STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF HOBBS STATION	2749 PEARSON PARKWAY, PLAINFIELD, , 46168

(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: February 5 and 6, 2026 Facility number: 016160 Residential Census: 29 Private: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 13, 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:	R 0090	Please accept this Plan of correction for Charter Senior Living of Hobbs Station. R 090 Resident 3's fall with major injury from 10/11/25 has been retrospectively reported to the Indiana Department of Health	03/16/2026

	(1) Informing the division within 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		via the Gateway Reporting System as of 3/31/2026. Documentation has been placed in the resident's clinical record. 2. Identification of Others Potentially Affected A facility wide audit of all incident and accident reports from the previous 12 months was completed on 3/31/2026 to identify any other events meeting reportable criteria that may not have been submitted. No other unreported incidents were identified. Systemic Changes to Prevent Recurrence The Incident Reporting Policy has been reviewed and revised to include: clear definitions of "unusual occurrences," timelines for reporting, responsible party for reporting, and required documentation. All leadership staff, including the ED, HWD, DON, and charge nurses, received re education on IDOH reporting requirements on 3/31/2026. A new 24 hour report log has been implemented to ensure required incidents are reviewed and reported by the ED or designee. 4. Monitoring to Ensure Ongoing Compliance The ED or designee will review all incident reports daily Monday–Friday for 12 weeks, and weekly thereafter for an	

	(B) dates and hours worked during 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 record review and interview, the facility failed to ensure a fall with a major injury (Resident 3) was reported to the Indiana Department of Health for 1 of 7 residents reviewed for quality of care. Findings include: During an interview on 2/4/26 at 10:40 a.m., Resident 3 indicated she had had several falls since her admission to the facility. She had a bad fall in the parking lot which resulted in her needing to go to the hospital for stitches, and she had bleeding from the ear. On 2/5/26 at 11:30 a.m., Resident 3's record was		additional 12 weeks. Any incident meeting reportable criteria will be verified for correct and timely submission. Results will be reviewed in monthly Quality Assurance & Performance Improvement (QAPI) meetings for six months. 5. Completion Date All corrective actions will be completed by 3/31/2026.	

	reviewed. She had diagnoses which included, but were not limited to, atrial fibrillation (AFib) with rapid ventricular response (a dangerous type of arrhythmia where the heart's upper chambers beat chaotically, and the lower chambers beat too fast, over 100 beats per minute, hindering effective blood pumping). An Incident Reporting form, dated 10/11/25, indicated Resident 3 sustained a fall while she had been walking in the parking lot. At the time of the fall she was observed with the following injuries: bleeding from inside the ear, abrasion to her right palm, laceration to her chin, abrasion to her nares, and an abrasion to the left side of her face. She was sent to a local emergency room. A hospital discharge summary, dated 10/11/25, indicated she had sustained a fracture of the tympanic plate (a small, curved piece of bone located in the skull that forms the floor and front wall of the bony ear canal. It acts as a protective, bony, U-shaped shelf that supports the ear canal leading to the eardrum). During an interview on 2/6/26 at 11:50 a.m., the Executive Director (ED) indicated she could not find evidence that the			

	previous Administrator had reported the resident's fall with fractures.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services	R 0217	Identification of Others Potentially Affected An audit of all residents' service plans was completed on 3/31/2026 to identify missing resident signatures. All missing signatures were addressed; each resident was approached to obtain the required signature or document refusal. 3. Systemic Changes to Prevent Recurrence The Service Plan Policy was updated to clearly require resident (or legal representative) signatures. A new service plan checklist has been added to the care planning workflow. Staff responsible for service plans received re-education on signature requirements. 4. Monitoring to Ensure Ongoing Compliance For 12 weeks, the HWD will audit ALIS 100% of completed service plans to confirm resident signatures are obtained. After the initial 12 weeks, audits will continue at 25% of service plans for an additional 3 months. Audit findings will be reported to QAPI monthly for six months. 5. Completion Date All corrective actions will be completed by 3/31/2026.	03/16/2026

	provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record reviews and interviews, the facility failed to ensure service plans were signed by the resident for 1 of 5 residents whose service plans were reviewed (Resident 9). Findings include: On 2/6/26 Resident 9's medical record was reviewed. He was an assisted living resident whose diagnoses included, but were not limited to, atrial fibrillation (a very common heart condition that causes the heart's upper chambers to quiver chaotically, leading to symptoms like rapid, uneven heartbeats, fatigue, and shortness of breath.). Resident 9's most recent service plan was reviewed, and it lacked a signature from the resident. The only signature present was from the previous Director of Nursing (DON). On 2/9/26 at 2:30 p.m. a copy of			

	a a current facility policy titled "Assessments and Service Plans", dated 2/2025 was provided. That policy did not speak to the nessecity of the Resident's signature on service plans.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observations and interviews, the facility failed to provide ongoing infection control surveillance.This had the potential to affect 29 of 29 residents residing in the facility. Findings include: On 2/6/26 at 10:45 a.m., the	R 0407	Corrective Action for Residents Affected No residents were identified as having active infection issues at the time of survey; however, the absence of surveillance documentation was corrected immediately. A complete infection control surveillance log was initiated on 3/31/2026. 2. Identification of Others Potentially Affected All residents have the potential to be affected. A full facility infection control assessment was completed, including review of vaccination status, infection trends, and recent symptoms. Systemic Changes to Prevent Recurrence The infection control program has been updated to include: surveillance expectations, symptom tracking, outbreak procedures, documentation requirements. The HWD received re-training on monthly surveillance expectations. A standardized Infection Control Surveillance Tool was implemented.	03/16/2026

	Health and Wellness Director (HWD) provided documentation and indicated it was theongoing infection control surveillance. The pages listed 5 resident names and was dated for August and September 2026. The facility was asked to provide further documentation, and none was received. A policy was received on 2/6/26 at 10:02 a.m. but it did not include information regarding an infection control program.		4. Monitoring to Ensure Ongoing Compliance The HWD will complete surveillance weekly and submit a summary to the ED. The ED will audit the surveillance logs weekly for 12 weeks, then monthly for 6 months. Surveillance compliance will be reviewed in monthly QAPI meetings. 5. Completion Date All corrective actions will be completed by 3/31/2026.	
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.	R 0410	1. Corrective Action for Residents Affected Residents 4, 5, and 9 had TB screening records reviewed. Missing second step PPD documentation was corrected as follows: If clinically appropriate, second step PPDs were administered and documented. If residents declined or were medically exempt, documentation was completed per policy. TB risk assessments and chest X rays were updated as necessary. 3. Systemic Changes to Prevent Recurrence The TB Screening Policy was updated and redistributed to all clinical staff. A standard admission checklist	03/16/2026

	(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure complete tuberculosis (TB) screening was completed upon residents' admission for 3 of 7 residents reviewed (Residents 4, 5, and 9). Findings include: 1. On 2/6/26 at 1:28 p.m., Resident 4's record was reviewed. Prior to her admission a 2-step purified protein derivative (PPD, TB skin test) was initiated. The first step PPD TB skin test was conducted on 6/28/25 and read on 6/30/25. The record lacked documentation of a 2nd step skin test. 2. On 2/6/26 at 1:45 p.m., Resident 5's record was reviewed. Prior to his admission a first step PPD TB skin test was conducted on 6/28/25 and read on 7/1/25. The record lacked documentation of a 2nd step skin test.		was implemented to ensure TB requirements are completed prior to resident move in. The HWD and admission nurse were retrained on 2 step PPD requirements. 4. Monitoring to Ensure Ongoing Compliance The HWD will audit Move in Manifest of all new admissions' TB screening records weekly for 12 weeks and monthly for the following 3 months. Audit results will be reviewed in QAPI monthly for six months. 5. Completion Date All corrective actions will be completed by 3/31/2026.	

	3. On 2/6/26 Resident 9's medical record was reviewed. He was an assisted living resident whose diagnoses included, but were not limited to, atrial fibrillation (a very common heart condition that causes the heart's upper chambers to quiver chaotically, leading to symptoms like rapid, uneven heartbeats, fatigue, and shortness of breath). The medical record lacked documentation of a 2-step PPD being administered upon Resident 9's admission. On 2/9/26 at 2:30 p.m. a copy of a current facility policy titled, "Tuberculin Screening," dated 4/17/24, was provided. That policy indicated "...2. Residents are required to have a 2-step PPD upon admission ...."			

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 SIGNATUREJacqueline Mullins	TITLEExecutive Director	(X6) DATE03/17/2026