliance audits. **5. Completion Date** • Provide a realistic date by which all corrective actions will be completed. • All corrective actions will be completed by September 30th, 2025.	

	talked to them about it, not to do injections... in the common area or dining room. I have told them to use the charting room, the resident's room or other private area. That's just common practice [to allow privacy and dignity.]" Resident C's clinical record was reviewed on 9-15-25 at 1:29 p.m. It indicated her diagnoses included, but were not limited to, diabetes, Parkinson's disease and Lewey-Body dementia. A review of her medication orders indicated she receives Novolog insulin routinely three (3) times daily with meals, plus receiving blood glucose testing every four (4) hours with specific instructions of additional Novolog insulin, based on the results of the blood glucose testing.			

On 9-15-25 at 12:10 p.m., the Executive Director provided a copy of "Resident Rights and Responsibilities." He indicated each resident receives a copy of this information prior to admission. This document indicated, "Residents have the right to have their rights recognized by the licensee...Residents have the right to a dignified existence, self-determination...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality."

This Residential tag relates to Intake IN00463227.

2.5-1.2(b)

2.5-1.2(d)

Based on observation, interview, and record review, the facility failed to provide a dignified environment for 2 of 3 residents reviewed for dignity related to conducting a blood draw during a meal service and conducting an injection of medication in the common area of the Memory Care Unit (MCU), both events occurring with other residents in close proximity. (Residents B and C)

Findings include:

A. During an interview with the Director of Nursing (DON) on 9-15-25 at 12:32 p.m., she was

shown two pictures of Resident B having a blood sample being obtained, while seated in the MCU's dining room at what appeared to be at the time of a meal, with plates of food and drink visible. The DON indicated the staff members present in the pictures were herself and Registered Nurse (RN) 3. She indicated, after verifying information from Resident B's clinical record, Resident B most recently had a blood sample obtained on 7-9-25. She indicated she thought this would have been the correct date, as the facility had terminated a contract with a lab service company related to obtaining blood samples in the dining room and in the MCU's common areas at the end of June 2025, and facility staff now obtain any needed blood samples.

The DON indicated facility staff were not to conduct blood draws in the dining room or common areas "to allow each resident privacy and follow resident rights....They [facility staff] know or should know [this] because I have talked to them about it, not to...draw blood in the common area or dining room. I have told them to use the charting room, the resident's room or other private area. That's just common practice [to allow privacy and dignity.]" She indicated, "I don't know why I would have done that or allowed

that at the breakfast table."

Resident B's clinical record was reviewed on 9-15-25 at 12:24 p.m. It indicated his diagnoses included, but were not limited to, dementia. It indicated he had been at the facility over three months, residing on the MCU of the facility. A nurse practitioner visit note, dated 6-23-25, indicated an order request to obtain multiple serum (blood) tests. Corresponding laboratory test results indicated the blood samples were obtained on 7-9-25 at 10:45 a.m.

B. During a care observation with Resident C and Licensed Practical Nurse (LPN) 4 on 9-15-25 at 11:50 a.m., LPN 4 was observed to prepare Novolog insulin for administration after obtaining a blood glucose reading with a continuous glucose monitor. LPN 4 then walked to Resident C, was seated in her wheelchair in the common area of the MCU and administered the insulin via an injection. One (1) other resident was seated within 10 feet of Resident C, two (2) other peers were seated within 20 feet, and 12 other peers were located greater than 25 feet from Resident C at the time of receiving the injection.

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on 9-15-25 at 11:55 a.m., she indicated she was not aware of any particular facility policies or procedures regarding where blood draws or injections can be conducted in the facility.

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Resident C's clinical record was reviewed on 9-15-25 at 1:29 p.m. It indicated her diagnoses included, but were not limited to, diabetes, Parkinson's disease and Lewey-Body dementia. A review of her medication orders indicated she receives Novolog insulin routinely three (3) times daily with meals, plus receiving blood glucose testing every four (4) hours with specific instructions of additional Novolog insulin, based on the results of the blood glucose testing.

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	Executive Director provided a copy of "Resident Rights and Responsibilities." He indicated each resident receives a copy of this information prior to admission. This document indicated, "Residents have the right to have their rights recognized by the licensee...Residents have the right to a dignified existence, self-determination...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality." This Residential tag relates to Intake IN00463227. 2.5-1.2(b) 2.5-1.2(d)			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE