STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER BEACH TERRACE	4905 MELTON RD, GARY, , 46403

(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. This visit included the Investigation of Complaints IN00457199 and IN00457281. Complaint IN00457199 - State deficiency related to the allegations is cited at R0117. Complaint IN00457281 - No deficiencies related to the allegations are cited. Survey dates: April 15 and 16, 2025 Facility number: 001140 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/21/25.	R 0000		
R 0116	Personnel - Noncompliance	R 0116	Employee files have been audited and any missing documentation	05/01/2025

	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 employee references were checked prior to employment for 2 of 3 employee records reviewed. (QMA 1 and CNA 1) Findings include: The employee records were reviewed on 4/16/25 at 11:05 a.m. The following items were missing: a. There was no reference check completed for QMA 1 who was hired on 10/31/24. b. There was no reference check completed for CNA 1 who was hired on 3/10/25. During an interview on 4/16/25 at 11:40 a.m., the Business Office Manager indicated she had called the references but did not document anything. Based on record review and interview, the facility failed to		has been corrected. Reference checks have been added to employee front sheet page. Business Office Manager responsible for documenting reference checks. Administrator to monitor new employee files visually, monthly; ongoing	

	ensure employee references were checked prior to employment for 2 of 3 employee records reviewed. (QMA 1 and CNA 1) Findings include: The employee records were reviewed on 4/16/25 at 11:05 a.m. The following items were missing: a. There was no reference check completed for QMA 1 who was hired on 10/31/24. b. There was no reference check completed for CNA 1 who was hired on 3/10/25. During an interview on 4/16/25 at 11:40 a.m., the Business Office Manager indicated she had called the references but did not document anything.			
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	R 0117	Facility contracts a security company from 11pm-7am to help ensure that there are always at least, based on this census, two (2) personnel in facility. Facility has contacted and contracted with a staffing agency to fill any shifts that might otherwise be understaffed. Staffing agency personnel, per staffing agency requirements, are CPR/first aide certified. DON responsible for scheduling of nursing staff. Business Office Manager to	05/01/2025

	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. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff were sufficient in number and there was a minimum of at least one staff person with current CPR and first aide certification working at all times. This had the potential to affect all residents residing in the facility. Findings include: 1. The Nursing Schedule, dated 3/26/25 - 4/22/25, indicated CNA 1 was the only staff member working the 11:00 p.m. to 7:00 a.m. shift on 4/13/25. The CNA was not CPR and first aide certified. During an interview on 4/16/25 at 12:30 p.m., the Director of Nursing indicated based on the		monitor by auditing nursing schedules weekly; ongoing CPR training has been mandated for 11pm-7am security personnel "outside agency" to ensure at least one person has CPR/first aide training on duty in the event that a new CNA has not completed the CPR/first aide training. Business Office Manager responsible for monthly checks of expired CPR/first aide certification. Administrator to monitor CPR book visually, monthly; ongoing	

facility's census on 4/13/25, there should have been two staff members working instead of one.

2. The Nursing Schedule, dated 4/12/25, indicated CNA 1 and CNA 3 worked the 11:00 p.m. to 7:00 a.m. shift. Both CNAs were not CPR or fist aide certified.

During an interview on 4/16/25 at 12:40 p.m., the Business Office Manager indicated the CNAs had not completed their CPR and first aide training.

This citation relates to Complaint IN00457199.

Based on record review and interview, the facility failed to ensure staff were sufficient in number and there was a minimum of at least one staff person with current CPR and first aide certification working at all times. This had the potential to affect all residents residing in the facility.

Findings include:

1. The Nursing Schedule, dated 3/26/25 - 4/22/25, indicated CNA 1 was the only staff member working the 11:00 p.m. to 7:00 a.m. shift on 4/13/25. The CNA was not CPR and first aide certified.

During an interview on 4/16/25 at 12:30 p.m., the Director of Nursing indicated based on the

	facility's census on 4/13/25, there should have been two staff members working instead of one. 2. The Nursing Schedule, dated 4/12/25, indicated CNA 1 and CNA 3 worked the 11:00 p.m. to 7:00 a.m. shift. Both CNAs were not CPR or fist aide certified. During an interview on 4/16/25 at 12:40 p.m., the Business Office Manager indicated the CNAs had not completed their CPR and first aide training. This citation relates to Complaint IN00457199.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the resident's environment was clean and in a state of good repair related to holes in the walls, an accumulation of dust and debris, loose tile and base boards, missing mirrors, urine odors, and an accumulation of food spillage in refrigerators for 3 of 4 units throughout the facility and	R 0144	1,2 Room 105 has been repaired. Box springs have been checked throughout building to make sure no others are slanting to the side. Mattresses have been checked throughout building for tears. Bathrooms throughout building have been checked for any missing ceramic tiles or detached baseboards. Some medicine cabinets will have mirrors; in other rooms plexiglass will be put in place of mirror. 3 Room 351 has been cleaned along register. 4 Nurses have been inserviced on the fact that the refrigerator for medications is for medications, not staffs food.	05/16/2025

	for 1 of 1 medication rooms. (The 100, 200, 300 Units and the Medication Room) Findings include: During the Environmental Tour on 4/16/25 at 10:40 a.m. with the Maintenance Director, the following was observed: 1. The 100 Unit In Room 105, there were holes in the wall next to bed 2. The cover of the air conditioning unit was loose and was being held up with duct tape. There was a crack in the ceiling. The box spring for bed 2 was slanting to the side. The mattress for bed 1 was torn down the middle. The base board behind the toilet in the bathroom was detached from the wall and there were two missing ceramic square tiles. The mirror from the medicine cabinet was missing and there was a hole in the wall behind the bathroom door. Two residents resided in this room and used the bathroom. 2. The 200 Unit a. The floor tile was loose and peeling next to the air conditioning unit in Room 207. A piece of ceramic tile was missing next to the sink in the bathroom. One resident resided in the bathroom. b. The mirror from the medicine		Refrigerator has been cleaned. Refrigerator will be replaced. 5 Fan in common area outside of medication room has been cleaned. Housekeeping and maintenance staff responsible for upkeep and cleaning. Housekeeping and maintenance supervisors to monitor daily, visually, five (5) times weekly; ongoing.	

	cabinet in the bathroom of Room 214 was missing. One resident resided in the room. 3. The 300 Unit A strong urine odor was noted in Room 351. There was also an accumulation of dust and dirt along the heat register. The mirror from the medicine cabinet in the bathroom was missing. One resident resided in this room. During an interview at that time, the Maintenance Director indicated all of the above were in need of cleaning and/or repair. 4. During an observation of the medication storage room on 4/15/25 at 11:00 a.m., the medication refrigerator was observed to have drips of brown spillage on the inside and near the bottom. The shelf inside of the door was filled with various foods and condiments. During an interview on 4/15/25 at 11:15 a.m., LPN 1 indicated the refrigerator was for medications like insulin and some eye drops, but some of the staff's food was in there currently.			

During an interview on 4/16/25 at 12:10 p.m., the Director of Nursing indicated food should not be kept in the medication refrigerator.

5. During a random observation on 4/15/25 at 11:30 a.m., a fan in the common area outside of the medication room was observed to have an accumulation of dust and dirt.

During an interview on 4/16/25 at 12:23 p.m., the Director of Nursing indicated the fan needed to be cleaned.

Based on observation and interview, the facility failed to ensure the resident's environment was clean and in a state of good repair related to holes in the walls, an accumulation of dust and debris, loose tile and base boards, missing mirrors, urine odors, and an accumulation of food spillage in refrigerators for 3 of 4 units throughout the facility and for 1 of 1 medication rooms. (The 100, 200, 300 Units and the Medication Room)

Findings include:

During the Environmental Tour on 4/16/25 at 10:40 a.m. with the Maintenance Director, the following was observed:

1. The 100 Unit

In Room 105, there were holes

	in the wall next to bed 2. The cover of the air conditioning unit was loose and was being held up with duct tape. There was a crack in the ceiling. The box spring for bed 2 was slanting to the side. The mattress for bed 1 was torn down the middle. The base board behind the toilet in the bathroom was detached from the wall and there were two missing ceramic square tiles. The mirror from the medicine cabinet was missing and there was a hole in the wall behind the bathroom door. Two residents resided in this room and used the bathroom. 2. The 200 Unit a. The floor tile was loose and peeling next to the air conditioning unit in Room 207. A piece of ceramic tile was missing next to the sink in the bathroom. One resident resided in the bathroom. b. The mirror from the medicine cabinet in the bathroom of Room 214 was missing. One resident resided in the room. 3. The 300 Unit			

	A strong urine odor was noted in Room 351. There was also an accumulation of dust and dirt along the heat register. The mirror from the medicine cabinet in the bathroom was missing. One resident resided in this room. During an interview at that time, the Maintenance Director indicated all of the above were in need of cleaning and/or repair. 4. During an observation of the medication storage room on 4/15/25 at 11:00 a.m., the medication refrigerator was observed to have drips of brown spillage on the inside and near the bottom. The shelf inside of the door was filled with various foods and condiments. During an interview on 4/15/25 at 11:15 a.m., LPN 1 indicated the refrigerator was for medications like insulin and some eye drops, but some of the staff's food was in there currently. During an interview on 4/16/25 at 12:10 p.m., the Director of Nursing indicated food should not be kept in the medication refrigerator. 5. During a random observation on 4/15/25 at 11:30 a.m., a fan in the common area outside of the medication room was observed to have an			

accumulation of dust and dirt.

During an interview on 4/16/25 at 12:23 p.m., the Director of Nursing indicated the fan needed to be cleaned.

Based on observation and interview, the facility failed to ensure the resident's environment was clean and in a state of good repair related to holes in the walls, an accumulation of dust and debris, loose tile and base boards, missing mirrors, urine odors, and an accumulation of food spillage in refrigerators for 3 of 4 units throughout the facility and for 1 of 1 medication rooms. (The 100, 200, 300 Units and the Medication Room)

Findings include:

During the Environmental Tour on 4/16/25 at 10:40 a.m. with the Maintenance Director, the following was observed:

1. The 100 Unit

In Room 105, there were holes in the wall next to bed 2. The cover of the air conditioning unit was loose and was being held up with duct tape. There was a crack in the ceiling. The box spring for bed 2 was slanting to the side. The mattress for bed 1 was torn down the middle. The base board behind the toilet in the bathroom was detached from the wall and there were

two missing ceramic square tiles. The mirror from the medicine cabinet was missing and there was a hole in the wall behind the bathroom door. Two residents resided in this room and used the bathroom.

2. The 200 Unit

a. The floor tile was loose and peeling next to the air conditioning unit in Room 207. A piece of ceramic tile was missing next to the sink in the bathroom. One resident resided in the bathroom.

b. The mirror from the medicine cabinet in the bathroom of Room 214 was missing. One resident resided in the room.

3. The 300 Unit

A strong urine odor was noted in Room 351. There was also an accumulation of dust and dirt along the heat register. The mirror from the medicine cabinet in the bathroom was missing. One resident resided in this room.

During an interview at that time, the Maintenance Director indicated all of the above were in need of cleaning and/or repair.

4. During an observation of the medication storage room on 4/15/25 at 11:00 a.m., the medication refrigerator was

observed to have drips of brown spillage on the inside and near the bottom. The shelf inside of the door was filled with various foods and condiments.

During an interview on 4/15/25 at 11:15 a.m., LPN 1 indicated the refrigerator was for medications like insulin and some eye drops, but some of the staff's food was in there currently.

During an interview on 4/16/25 at 12:10 p.m., the Director of Nursing indicated food should not be kept in the medication refrigerator.

5. During a random observation on 4/15/25 at 11:30 a.m., a fan in the common area outside of the medication room was observed to have an accumulation of dust and dirt.

During an interview on 4/16/25 at 12:23 p.m., the Director of Nursing indicated the fan needed to be cleaned.

Based on observation and interview, the facility failed to ensure the resident's environment was clean and in a state of good repair related to holes in the walls, an accumulation of dust and debris, loose tile and base boards, missing mirrors, urine odors, and an accumulation of food spillage in refrigerators for 3 of 4 units throughout the facility and

for 1 of 1 medication rooms. (The 100, 200, 300 Units and the Medication Room)

Findings include:

During the Environmental Tour on 4/16/25 at 10:40 a.m. with the Maintenance Director, the following was observed:

1. The 100 Unit

In Room 105, there were holes in the wall next to bed 2. The cover of the air conditioning unit was loose and was being held up with duct tape. There was a crack in the ceiling. The box spring for bed 2 was slanting to the side. The mattress for bed 1 was torn down the middle. The base board behind the toilet in the bathroom was detached from the wall and there were two missing ceramic square tiles. The mirror from the medicine cabinet was missing and there was a hole in the wall behind the bathroom door. Two residents resided in this room and used the bathroom.

2. The 200 Unit

a. The floor tile was loose and peeling next to the air conditioning unit in Room 207. A piece of ceramic tile was missing next to the sink in the bathroom. One resident resided in the bathroom.

b. The mirror from the medicine

	cabinet in the bathroom of Room 214 was missing. One resident resided in the room. 3. The 300 Unit A strong urine odor was noted in Room 351. There was also an accumulation of dust and dirt along the heat register. The mirror from the medicine cabinet in the bathroom was missing. One resident resided in this room. During an interview at that time, the Maintenance Director indicated all of the above were in need of cleaning and/or repair. 4. During an observation of the medication storage room on 4/15/25 at 11:00 a.m., the medication refrigerator was observed to have drips of brown spillage on the inside and near the bottom. The shelf inside of the door was filled with various foods and condiments. During an interview on 4/15/25 at 11:15 a.m., LPN 1 indicated the refrigerator was for medications like insulin and some eye drops, but some of the staff's food was in there currently.			

	During an interview on 4/16/25 at 12:10 p.m., the Director of Nursing indicated food should not be kept in the medication refrigerator. 5. During a random observation on 4/15/25 at 11:30 a.m., a fan in the common area outside of the medication room was observed to have an accumulation of dust and dirt. During an interview on 4/16/25 at 12:23 p.m., the Director of Nursing indicated the fan needed to be cleaned.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in	R 0216	Service plan for resident nine (9) has been updated to indicate that he has been assessed to self administer medications to be taken later on the days that he will be out of the facility for medication time. Charge nurse responsible for checking with resident if he will be out of building for next round of medications. DON to monitor visually, during medication pass, one (1) time weekly; ongoing.	05/01/2025

	the facility. Based on observation, record review and interview, the facility failed to complete a self-administration assessment for a resident who administered their own medications for 1 of 5 residents observed during medication pass. (Resident 9) Finding includes: During observation of a medication pass on 4/15/25 at 11:10 a.m., LPN 1 administered Resident 9 his morning medications. She then handed the resident a packet which contained two medications the resident was scheduled to take at noon: benztropine (a medication that treats the side effects caused by antipsychotic medications) and hydroxyzine (a medication used to help control anxiety). The resident put the packet in his pocket and indicated to LPN 1 that he would take them later. At that time, LPN 1 indicated she gave the resident his medications to take later because his morning pills were taken late due to his doctor's appointment. The resident's record was reviewed on 4/16/25 at 9:43 a.m. Diagnoses included, but were not limited to, schizophrenia and arthritis. The Service Plan, dated			

	1/16/24, indicated the resident was dependent on total assistance for medications and nurses were to administer his medications. During an interview on 4/15/25 at 3:10 p.m. the Director of Nursing indicated the resident had not been assessed to self-administer medications, and the nurse should not have given him his medications to take later. Based on observation, record review and interview, the facility failed to complete a self-administration assessment for a resident who administered their own medications for 1 of 5 residents observed during medication pass. (Resident 9) Finding includes: During observation of a medication pass on 4/15/25 at 11:10 a.m., LPN 1 administered Resident 9 his morning medications. She then handed the resident a packet which contained two medications the resident was scheduled to take at noon: benztropine (a medication that treats the side effects caused by antipsychotic medications) and hydroxyzine (a medication used to help control anxiety). The resident put the packet in his pocket and indicated to LPN 1 that he would take them later. At that			

	time, LPN 1 indicated she gave the resident his medications to take later because his morning pills were taken late due to his doctor's appointment. The resident's record was reviewed on 4/16/25 at 9:43 a.m. Diagnoses included, but were not limited to, schizophrenia and arthritis. The Service Plan, dated 1/16/24, indicated the resident was dependent on total assistance for medications and nurses were to administer his medications. During an interview on 4/15/25 at 3:10 p.m. the Director of Nursing indicated the resident had not been assessed to self-administer medications, and the nurse should not have given him his medications to take later.			
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;	R 0217	Service plans have been audited and service plans will be signed by resident or indicate residents refusal to sign. Charge nurse responsible for obtaining or documenting residents signature. DON to monitor service plans visually, monthly; ongoing.	05/16/2025

(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 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 review and interview, the facility failed to ensure the service plan was signed by the resident for 6 of 8 records reviewed. (Residents 6, 8, 2, 3, 4, and 7)

Findings include:

	1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The Service Plan, dated 1/31/25, was not signed by the resident. 2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The Service Plan, dated 2/25/25, was not signed by the resident. During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated most of the residents won't sign their service plan. She indicated that she would document "refused" next time. 5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia. The 1/15/24 Service Plan, updated on 2/27/25, lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans			

	signed by the residents. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. The 1/15/24 Service Plan lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 3. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. Diagnoses included, but were not limited to, prostate cancer and chronic obstructive pulmonary disease. The most recent Service Plan was completed on 4/10/25. It was not signed by the resident. 4. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension. The most recent Service Plan was completed on 1/6/24 and reviewed on 2/5/25. It was not signed by the resident. Based on record review and interview, the facility failed to ensure the service plan was			

signed by the resident for 6 of 8 records reviewed. (Residents 6, 8, 2, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The Service Plan, dated 1/31/25, was not signed by the resident.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The Service Plan, dated 2/25/25, was not signed by the resident.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated most of the residents won't sign their service plan. She indicated that she would document "refused" next time.

5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

The 1/15/24 Service Plan, updated on 2/27/25, lacked a

resident signature.

During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents.

6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia.

The 1/15/24 Service Plan lacked a resident signature.

During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents.

3. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. Diagnoses included, but were not limited to, prostate cancer and chronic obstructive pulmonary disease.

The most recent Service Plan was completed on 4/10/25. It was not signed by the resident.

4. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension.

The most recent Service Plan was completed on 1/6/24 and

reviewed on 2/5/25. It was not signed by the resident.

Based on record review and interview, the facility failed to ensure the service plan was signed by the resident for 6 of 8 records reviewed. (Residents 6, 8, 2, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The Service Plan, dated 1/31/25, was not signed by the resident.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The Service Plan, dated 2/25/25, was not signed by the resident.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated most of the residents won't sign their service plan. She indicated that she would document "refused" next time.

5. The record for Resident 4 was reviewed on 4/15/25 at

	10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia. The 1/15/24 Service Plan, updated on 2/27/25, lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. The 1/15/24 Service Plan lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 3. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. Diagnoses included, but were not limited to, prostate cancer and chronic obstructive pulmonary disease. The most recent Service Plan was completed on 4/10/25. It was not signed by the resident. 4. Resident 3's record was reviewed on 4/15/25 at 10:30			

	a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension. The most recent Service Plan was completed on 1/6/24 and reviewed on 2/5/25. It was not signed by the resident. Based on record review and interview, the facility failed to ensure the service plan was signed by the resident for 6 of 8 records reviewed. (Residents 6, 8, 2, 3, 4, and 7) Findings include: 1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The Service Plan, dated 1/31/25, was not signed by the resident. 2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The Service Plan, dated 2/25/25, was not signed by the resident. During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated most of the residents won't sign their			

	service plan. She indicated that she would document "refused" next time. 5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia. The 1/15/24 Service Plan, updated on 2/27/25, lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. The 1/15/24 Service Plan lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 3. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. Diagnoses included, but were not limited to, prostate cancer and chronic obstructive pulmonary disease.			

	The most recent Service Plan was completed on 4/10/25. It was not signed by the resident. 4. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension. The most recent Service Plan was completed on 1/6/24 and reviewed on 2/5/25. It was not signed by the resident. Based on record review and interview, the facility failed to ensure the service plan was signed by the resident for 6 of 8 records reviewed. (Residents 6, 8, 2, 3, 4, and 7) Findings include: 1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The Service Plan, dated 1/31/25, was not signed by the resident. 2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The Service Plan, dated 2/25/25, was not signed by the			

resident.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated most of the residents won't sign their service plan. She indicated that she would document "refused" next time.

5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

The 1/15/24 Service Plan, updated on 2/27/25, lacked a resident signature.

During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents.

6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia.

The 1/15/24 Service Plan lacked a resident signature.

During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents.

3. Resident 2's record was

	reviewed on 4/15/25 at 11:45 a.m. Diagnoses included, but were not limited to, prostate cancer and chronic obstructive pulmonary disease. The most recent Service Plan was completed on 4/10/25. It was not signed by the resident. 4. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension. The most recent Service Plan was completed on 1/6/24 and reviewed on 2/5/25. It was not signed by the resident. Based on record review and interview, the facility failed to ensure the service plan was signed by the resident for 6 of 8 records reviewed. (Residents 6, 8, 2, 3, 4, and 7) Findings include: 1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The Service Plan, dated 1/31/25, was not signed by the resident. 2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included,			

	but were not limited to, depression, hypertension, and hyperthyroidism. The Service Plan, dated 2/25/25, was not signed by the resident. During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated most of the residents won't sign their service plan. She indicated that she would document "refused" next time. 5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia. The 1/15/24 Service Plan, updated on 2/27/25, lacked a resident signature. During an interview on 4/16/25 at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. The 1/15/24 Service Plan lacked a resident signature. During an interview on 4/16/25			

	at 11:30 a.m., the Director of Nursing indicated she did not get any of the service plans signed by the residents. 3. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. Diagnoses included, but were not limited to, prostate cancer and chronic obstructive pulmonary disease. The most recent Service Plan was completed on 4/10/25. It was not signed by the resident. 4. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension. The most recent Service Plan was completed on 1/6/24 and reviewed on 2/5/25. It was not signed by the resident.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and	R 0243	Charts were audited and this is the only resident with these dosing parameters. Pharmacy has been informed that the sliding scale must be added, and it was. Dosing parameters has been added to indicate how much insulin was given. Pharmacy responsible for inputting sliding scale.	04/17/2025

	(D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to document how much insulin was administered for 1 of 8 records reviewed. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. A Physician's Order, dated 3/25/25, indicated the resident was to receive his baseline dose of 6 units of insulin with every meal. If the resident's blood sugar was above 150, the following Humalog insulin was to be added to the baseline dose: 150-200=1 unit 201-250=2 units 251-300=3 units 301-350=4 units 351-400=5 units The March 2025 Medication Administration Record (MAR), indicated the amount of insulin the resident received was not documented on the following		DON to monitor visually, one (1) time weekly, during med pass; ongoing.	

dates and times:

- 3/25/25 at 2:00 p.m. and 8:00 p.m.

- 3/26/25 at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

- 3/27/25 at 8:00 a.m. and 2:00 p.m.

- 3/28/25 at 2:00 p.m.

- 3/31/25 at 8:00 a.m. and 2:00 p.m.

The April 2025 MAR, indicated the amount of insulin the resident received was not documented on the following dates and time:

- 4/1/25 at 8:00 p.m.

- 4/2/25 at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

- 4/3/25 at 8:00 a.m. and 2:00 p.m.

- 4/4/25 at 8:00 a.m. and 2:00 p.m.

- 4/7/25 at 8:00 a.m.

- 4/9/25, 4/10/25, 4/11/25, and 4/14/25 at 8:00 a.m. and 2:00 p.m.

- 4/15/25 at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

- 4/16/25 at 8:00 a.m.

During an interview on 4/16/25

at 9:30 a.m., the Director of Nursing indicated when the pharmacy transcribed the order, they did not include an area on the MAR to document how much insulin was given.

Based on record review and interview, the facility failed to document how much insulin was administered for 1 of 8 records reviewed. (Resident 6)

Finding includes:

The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

A Physician's Order, dated 3/25/25, indicated the resident was to receive his baseline dose of 6 units of insulin with every meal. If the resident's blood sugar was above 150, the following Humalog insulin was to be added to the baseline dose:

150-200=1 unit

201-250=2 units

251-300=3 units

301-350=4 units

351-400=5 units

The March 2025 Medication Administration Record (MAR),

	indicated the amount of insulin the resident received was not documented on the following dates and times: - 3/25/25 at 2:00 p.m. and 8:00 p.m. - 3/26/25 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. - 3/27/25 at 8:00 a.m. and 2:00 p.m. - 3/28/25 at 2:00 p.m. - 3/31/25 at 8:00 a.m. and 2:00 p.m. The April 2025 MAR, indicated the amount of insulin the resident received was not documented on the following dates and time: - 4/1/25 at 8:00 p.m. - 4/2/25 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. - 4/3/25 at 8:00 a.m. and 2:00 p.m. - 4/4/25 at 8:00 a.m. and 2:00 p.m. - 4/7/25 at 8:00 a.m. - 4/9/25, 4/10/25, 4/11/25, and 4/14/25 at 8:00 a.m. and 2:00 p.m. - 4/15/25 at 8:00 a.m., 2:00 p.m., and 8:00 p.m.			

	- 4/16/25 at 8:00 a.m. During an interview on 4/16/25 at 9:30 a.m., the Director of Nursing indicated when the pharmacy transcribed the order, they did not include an area on the MAR to document how much insulin was given.			
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. Based on observation, record review and interview, the facility failed to ensure sanitary conditions were maintained related to no chemical sanitation buckets, no temperature gauge in the freezer, frozen food boxes stored on the floor and stacked to the ceiling in the freezer, thick ice accumulation on stored boxes in the freezer; unlabeled, undated and uncovered food in the refrigerator and dry storage area, dirty shelves, and not monitoring chemical dishwasher solution in 1 of 1 kitchen. (The Main Kitchen) Findings include: During the initial kitchen	R 0273	A. Dietary staff has been inserviced on the use of chemical sanitation buckets to be located in the kitchen. B. The thermometer located in the freezer has been re-hung. C. Dietary staff has been inserviced on proper storage of food in freezer. D. Dietary staff has been inserviced on labeling and dating all open food. E. Dry storage bins have been cleaned and labeled. New lids are being purchased F. Shelves below counters have been cleaned	05/16/2025

	sanitation tour with the Dietary Manager (DM) on 4/15/25 at 9:40 a.m., the following was observed: a. There were no chemical sanitation buckets located in the kitchen, just empty buckets on top of the counter. b. There was no thermometer in the freezer. c. The frozen food boxes in the freezer were on the floor and stacked ceiling high, creating a large accumulation of ice on several boxes in the freezer. d. In the walk-in refrigerator, there were jars of ranch dressing, jalapeno, relish, cantaloupe chunks, cottage cheese, and Italian dressing that were opened but not dated. There was a tray of corn bread muffins that was uncovered and undated. e. There were two dry storage bins on the floor that were unlabeled and undated. The lid on one of the bins was cracked and had a hole in it. f. The shelves below the counters had an accumulation of dirt and debris. g. There was no routine testing		G. Policy has been developed indicating that our dish washing machine sanitizer testing is done once every four (4) weeks by our dish washing machine company. Sanitizer test results are marked on the customer service reports. Last test completed on April 2, 2025, results showing 50 ppm. Dietary Manager has been trained by dish washing machine personnel on the use of sanitizing test strips and has received a vial of them. Cook responsible for making sure closing work is being done. Dietary Manager responsible for inspecting the kitchen every morning for completion of closing work, visually, five (5) times weekly; ongoing	

of the chemicals in the chemical dishwasher.

During an interview with the DM during the initial kitchen tour, she indicated food items should be covered, labeled and dated. She also indicated there was a delivery of food yesterday, that was why the freezer was disorganized and the shelves were dirty because food was being prepared. She indicated a company came out once a month to service the dishwasher. She had test strips available but did not use them or know how to use them.

During an interview on 4/15/25 at 9:45 a.m., Dietary Aide 1 indicated he was unable to find the thermometer in the freezer, he thought it had been knocked down. He indicated the ice accumulation happened when the freezer door was left open, the freezer would start to defrost and drip onto the boxes below.

A dishwasher policy and kitchen sanitation policy was requested and not available.

The document, "Food Labeling Policy", dated 3/2/24, indicated, "All opened food shall be labeled and dated...."

Based on observation, record review and interview, the facility failed to ensure sanitary conditions were maintained related to no chemical sanitation

	buckets, no temperature gauge in the freezer, frozen food boxes stored on the floor and stacked to the ceiling in the freezer, thick ice accumulation on stored boxes in the freezer; unlabeled, undated and uncovered food in the refrigerator and dry storage area, dirty shelves, and not monitoring chemical dishwasher solution in 1 of 1 kitchen. (The Main Kitchen) Findings include: During the initial kitchen sanitation tour with the Dietary Manager (DM) on 4/15/25 at 9:40 a.m., the following was observed: a. There were no chemical sanitation buckets located in the kitchen, just empty buckets on top of the counter. b. There was no thermometer in the freezer. c. The frozen food boxes in the freezer were on the floor and stacked ceiling high, creating a large accumulation of ice on several boxes in the freezer. d. In the walk-in refrigerator, there were jars of ranch dressing, jalapeno, relish, cantaloupe chunks, cottage cheese, and Italian dressing			

that were opened but not dated. There was a tray of corn bread muffins that was uncovered and undated.

e. There were two dry storage bins on the floor that were unlabeled and undated. The lid on one of the bins was cracked and had a hole in it.

f. The shelves below the counters had an accumulation of dirt and debris.

g. There was no routine testing of the chemicals in the chemical dishwasher.

During an interview with the DM during the initial kitchen tour, she indicated food items should be covered, labeled and dated. She also indicated there was a delivery of food yesterday, that was why the freezer was disorganized and the shelves were dirty because food was being prepared. She indicated a company came out once a month to service the dishwasher. She had test strips available but did not use them or know how to use them.

During an interview on 4/15/25 at 9:45 a.m., Dietary Aide 1 indicated he was unable to find the thermometer in the freezer, he thought it had been knocked down. He indicated the ice accumulation happened when the freezer door was left open, the freezer would start to defrost

	and drip onto the boxes below. A dishwasher policy and kitchen sanitation policy was requested and not available. The document, "Food Labeling Policy", dated 3/2/24, indicated, "All opened food shall be labeled and dated...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. 5. The record for Resident 4 was reviewed on 4/15/25 at	R 0298	Facility has contracted with a new pharmacy due to pharmacy reviews not being done in a timely manner and/or off site. New pharmacy responsible for doing reviews in house. DON to monitor charts, visually, monthly; ongoing.	04/21/2025

	10:54 a.m. Diagnoses included, but were not limited to, schizophrenia and dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. During an interview on 4/15/25 at 2:35 p.m., the Director of Nursing indicated that was a time when they had problems with their previous pharmacy. They weren't getting everything they were supposed to, and they switched over to a new pharmacy. Based on record review and interview, the facility failed to ensure residents' medications were reviewed every 60 days by a licensed pharmacist for 6 of 8 residents reviewed. (Residents 2, 3, 6, 8, 4, and 7) Findings include: 1. Resident 2's record was reviewed on 4/15/25 at 11:45			

a.m. The resident was on leave of absence from the facility from September 2024 until April 2025. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through September 2024.

2. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. The resident was admitted on 3/20/01. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through December 2024.

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated they did not have a pharmacist available to review residents' medications prior to January of this year.

3. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The resident was admitted to the facility on 9/26/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

4. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to,

depression, hypertension, and hyperthyroidism. The resident was admitted to the facility on 10/19/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated the previous pharmacy had not reviewed each resident's medication at least once every 60 days.

5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia and dementia.

There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024.

6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia.

There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024.

During an interview on 4/15/25 at 2:35 p.m., the Director of

	Nursing indicated that was a time when they had problems with their previous pharmacy. They weren't getting everything they were supposed to, and they switched over to a new pharmacy. Based on record review and interview, the facility failed to ensure residents' medications were reviewed every 60 days by a licensed pharmacist for 6 of 8 residents reviewed. (Residents 2, 3, 6, 8, 4, and 7) Findings include: 1. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. The resident was on leave of absence from the facility from September 2024 until April 2025. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through September 2024. 2. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. The resident was admitted on 3/20/01. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through December 2024.			

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated they did not have a pharmacist available to review residents' medications prior to January of this year.

3. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The resident was admitted to the facility on 9/26/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

4. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The resident was admitted to the facility on 10/19/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated the previous pharmacy had not reviewed each resident's medication at least once every 60 days.

	5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia and dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. During an interview on 4/15/25 at 2:35 p.m., the Director of Nursing indicated that was a time when they had problems with their previous pharmacy. They weren't getting everything they were supposed to, and they switched over to a new pharmacy. Based on record review and interview, the facility failed to ensure residents' medications were reviewed every 60 days by a licensed pharmacist for 6 of 8 residents reviewed. (Residents 2, 3, 6, 8, 4, and 7) Findings include:			

	1. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. The resident was on leave of absence from the facility from September 2024 until April 2025. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through September 2024. 2. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. The resident was admitted on 3/20/01. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through December 2024. During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated they did not have a pharmacist available to review residents' medications prior to January of this year. 3. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The resident was admitted to the facility on 9/26/18. There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024. 4. The record for Resident 8 was reviewed on 4/15/25 at			

	2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The resident was admitted to the facility on 10/19/18. There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024. During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated the previous pharmacy had not reviewed each resident's medication at least once every 60 days. 5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia and dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024.			

During an interview on 4/15/25 at 2:35 p.m., the Director of Nursing indicated that was a time when they had problems with their previous pharmacy. They weren't getting everything they were supposed to, and they switched over to a new pharmacy.

Based on record review and interview, the facility failed to ensure residents' medications were reviewed every 60 days by a licensed pharmacist for 6 of 8 residents reviewed. (Residents 2, 3, 6, 8, 4, and 7)

Findings include:

1. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. The resident was on leave of absence from the facility from September 2024 until April 2025. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through September 2024.

2. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. The resident was admitted on 3/20/01. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through December 2024.

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated they did not have a pharmacist available to

review residents' medications prior to January of this year.

3. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The resident was admitted to the facility on 9/26/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

4. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The resident was admitted to the facility on 10/19/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated the previous pharmacy had not reviewed each resident's medication at least once every 60 days.

5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to,

schizophrenia and dementia.

There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024.

6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia.

There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024.

During an interview on 4/15/25 at 2:35 p.m., the Director of Nursing indicated that was a time when they had problems with their previous pharmacy. They weren't getting everything they were supposed to, and they switched over to a new pharmacy.

Based on record review and interview, the facility failed to ensure residents' medications were reviewed every 60 days by a licensed pharmacist for 6 of 8 residents reviewed. (Residents 2, 3, 6, 8, 4, and 7)

Findings include:

1. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. The resident was on leave of absence from the facility from

September 2024 until April 2025. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through September 2024.

2. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. The resident was admitted on 3/20/01. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through December 2024.

During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated they did not have a pharmacist available to review residents' medications prior to January of this year.

3. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The resident was admitted to the facility on 9/26/18.

There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024.

4. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The resident

	was admitted to the facility on 10/19/18. There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024. During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated the previous pharmacy had not reviewed each resident's medication at least once every 60 days. 5. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia and dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. 6. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia. There was no evidence of pharmacy reviews being completed every 60 days from May 2024 until December 2024. During an interview on 4/15/25 at 2:35 p.m., the Director of Nursing indicated that was a time when they had problems			

	with their previous pharmacy. They weren't getting everything they were supposed to, and they switched over to a new pharmacy. Based on record review and interview, the facility failed to ensure residents' medications were reviewed every 60 days by a licensed pharmacist for 6 of 8 residents reviewed. (Residents 2, 3, 6, 8, 4, and 7) Findings include: 1. Resident 2's record was reviewed on 4/15/25 at 11:45 a.m. The resident was on leave of absence from the facility from September 2024 until April 2025. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through September 2024. 2. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. The resident was admitted on 3/20/01. There was no documentation the pharmacist had reviewed the resident's medications from May 2024 through December 2024. During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated they did not have a pharmacist available to review residents' medications prior to January of this year. 3. The record for Resident 6			

	was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes. The resident was admitted to the facility on 9/26/18. There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024. 4. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. The resident was admitted to the facility on 10/19/18. There was no documentation the pharmacist had reviewed the resident's medications every 60 days from May 2024 through December 2024. During an interview on 4/15/25 at 1:40 p.m., the Director of Nursing indicated the previous pharmacy had not reviewed each resident's medication at least once every 60 days.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained	R 0349	1 Nurses have been inserviced on the importance of completing at least seventy-two (72) hour documentation after a change in condition. 2 Resident was receiving proper	04/25/2025

	under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to fall follow up, medication administration, and clarification of medication orders for 1 of 8 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 8, 10, and 11) Findings include: 1. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. A Nurse's Note, dated 4/9/25 at 8:14 a.m., indicated the resident returned to the facility after being intoxicated. A large abrasion was observed over the left eye, the corner of the left eye, and the nose. The resident denied pain or discomfort and still appeared to be slightly		doses indicated by blood sugar checks. QuickMar computer system dropped the box for the 11am medication pass. QuickMar is aware of the error and the problem has been corrected. QuickMar has indicated that this was a system error on their part. Ozempic was not administered on 04/01, 04/02, 04/09, 04/11, 04/12 ,04/13. This was another QuickMar error that has been corrected, other Ozempic client orders are correct. 3 Nurses have been inserviced on the importance of charting medication exemptions Charge nurse responsible for documentation. DON to monitor weekly during med pass; ongoing.	

intoxicated.

There were no additional nurse's notes for review.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated documentation should have been completed for at least 72 hours after the incident.

2. The record for Resident 10 was reviewed on 4/15/25 at 2:50 p.m. The April 2025 Medication Administration Record (MAR) indicated the resident was to receive 34 units of Insulin Lispro (a fast-acting insulin) four times a day with meals and nightly. The medication was scheduled and signed out for three times each day: 8:00 a.m., 4:00 p.m., and 8:00 p.m. The MAR indicated the order for the insulin was from 1/27/25, but the physician's order was not found in the record.

The April 2025 MAR indicated the resident was to receive Ozempic (an injected medication that lowers blood sugar) every Monday. The medication was signed out as given on 4/1/25 (Tuesday), 4/2/25 (Wednesday), 4/9/25 (Wednesday), 4/11/25 (Friday), 4/12/25 (Saturday), and 4/13/25 (Sunday).

During an interview on 4/15/25 at 3:10 p.m., the Director of

	Nursing (DON) indicated the Lispro order should read three times a day, and that she would look for the order to clarify the MAR. The DON indicated the Ozempic was documented incorrectly. She was sure the resident only received Ozempic once per week because she prepared the medication pens herself. On 4/16/25 at 8:45 a.m., the DON indicated she had not found the Lispro order yet to clarify the MAR. No further information was received by the end of the survey. 3. During observation of a medication pass on 4/15/2025 at 11:14 a.m., LPN 1 administered the following medications to Resident 11: valproic acid (for bipolar disorder and seizures), benztropine (treats the side effects caused by antipsychotic medications), duloxetine (for depression and anxiety), cyclobenzaprine (for muscle spasms), docusate sodium (a stool softener), hydroxyzine pamoate (for anxiety), losartan/hydrochlorothiazide (for high blood pressure), olanzapine (an anti-psychotic), naproxen (an anti-inflammatory), and omeprazole (to decrease stomach acid). At that time, LPN 1 indicated the resident was receiving the medications late			

because she had a doctor's appointment that morning.

The record for Resident 11 was reviewed on 4/16/25 at 9:30 a.m. The MAR indicated the resident did not receive her 10 morning medications because she was at an appointment.

During an interview on 4/16/25 at 3:10 p.m., the Director of Nursing indicated the nurse should have changed her documentation to indicate the resident did receive her morning medications on 4/15/25.

Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to fall follow up, medication administration, and clarification of medication orders for 1 of 8 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 8, 10, and 11)

Findings include:

1. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

A Nurse's Note, dated 4/9/25 at 8:14 a.m., indicated the resident returned to the facility after being intoxicated. A large

	abrasion was observed over the left eye, the corner of the left eye, and the nose. The resident denied pain or discomfort and still appeared to be slightly intoxicated. There were no additional nurse's notes for review. During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated documentation should have been completed for at least 72 hours after the incident. 2. The record for Resident 10 was reviewed on 4/15/25 at 2:50 p.m. The April 2025 Medication Administration Record (MAR) indicated the resident was to receive 34 units of Insulin Lispro (a fast-acting insulin) four times a day with meals and nightly. The medication was scheduled and signed out for three times each day: 8:00 a.m., 4:00 p.m., and 8:00 p.m. The MAR indicated the order for the insulin was from 1/27/25, but the physician's order was not found in the record. The April 2025 MAR indicated the resident was to receive Ozempic (an injected medication that lowers blood sugar) every Monday. The medication was signed out as given on 4/1/25 (Tuesday), 4/2/25 (Wednesday), 4/9/25			

	(Wednesday), 4/11/25 (Friday), 4/12/25 (Saturday), and 4/13/25 (Sunday). During an interview on 4/15/25 at 3:10 p.m., the Director of Nursing (DON) indicated the Lispro order should read three times a day, and that she would look for the order to clarify the MAR. The DON indicated the Ozempic was documented incorrectly. She was sure the resident only received Ozempic once per week because she prepared the medication pens herself. On 4/16/25 at 8:45 a.m., the DON indicated she had not found the Lispro order yet to clarify the MAR. No further information was received by the end of the survey. 3. During observation of a medication pass on 4/15/2025 at 11:14 a.m., LPN 1 administered the following medications to Resident 11: valproic acid (for bipolar disorder and seizures), benztropine (treats the side effects caused by antipsychotic medications), duloxetine (for depression and anxiety), cyclobenzaprine (for muscle spasms), docusate sodium (a stool softener), hydroxyzine pamoate (for anxiety), losartan/hydrochlorothiazide (for high blood pressure), olanzapine (an anti-psychotic),			

naproxen (an anti-inflammatory), and omeprazole (to decrease stomach acid). At that time, LPN 1 indicated the resident was receiving the medications late because she had a doctor's appointment that morning.

The record for Resident 11 was reviewed on 4/16/25 at 9:30 a.m. The MAR indicated the resident did not receive her 10 morning medications because she was at an appointment.

During an interview on 4/16/25 at 3:10 p.m., the Director of Nursing indicated the nurse should have changed her documentation to indicate the resident did receive her morning medications on 4/15/25.

Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to fall follow up, medication administration, and clarification of medication orders for 1 of 8 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 8, 10, and 11)

Findings include:

1. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and

hyperthyroidism.

A Nurse's Note, dated 4/9/25 at 8:14 a.m., indicated the resident returned to the facility after being intoxicated. A large abrasion was observed over the left eye, the corner of the left eye, and the nose. The resident denied pain or discomfort and still appeared to be slightly intoxicated.

There were no additional nurse's notes for review.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated documentation should have been completed for at least 72 hours after the incident.

2. The record for Resident 10 was reviewed on 4/15/25 at 2:50 p.m. The April 2025 Medication Administration Record (MAR) indicated the resident was to receive 34 units of Insulin Lispro (a fast-acting insulin) four times a day with meals and nightly. The medication was scheduled and signed out for three times each day: 8:00 a.m., 4:00 p.m., and 8:00 p.m. The MAR indicated the order for the insulin was from 1/27/25, but the physician's order was not found in the record.

The April 2025 MAR indicated the resident was to receive Ozempic (an injected

	medication that lowers blood sugar) every Monday. The medication was signed out as given on 4/1/25 (Tuesday), 4/2/25 (Wednesday), 4/9/25 (Wednesday), 4/11/25 (Friday), 4/12/25 (Saturday), and 4/13/25 (Sunday). During an interview on 4/15/25 at 3:10 p.m., the Director of Nursing (DON) indicated the Lispro order should read three times a day, and that she would look for the order to clarify the MAR. The DON indicated the Ozempic was documented incorrectly. She was sure the resident only received Ozempic once per week because she prepared the medication pens herself. On 4/16/25 at 8:45 a.m., the DON indicated she had not found the Lispro order yet to clarify the MAR. No further information was received by the end of the survey. 3. During observation of a medication pass on 4/15/2025 at 11:14 a.m., LPN 1 administered the following medications to Resident 11: valproic acid (for bipolar disorder and seizures), benztropine (treats the side effects caused by antipsychotic medications), duloxetine (for depression and anxiety), cyclobenzaprine (for muscle spasms), docusate sodium (a			

stool softener), hydroxyzine pamoate (for anxiety), losartan/hydrochlorothiazide (for high blood pressure), olanzapine (an anti-psychotic), naproxen (an anti-inflammatory), and omeprazole (to decrease stomach acid). At that time, LPN 1 indicated the resident was receiving the medications late because she had a doctor's appointment that morning.

The record for Resident 11 was reviewed on 4/16/25 at 9:30 a.m. The MAR indicated the resident did not receive her 10 morning medications because she was at an appointment.

During an interview on 4/16/25 at 3:10 p.m., the Director of Nursing indicated the nurse should have changed her documentation to indicate the resident did receive her morning medications on 4/15/25.

Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to fall follow up, medication administration, and clarification of medication orders for 1 of 8 records reviewed and for 2 of 5 residents observed during medication administration. (Residents 8, 10, and 11)

Findings include:

	1. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism. A Nurse's Note, dated 4/9/25 at 8:14 a.m., indicated the resident returned to the facility after being intoxicated. A large abrasion was observed over the left eye, the corner of the left eye, and the nose. The resident denied pain or discomfort and still appeared to be slightly intoxicated. There were no additional nurse's notes for review. During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated documentation should have been completed for at least 72 hours after the incident. 2. The record for Resident 10 was reviewed on 4/15/25 at 2:50 p.m. The April 2025 Medication Administration Record (MAR) indicated the resident was to receive 34 units of Insulin Lispro (a fast-acting insulin) four times a day with meals and nightly. The medication was scheduled and signed out for three times each day: 8:00 a.m., 4:00 p.m., and 8:00 p.m. The MAR indicated the order for the insulin was from 1/27/25, but the physician's			

order was not found in the record.

The April 2025 MAR indicated the resident was to receive Ozempic (an injected medication that lowers blood sugar) every Monday. The medication was signed out as given on 4/1/25 (Tuesday), 4/2/25 (Wednesday), 4/9/25 (Wednesday), 4/11/25 (Friday), 4/12/25 (Saturday), and 4/13/25 (Sunday).

During an interview on 4/15/25 at 3:10 p.m., the Director of Nursing (DON) indicated the Lispro order should read three times a day, and that she would look for the order to clarify the MAR. The DON indicated the Ozempic was documented incorrectly. She was sure the resident only received Ozempic once per week because she prepared the medication pens herself.

On 4/16/25 at 8:45 a.m., the DON indicated she had not found the Lispro order yet to clarify the MAR. No further information was received by the end of the survey.

3. During observation of a medication pass on 4/15/2025 at 11:14 a.m., LPN 1 administered the following medications to Resident 11: valproic acid (for bipolar disorder and seizures),

	benztropine (treats the side effects caused by antipsychotic medications), duloxetine (for depression and anxiety), cyclobenzaprine (for muscle spasms), docusate sodium (a stool softener), hydroxyzine pamoate (for anxiety), losartan/hydrochlorothiazide (for high blood pressure), olanzapine (an anti-psychotic), naproxen (an anti-inflammatory), and omeprazole (to decrease stomach acid). At that time, LPN 1 indicated the resident was receiving the medications late because she had a doctor's appointment that morning. The record for Resident 11 was reviewed on 4/16/25 at 9:30 a.m. The MAR indicated the resident did not receive her 10 morning medications because she was at an appointment. During an interview on 4/16/25 at 3:10 p.m., the Director of Nursing indicated the nurse should have changed her documentation to indicate the resident did receive her morning medications on 4/15/25.			
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	R 0412	TB risk assessments will be completed as resident is admitted to facility and will be completed by the end of June annually to ensure TB risk assessments are up to date. Charge nurses responsible for	05/01/2025

	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. 3. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension. The resident's last TB risk assessment was completed on 1/16/24. 4. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia. There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24. During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year. 5. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included,		initial risk assessment. DON to monitor when auditing charts, quarterly, ongoing.	

but were not limited to, depression, COPD (chronic obstructive pulmonary disease), and early dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

Based on record review and interview, the facility failed to ensure annual tuberculosis risk assessments were completed for 5 of 8 records reviewed. (Residents 6, 8, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The last annual tuberculosis (TB) risk assessment was dated 1/22/24.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The last annual tuberculosis (TB) risk assessment was dated 1/18/24.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated the TB risk assessments were to be updated yearly.

3. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension.

The resident's last TB risk assessment was completed on 1/16/24.

4. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

5. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease),

and early dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

Based on record review and interview, the facility failed to ensure annual tuberculosis risk assessments were completed for 5 of 8 records reviewed. (Residents 6, 8, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The last annual tuberculosis (TB) risk assessment was dated 1/22/24.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The last annual tuberculosis (TB) risk assessment was dated 1/18/24.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated the TB risk assessments were to be updated yearly.

3. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension.

The resident's last TB risk assessment was completed on 1/16/24.

4. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

5. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease),

and early dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

Based on record review and interview, the facility failed to ensure annual tuberculosis risk assessments were completed for 5 of 8 records reviewed. (Residents 6, 8, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The last annual tuberculosis (TB) risk assessment was dated 1/22/24.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The last annual tuberculosis (TB) risk assessment was dated 1/18/24.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated the TB risk assessments were to be updated yearly.

3. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension.

The resident's last TB risk assessment was completed on 1/16/24.

4. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

5. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease),

and early dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

Based on record review and interview, the facility failed to ensure annual tuberculosis risk assessments were completed for 5 of 8 records reviewed. (Residents 6, 8, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The last annual tuberculosis (TB) risk assessment was dated 1/22/24.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The last annual tuberculosis (TB) risk assessment was dated 1/18/24.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated the TB risk assessments were to be updated yearly.

3. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension.

The resident's last TB risk assessment was completed on 1/16/24.

4. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

5. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease),

and early dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

Based on record review and interview, the facility failed to ensure annual tuberculosis risk assessments were completed for 5 of 8 records reviewed. (Residents 6, 8, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The last annual tuberculosis (TB) risk assessment was dated 1/22/24.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

The last annual tuberculosis (TB) risk assessment was dated 1/18/24.

During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated the TB risk assessments were to be updated yearly.

3. Resident 3's record was reviewed on 4/15/25 at 10:30 a.m. Diagnoses included, but were not limited to, chronic schizophrenia and hypertension.

The resident's last TB risk assessment was completed on 1/16/24.

4. The record for Resident 4 was reviewed on 4/15/25 at 10:54 a.m. Diagnoses included, but were not limited to, schizophrenia, and dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

5. The record for Resident 7 was reviewed on 4/15/25 at 2:20 p.m. Diagnoses included, but were not limited to, depression, COPD (chronic obstructive pulmonary disease),

and early dementia.

There was no evidence an annual tuberculosis (TB) risk assessment had been completed for the resident since 1/15/24.

During an interview on 4/16/25 at 9:24 a.m., the Director of Nursing indicated she had not updated the TB risk assessments this year.

Based on record review and interview, the facility failed to ensure annual tuberculosis risk assessments were completed for 5 of 8 records reviewed. (Residents 6, 8, 3, 4, and 7)

Findings include:

1. The record for Resident 6 was reviewed on 4/15/25 at 1:10 p.m. Diagnoses included, but were not limited to, stroke, hypertension, kidney disease, and diabetes.

The last annual tuberculosis (TB) risk assessment was dated 1/22/24.

2. The record for Resident 8 was reviewed on 4/15/25 at 2:54 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperthyroidism.

	The last annual tuberculosis (TB) risk assessment was dated 1/18/24. During an interview on 4/16/25 at 9:00 a.m., the Director of Nursing indicated the TB risk assessments were to be updated yearly.			

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