STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE VILLAGE	17650 GENERATIONS DR, SOUTH BEND, , 46635

(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: July 1 & 2, 2025 Facility number: 001148 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/8/2025	R 0000		
R 0033	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(h)(1-2) (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known	R 0033	The facility will have postings consistent with State Regulations for residents upon admission. The current postings have been removed and updated to include the address for the Indiana State Department and local Mental Health Services. Other postings in the facility have been reviewed and found to be in	08/05/2025

	addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure the posted information required regarding the local and state agency's addresses and phone numbers was complete. This deficient practice affected 55 of 55 residents. Finding includes: During an observation, on 7/1/2025 at 10:08 A.M., the local and state agency's information was observed on the first and second floors of the facility. The posted information lacked an address for Indiana Department of Health and the area Ombudsman and there was not any information for the		compliance. No new issues noted. The postings will be audited at least monthly by the Administrator or designee for three months or until problem is considered resolved to ensure continued compliance. Any negative findings will add an additional month of auditing until 100% compliance is achieved. Results of audits will be reported to the management team of the facility to ensure compliance.	

local agency on aging and a local mental health facility.

During an interview, on 7/2/2025 at 10:42 A.M., the Executive Director indicated he was not aware these phone numbers and addresses should be accessible for the residents and indicated these phone numbers and addresses should have been posted.

A policy for the local and state agency's required posted information was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for the local and state agency's required posted information. The Director of Nursing indicated they follow state regulation for posting the local and state agency's required information.

Based on observation and interview, the facility failed to ensure the posted information required regarding the local and state agency's addresses and phone numbers was complete. This deficient practice affected 55 of 55 residents.

Finding includes:

During an observation, on 7/1/2025 at 10:08 A.M., the local and state agency's information was observed on

	the first and second floors of the facility. The posted information lacked an address for Indiana Department of Health and the area Ombudsman and there was not any information for the local agency on aging and a local mental health facility. During an interview, on 7/2/2025 at 10:42 A.M., the Executive Director indicated he was not aware these phone numbers and addresses should be accessible for the residents and indicated these phone numbers and addresses should have been posted. A policy for the local and state agency's required posted information was requested, on 7/2/2025 at 11:23 A.M. On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for the local and state agency's required posted information. The Director of Nursing indicated they follow state regulation for posting the local and state agency's required information.			
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state	R 0042	Annual survey results will be posted in manner that is accessible to the public. The facility has added a posting notifying the public that annual survey results are available and	08/05/2025

	surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure a copy of the most recent annual survey results was available and a notice of the where to locate the most recent annual survey results was posted. This deficient practice affected 55 of 55 residents in the facility. Finding includes: During a tour of the facility, on 7/1/2025 from 10:06 A.M. through 10:20 A.M., the annual survey results and a sign regarding the survey results availability could not be located. During an interview, on 7/2/2025 at 10:41 A.M., the Executive Director indicated the annual survey results were located at the front receptionist's desk.		located behind the front desk. Postings have been reviewed and found to be in compliance with State Regulations. No new issues noted. Postings will be audited at least monthly by the Administrator or designee or until problem is considered resolved. Any negative findings will add an additional month of auditing until 100% compliance is achieved. Results of audit will be reported to the management team on a monthly basis to ensure continued compliance.	

	During an observation with the Executive Director, on 7/2/2025 at 11:35 A.M., the annual survey results were located behind the receptionist desk's glass sliding window in a lavender binder. The binder could not be seen from outside the reception area. There was no signage posted to inform residents and/or the public of where the annual survey results were kept. A policy for the availability of the annual survey results and signage of availability was requested, on 7/2/2025 at 11:23 A.M. On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for the availability of the annual survey results and signage of availability. The Director of Nursing indicated the facility followed state regulation regarding the availability of the annual survey results and signage of availability. Based on observation and interview, the facility failed to ensure a copy of the most recent annual survey results was available and a notice of the where to locate the most recent annual survey results was posted. This deficient practice affected 55 of 55 residents in the facility.			

Finding includes:

During a tour of the facility, on 7/1/2025 from 10:06 A.M. through 10:20 A.M., the annual survey results and a sign regarding the survey results availability could not be located.

During an interview, on 7/2/2025 at 10:41 A.M., the Executive Director indicated the annual survey results were located at the front receptionist's desk.

During an observation with the Executive Director, on 7/2/2025 at 11:35 A.M., the annual survey results were located behind the receptionist desk's glass sliding window in a lavender binder. The binder could not be seen from outside the reception area. There was no signage posted to inform residents and/or the public of where the annual survey results were kept.

A policy for the availability of the annual survey results and signage of availability was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for the availability of the annual survey results and signage of availability. The Director of Nursing indicated the facility followed state regulation regarding the availability of the

	annual survey results and signage of availability.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to implement a written policy manual to ensure that resident care and facility objectives were attained. This had the potential to affect 55 of 55 residents residing in the facility. Finding includes: A review of the facilities policy manual was completed on 7/2/2025 at 1:31 P.M.	R 0091	The facility has obtained access to written policies and procedures to ensure resident care and facility objectives are attained. The facility has access to Med Recs and Optima for policies and procedures to ensure resident care and facility objectives are attained. All policies noted by the survey team are available for use by the staff and management. Other policies have been reviewed to ensure that policies are comprehensive and thorough. No new issues noted. Access to policies and procedures will be verified on a monthly basis. The results of verification will be reported to the management team for 3 months or until problem is considered resolved.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	08/05/2025

	The facility lacked policies for the following: - A Mental Health Screening policy - A Pre-admission and Semi-annual Weight policy - An Annual Health Statement policy - A Comprehensive Care Plan policy - A Tuberculosis Screening for Residents policy - An Emergency Binder policy - A Service Plan policy - A Self-administration of Medications Evaluation policy - A policy regarding PRN Medication Administration by a QMA. - A Fire Drill policy - A Resident Rights policy - A policy regarding posted information for the Ombudsman. - A policy regarding the accessibility of annual survey results. During an interview, on 7/2/2025 at 1:40 P.M., the DON indicated she had "typed up" her own policies and used them to teach staff. She indicated she did not			

	have written policies for the above areas and instead followed the state regulations. Based on record review and interview, the facility failed to implement a written policy manual to ensure that resident care and facility objectives were attained. This had the potential to affect 55 of 55 residents residing in the facility. Finding includes: A review of the facilities policy manual was completed on 7/2/2025 at 1:31 P.M. The facility lacked policies for the following: - A Mental Health Screening policy - A Pre-admission and Semi-annual Weight policy - An Annual Health Statement policy - A Comprehensive Care Plan policy - A Tuberculosis Screening for Residents policy - An Emergency Binder policy - A Service Plan policy - A Self-administration of Medications Evaluation policy			

	- A policy regarding PRN Medication Administration by a QMA. - A Fire Drill policy - A Resident Rights policy - A policy regarding posted information for the Ombudsman. - A policy regarding the accessibility of annual survey results. During an interview, on 7/2/2025 at 1:40 P.M., the DON indicated she had "typed up" her own policies and used them to teach staff. She indicated she did not have written policies for the above areas and instead followed the state regulations.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure criminal background checks were completed for new	R 0116	The facility will ensure that all employees have criminal background checks processed upon hire. The one employee without a criminal background has had a background check processed. No criminal history. Her criminal background has been added to her file. All other records have been reviewed for active employees. No other missing backgrounds checks found. No new issues noted.	08/05/2025

	hires for 1 of 5 employee records reviewed (LPN 2). Finding includes: A review of employee records was completed on 7/2/2025 at 10:15 A.M. Employee records indicated that LPN 2 was hired on 9/24/2024. Employee records lacked documentation that a criminal background check was completed upon hire for LPN 2. During an interview, on 7/2/2025 at 10:45 A.M., the DON indicated LPN 2 should have had a criminal background check completed prior to their employment. On 7/2/2025 at 1:26 P.M., the DON provided the policy titled, "Criminal Background Check Policy", dated 7/2/205 and indicated it was the policy currently being used by the facility. The policy indicated, "....Purpose: To ensure a safe and secure environment for residents, staff, and visitors by conducting comprehensive criminal background checks on all employees, contractors, and volunteers...." Based on record review and interview, the facility failed to ensure criminal background checks were completed for new hires for 1 of 5 employee		Background checks will be completed upon hire. New employees are not authorized to start employment until their background checks have been processed and approved for hire by the Administrator or designee. All new hires will be audited upon hire and by the Administrator or designee at least monthly. Results of audits will be reported to the management team to ensure continued compliance.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	

	records reviewed (LPN 2). Finding includes: A review of employee records was completed on 7/2/2025 at 10:15 A.M. Employee records indicated that LPN 2 was hired on 9/24/2024. Employee records lacked documentation that a criminal background check was completed upon hire for LPN 2. During an interview, on 7/2/2025 at 10:45 A.M., the DON indicated LPN 2 should have had a criminal background check completed prior to their employment. On 7/2/2025 at 1:26 P.M., the DON provided the policy titled, "Criminal Background Check Policy", dated 7/2/205 and indicated it was the policy currently being used by the facility. The policy indicated, "....Purpose: To ensure a safe and secure environment for residents, staff, and visitors by conducting comprehensive criminal background checks on all employees, contractors, and volunteers...."			
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee	R 0118	All staff working in position that require licensing shall have a current license to work in the facility.	08/05/2025

	providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to ensure professional licenses were not expired for working staff for 1 of 5 employee records reviewed (CNA 5). Finding includes: A review of employee records was completed on 7/2/2025 at 10:20 A.M. and indicated CNA 5 had been hired on 8/9/2024. A review of CNA 5's state certification indicated his certification had expired on 2/10/2025 and had not been renewed. A review of the staffing schedules from 6/29/2025 to 7/5/2025 indicated CNA 5 had been scheduled to work on the following days: - 6/30/2025 - 7/1/2025		Employee identified by the State as having an expired license, renewed his license during the survey. All licenses have been reviewed and found to be in compliance. No new issues noted. Licenses will be kept in a binder and audited on a monthly basis by the Administrator or designee to ensure that all personnel are licensed per job/state requirements.Any negative findings will add an additional month of auditing until 100% compliance is achieved. Audits will be reviewed by the management team at least monthly to ensure continued compliance.	

- 7/2/2025

- 7/3/2025

During an interview on 7/2/2025 at 11:40 A.M., the ED indicated CNA 5 was to be taken off of the schedule and sent home. He indicated he should not have been working on the floor with an expired certificate.

On 7/2/2025 at 12:17 P.M., the DON provided the policy titled, "Clinical Staff Licensure and Expired License Management", dated 7/2/2025 and indicated it was the policy currently being used by the facility. The policy indicated, "....Purpose: To ensure that all clinical staff hold and maintain a valid, current, and unrestricted license or certification as required by Indiana...."

Based on record review and interview, the facility failed to ensure professional licenses were not expired for working staff for 1 of 5 employee records reviewed (CNA 5).

Finding includes:

A review of employee records was completed on 7/2/2025 at 10:20 A.M. and indicated CNA 5 had been hired on 8/9/2024.

A review of CNA 5's state certification indicated his certification had expired on 2/10/2025 and had not been

	renewed. A review of the staffing schedules from 6/29/2025 to 7/5/2025 indicated CNA 5 had been scheduled to work on the following days: - 6/30/2025 - 7/1/2025 - 7/2/2025 - 7/3/2025 During an interview on 7/2/2025 at 11:40 A.M., the ED indicated CNA 5 was to be taken off of the schedule and sent home. He indicated he should not have been working on the floor with an expired certificate. On 7/2/2025 at 12:17 P.M., the DON provided the policy titled, "Clinical Staff Licensure and Expired License Management", dated 7/2/2025 and indicated it was the policy currently being used by the facility. The policy indicated, "....Purpose: To ensure that all clinical staff hold and maintain a valid, current, and unrestricted license or certification as required by Indiana...."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be	R 0121	New hires will receive health screenings prior to starting employment.	08/05/2025

	required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.		The employees identified have been scheduled to have health screenings completed. A contract has been initiated with a local health care center to complete health screenings on behalf of the facility. When not available, the NP will conduct the health screenings. New hires will be required to complete a health screen prior to starting work. A record review will identify those who are not in compliance. Any employee found to be out of compliance will be required to complete a health screen. Employees will be tracked using SF 5440 to ensure continued compliance. Results of tracking will be reported to the management team on a monthly basis for continued monitoring.	

	(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to complete an employee health screen for new hires for 2 of 5 employee records reviewed. (LPN 2 & Dietary Aide 4) Finding includes: Employee records were reviewed on 7/2/2025 at 10:20 A.M. and indicated LPN 2 had been hired on 9/24/2024 and Dietary Aide 4 had been hired on 3/26/2025. Employee records lacked documentation that an employee health screen was completed for LPN 2 and Dietary Aide 4 upon hire. During an interview, on 7/2/2025 at 10:45 A.M., the DON indicated LPN 2 and Dietary Aide 4 should have had employee health screens completed upon hire. On 7/2/2025 at 1:26 P.M. the DON provided the policy titled, "Conditional Physical Examination and Health Clearance Policy", dated 7/2/2025 and indicated it was the policy currently being used			

by the facility. The policy indicated, "3. (name of facility) does not require routine or pre-employment physical examinations for staff...."

Based on record review and interview, the facility failed to complete an employee health screen for new hires for 2 of 5 employee records reviewed. (LPN 2 & Dietary Aide 4)

Finding includes:

Employee records were reviewed on 7/2/2025 at 10:20 A.M. and indicated LPN 2 had been hired on 9/24/2024 and Dietary Aide 4 had been hired on 3/26/2025.

Employee records lacked documentation that an employee health screen was completed for LPN 2 and Dietary Aide 4 upon hire.

During an interview, on 7/2/2025 at 10:45 A.M., the DON indicated LPN 2 and Dietary Aide 4 should have had employee health screens completed upon hire.

On 7/2/2025 at 1:26 P.M. the DON provided the policy titled, "Conditional Physical Examination and Health Clearance Policy", dated 7/2/2025 and indicated it was the policy currently being used by the facility. The policy indicated, "3. (name of facility)

	does not require routine or pre-employment physical examinations for staff...."			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.	R 0123	All employees will have job description that define duties of the job. Employee identified during the survey has signed her job description. All files have been audited for job descriptions. No other issues were identified. Personnel files will be audited for job descriptions at least monthly and upon hire. All employees are required to have job descriptions in his or her file and signed. Audits will be reviewed by the management team on at least a monthly basis to ensure continued compliance.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	08/05/2025

	Based on record review and interview, the facility failed to ensure employee records included signed job descriptions for 1 of 5 employee records reviewed (Dietary Aide 4). Finding includes: A review of employee files was completed on 7/2/2025 at 10:20 A.M. and indicated Dietary Aide 4 had been hired on 3/26/2025. Dietary Aide 4's employee file lacked documentation of a signed job description. During an interview, on 7/2/2025 at 10:45 A.M., the DON indicated Dietary Aide 4 should have had a signed job description. On 7/2/2025 at 1:26 P.M., the DON provided the policy titled, "Job Description Management Policy", dated 7/2/2025 and indicated it was the policy currently being used by the facility. The policy indicated, "....3. Policy Statement: Employees are required to review and sign their job description at the time of hire...." Based on record review and interview, the facility failed to ensure employee records included signed job descriptions for 1 of 5 employee records reviewed (Dietary Aide 4).			

	Finding includes: A review of employee files was completed on 7/2/2025 at 10:20 A.M. and indicated Dietary Aide 4 had been hired on 3/26/2025. Dietary Aide 4's employee file lacked documentation of a signed job description. During an interview, on 7/2/2025 at 10:45 A.M., the DON indicated Dietary Aide 4 should have had a signed job description. On 7/2/2025 at 1:26 P.M., the DON provided the policy titled, "Job Description Management Policy", dated 7/2/2025 and indicated it was the policy currently being used by the facility. The policy indicated, "....3. Policy Statement: Employees are required to review and sign their job description at the time of hire...."			
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	R 0216	Resident will receive weights upon admission. Resident #2's weight has been updated in his medical record. Weights for all of residents were reviewed and found to be in compliance.	08/05/2025

	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 the facility. 2. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's current Physician Orders included: May self administer medications after Self Administration Assessment completed. A Medication Self-Administration Safety Screen, dated 1/24/2025, indicated ongoing assessments should have occurred quarterly. The the following sections of the assessment were incomplete and/or left blank: Section A. Medications: List all medications that are being considered for resident self administration. List medication, route, dose and frequency. Indicate where the medication will be stored. Medication #1 1a) order - was documented as "See EMAR for medication list." Orders 2a		New residents will be weighed upon admission. Weights will be updated in the medical record. Weights will be audited monthly by the DON or designee. Audits of weights will be reported to the management team on a monthly basis to ensure continued compliance. All residents who are self-administration will be assessed on a quarterly basis. Resident identified by the State had an assessment that was late. Resident has been assessed again and has been found to be compliant and to continue as self-administration. Other assessments for residents who are self-administration have been reviewed and found to be in compliance. No new issues noted. Resident who are self-administration will be audited on a monthly basis to ensure that assessments are timely and accurate. Any found to be out of compliance will be updated immediately. Results of audits will be reported to the management team on a	

	through 10a were all blank. B. Evaluation 7. The resident can demonstrate secure storage of medications kept in room. There was no Medication Self-Administration Safety Screen completed for April 2025, when the quarterly assessment would have been due. During an interview, on 7/2/2025 at 10:50 A.M., the Director of Nursing indicated the self-administration medication safety screen, dated 1/24/2025, had not been fully completed with the medications the resident was self-administering and another self- administration safety screen should have been completed in April. During an interview, on 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding Self-Administration of Medications was not available. Based on record review and interview, the facility failed to ensure resident weights were completed on admission for 1 of 7 residents reviewed for admission weights (Resident 2). In addition, the facility failed to ensure Self Administration of Medication assessments were complete and timely for 1 of 2 residents reviewed for self administration of medications		monthly basis x3 or until problem is considered to be resolved.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	

	(Resident 7) Findings include: 1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. The resident was admitted to the facility on 6/20/2025. Resident 2's record lacked documentation that a weight had been assessed and documented upon the resident's admission to the facility. During an interview on 7/2/2025 at 9:33 A.M., the DON indicated Resident 2 should have had an admission weight obtained and documented. 2. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's current Physician Orders included: May self administer medications after Self Administration Assessment completed. A Medication Self-Administration Safety Screen, dated 1/24/2025, indicated ongoing assessments should have occurred quarterly. The the following sections of the assessment were incomplete and/or left blank: Section A. Medications: List all medications			

	that are being considered for resident self administration. List medication, route, dose and frequency. Indicate where the medication will be stored. Medication #1 1a) order - was documented as "See EMAR for medication list." Orders 2a through 10a were all blank. B. Evaluation 7. The resident can demonstrate secure storage of medications kept in room. There was no Medication Self-Administration Safety Screen completed for April 2025, when the quarterly assessment would have been due. During an interview, on 7/2/2025 at 10:50 A.M., the Director of Nursing indicated the self-administration medication safety screen, dated 1/24/2025, had not been fully completed with the medications the resident was self-administering and another self- administration safety screen should have been completed in April. During an interview, on 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding Self-Administration of Medications was not available. Based on record review and interview, the facility failed to ensure resident weights were completed on admission for 1 of			

	7 residents reviewed for admission weights (Resident 2). In addition, the facility failed to ensure Self Administration of Medication assessments were complete and timely for 1 of 2 residents reviewed for self administration of medications (Resident 7) Findings include: 1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. The resident was admitted to the facility on 6/20/2025. Resident 2's record lacked documentation that a weight had been assessed and documented upon the resident's admission to the facility. During an interview on 7/2/2025 at 9:33 A.M., the DON indicated Resident 2 should have had an admission weight obtained and documented. 2. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's current Physician Orders included: May self administer medications after Self Administration Assessment completed. A Medication			

	Self-Administration Safety Screen, dated 1/24/2025, indicated ongoing assessments should have occurred quarterly. The the following sections of the assessment were incomplete and/or left blank: Section A. Medications: List all medications that are being considered for resident self administration. List medication, route, dose and frequency. Indicate where the medication will be stored. Medication #1 1a) order - was documented as "See EMAR for medication list." Orders 2a through 10a were all blank. B. Evaluation 7. The resident can demonstrate secure storage of medications kept in room. There was no Medication Self-Administration Safety Screen completed for April 2025, when the quarterly assessment would have been due. During an interview, on 7/2/2025 at 10:50 A.M., the Director of Nursing indicated the self-administration medication safety screen, dated 1/24/2025, had not been fully completed with the medications the resident was self-administering and another self- administration safety screen should have been completed in April. During an interview, on 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility			

	policy regarding Self-Administration of Medications was not available. Based on record review and interview, the facility failed to ensure resident weights were completed on admission for 1 of 7 residents reviewed for admission weights (Resident 2). In addition, the facility failed to ensure Self Administration of Medication assessments were complete and timely for 1 of 2 residents reviewed for self administration of medications (Resident 7) Findings include: 1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. The resident was admitted to the facility on 6/20/2025. Resident 2's record lacked documentation that a weight had been assessed and documented upon the resident's admission to the facility. During an interview on 7/2/2025 at 9:33 A.M., the DON indicated Resident 2 should have had an admission weight obtained and documented.			

	2. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's current Physician Orders included: May self administer medications after Self Administration Assessment completed. A Medication Self-Administration Safety Screen, dated 1/24/2025, indicated ongoing assessments should have occurred quarterly. The the following sections of the assessment were incomplete and/or left blank: Section A. Medications: List all medications that are being considered for resident self administration. List medication, route, dose and frequency. Indicate where the medication will be stored. Medication #1 1a) order - was documented as "See EMAR for medication list." Orders 2a through 10a were all blank. B. Evaluation 7. The resident can demonstrate secure storage of medications kept in room. There was no Medication Self-Administration Safety Screen completed for April 2025, when the quarterly assessment would have been due. During an interview, on 7/2/2025			

at 10:50 A.M., the Director of Nursing indicated the self-administration medication safety screen, dated 1/24/2025, had not been fully completed with the medications the resident was self-administering and another self- administration safety screen should have been completed in April.

During an interview, on 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding Self-Administration of Medications was not available.

Based on record review and interview, the facility failed to ensure resident weights were completed on admission for 1 of 7 residents reviewed for admission weights (Resident 2). In addition, the facility failed to ensure Self Administration of Medication assessments were complete and timely for 1 of 2 residents reviewed for self administration of medications (Resident 7)

Findings include:

1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. The resident was admitted to the facility on 6/20/2025.

Resident 2's record lacked documentation that a weight had been assessed and documented upon the resident's

	admission to the facility. During an interview on 7/2/2025 at 9:33 A.M., the DON indicated Resident 2 should have had an admission weight obtained and documented.			
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.	R 0217	Service plans will be developed with the resident and/or representative, signed and update in each resident medical record. All residents will have service plans updated, reviewed and signed in conjunction with the resident and/or representative. New forms have been obtained to achieve this goal. The process of updating records service plans has begun and will continue until completed. All residents shall have a service plan consistent with their needs. Service plans will be audited on a monthly basis x 6 months to ensure that they are completed thoroughly and accurately.Any negative findings will add an additional month of auditing until 100% compliance is achieved. The results of the audits will be reported to the management team to ensure continued compliance.	08/05/2025

(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.

4. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. There was no Service Plan signed by the resident and/or their representative.

During an interview, on 7/2/2025 at 10:08 A.M., Resident 5 indicated he had not participated in the development of a service plan for his care.

5. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. There was no current Service plan signed by the resident and/or their representative. The most recent service plan had been completed upon the resident's admission on 5/8/2024.

6. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. There was no Service plan for Resident 7.

	7. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. There was no service plans of care for Resident 8. During an interview, on 7/2/2025 at 1:10 P.M., the Director of Nursing indicated there were no service plans for these residents and there should have been. On 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the facility had no policies available regarding initiating service plans. Based on record review and interview the facility failed to document services provided in a Service Plan and failed to ensure the plan was signed by the resident and/or their representative for 7 out of 7 residents reviewed for Service Plans. (Residents 2, 3, 4, 5, 6, 7 & 8) Findings include: 1. A record review for Resident 2 was completed on 7/2/2025 at 11:27 A.M. There was no Service Plan signed by the resident and/or their representative. 2. A record review for Resident 3 was completed on 7/2/2025 at 2:13 P.M. There was no Service Plan signed by the resident and/or their representative.			

	3. A record review for Resident 4 was completed on 7/2/2025 at 1:48 P.M.. There was no Service Plan signed by the resident and/or their representative. 4. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. There was no Service Plan signed by the resident and/or their representative. During an interview, on 7/2/2025 at 10:08 A.M., Resident 5 indicated he had not participated in the development of a service plan for his care. 5. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. There was no current Service plan signed by the resident and/or their representative. The most recent service plan had been completed upon the resident's admission on 5/8/2024. 6. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. There was no Service plan for Resident 7. 7. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. There was no service plans of care for Resident 8. During an interview, on 7/2/2025 at 1:10 P.M., the Director of Nursing indicated there were no			

service plans for these residents and there should have been.

On 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the facility had no policies available regarding initiating service plans.

Based on record review and interview the facility failed to document services provided in a Service Plan and failed to ensure the plan was signed by the resident and/or their representative for 7 out of 7 residents reviewed for Service Plans. (Residents 2, 3, 4, 5, 6, 7 & 8)

Findings include:

1. A record review for Resident 2 was completed on 7/2/2025 at 11:27 A.M. There was no Service Plan signed by the resident and/or their representative.

2. A record review for Resident 3 was completed on 7/2/2025 at 2:13 P.M. There was no Service Plan signed by the resident and/or their representative.

3. A record review for Resident 4 was completed on 7/2/2025 at 1:48 P.M.. There was no Service Plan signed by the resident and/or their representative.

4. A record review for Resident 5 was completed, on 7/1/2025

at 1:47 P.M. There was no Service Plan signed by the resident and/or their representative.

During an interview, on 7/2/2025 at 10:08 A.M., Resident 5 indicated he had not participated in the development of a service plan for his care.

5. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. There was no current Service plan signed by the resident and/or their representative. The most recent service plan had been completed upon the resident's admission on 5/8/2024.

6. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. There was no Service plan for Resident 7.

7. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. There was no service plans of care for Resident 8.

During an interview, on 7/2/2025 at 1:10 P.M., the Director of Nursing indicated there were no service plans for these residents and there should have been.

On 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the facility had no policies available regarding initiating service plans.

	Based on record review and interview the facility failed to document services provided in a Service Plan and failed to ensure the plan was signed by the resident and/or their representative for 7 out of 7 residents reviewed for Service Plans. (Residents 2, 3, 4, 5, 6, 7 & 8) Findings include: 1. A record review for Resident 2 was completed on 7/2/2025 at 11:27 A.M. There was no Service Plan signed by the resident and/or their representative. 2. A record review for Resident 3 was completed on 7/2/2025 at 2:13 P.M. There was no Service Plan signed by the resident and/or their representative. 3. A record review for Resident 4 was completed on 7/2/2025 at 1:48 P.M.. There was no Service Plan signed by the resident and/or their representative. 4. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. There was no Service Plan signed by the resident and/or their representative. During an interview, on 7/2/2025 at 10:08 A.M., Resident 5 indicated he had not participated in the development			

	of a service plan for his care. 5. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. There was no current Service plan signed by the resident and/or their representative. The most recent service plan had been completed upon the resident's admission on 5/8/2024. 6. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. There was no Service plan for Resident 7. 7. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. There was no service plans of care for Resident 8. During an interview, on 7/2/2025 at 1:10 P.M., the Director of Nursing indicated there were no service plans for these residents and there should have been. On 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the facility had no policies available regarding initiating service plans. Based on record review and interview the facility failed to document services provided in a Service Plan and failed to ensure the plan was signed by the resident and/or their representative for 7 out of 7 residents reviewed for Service Plans. (Residents 2, 3, 4, 5, 6, 7			

	& 8) Findings include: 1. A record review for Resident 2 was completed on 7/2/2025 at 11:27 A.M. There was no Service Plan signed by the resident and/or their representative. 2. A record review for Resident 3 was completed on 7/2/2025 at 2:13 P.M. There was no Service Plan signed by the resident and/or their representative. 3. A record review for Resident 4 was completed on 7/2/2025 at 1:48 P.M.. There was no Service Plan signed by the resident and/or their representative. 4. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. There was no Service Plan signed by the resident and/or their representative. During an interview, on 7/2/2025 at 10:08 A.M., Resident 5 indicated he had not participated in the development of a service plan for his care. 5. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. There was no current Service plan signed by the resident and/or their representative. The most recent service plan had been			

	completed upon the resident's admission on 5/8/2024. 6. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. There was no Service plan for Resident 7. 7. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. There was no service plans of care for Resident 8. During an interview, on 7/2/2025 at 1:10 P.M., the Director of Nursing indicated there were no service plans for these residents and there should have been. On 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the facility had no policies available regarding initiating service plans. Based on record review and interview the facility failed to document services provided in a Service Plan and failed to ensure the plan was signed by the resident and/or their representative for 7 out of 7 residents reviewed for Service Plans. (Residents 2, 3, 4, 5, 6, 7 & 8) Findings include: 1. A record review for Resident 2 was completed on 7/2/2025 at 11:27 A.M. There was no Service Plan signed by the resident and/or their			

representative.

2. A record review for Resident 3 was completed on 7/2/2025 at 2:13 P.M. There was no Service Plan signed by the resident and/or their representative.

3. A record review for Resident 4 was completed on 7/2/2025 at 1:48 P.M.. There was no Service Plan signed by the resident and/or their representative.

4. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. There was no Service Plan signed by the resident and/or their representative.

During an interview, on 7/2/2025 at 10:08 A.M., Resident 5 indicated he had not participated in the development of a service plan for his care.

5. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. There was no current Service plan signed by the resident and/or their representative. The most recent service plan had been completed upon the resident's admission on 5/8/2024.

6. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. There was no Service plan for Resident 7.

7. The record for Resident 8

	was completed on 7/2/2025 at 11:10 A.M. There was no service plans of care for Resident 8. During an interview, on 7/2/2025 at 1:10 P.M., the Director of Nursing indicated there were no service plans for these residents and there should have been. On 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the facility had no policies available regarding initiating service plans. Based on record review and interview the facility failed to document services provided in a Service Plan and failed to ensure the plan was signed by the resident and/or their representative for 7 out of 7 residents reviewed for Service Plans. (Residents 2, 3, 4, 5, 6, 7 & 8) Findings include: 1. A record review for Resident 2 was completed on 7/2/2025 at 11:27 A.M. There was no Service Plan signed by the resident and/or their representative. 2. A record review for Resident 3 was completed on 7/2/2025 at 2:13 P.M. There was no Service Plan signed by the resident and/or their representative. 3. A record review for Resident			

	4 was completed on 7/2/2025 at 1:48 P.M.. There was no Service Plan signed by the resident and/or their representative.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure staff obtained a nurse's permission to administer an as needed (PRN) medications provided by a qualified medication assistant (QMA) for 1 of 7 residents reviewed. (Resident 5) Finding includes: A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus	R 0246	All QMA's administering PRN medications will have the permission of a Licensed Nurse. Audit of records indicate that permission has been granted to administer medications via text message. QMA's and Nurses will document in the resident file permission of a nurse to administer a PRN medication. Nurses and QMA's will be in-serviced on this regulatory issue. The DON or designee will audit medication administration on at least a daily basis to ensure compliance with this rule. Staff found to be out of compliance will be re-educated and/or disciplined. Results of audits will be reviewed by the management team at least monthly to ensure continued compliance. Audits will continue monthly x3 or until problem is considered to be resolved.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	08/05/2025

type 2.

A Physician's Order, dated 5/20/2025, indicated Morphine Sulfate ER (extended release) oral tablet 15 milligrams every 12 hours as needed for pain.

A review of the June Medication Administration Record (MAR) indicated Resident 5 had received Morphine Sulfate ER administered by QMAs without prior approval from a nurse.

QMA 7 had administered Morphine Sulfate ER, without a nurse's prior approval, on the following days: 6/1/2025 at 8:30 P.M., 6/10/2025 at 8:39 P.M., 6/14/3035 at 9:08 P.M., 6/24/2025 at 8:00 P.M. and 6/28/2025 at 9:00 P.M.

QMA 3 had administered Morphine Sulfate ER, without a nurse's prior approval, on the following days: 6/11/2025 at 9:00 A.M., 6/12/2025 at 9:30 A.M., and 6/25/2025 at 8:07 A.M.

QMA 8 had administered Morphine Sulfate ER, without a nurse's prior approval, on 6/13/2025 at 10:37 P.M.

A Physician's Order, dated 5/20/2025, indicated ondansetron (Zofran) 4 milligram tablet every 6 hours as needed (PRN) for nausea and vomiting.

	A review of the June MAR indicated Resident 5 had received ondansetron, administered by QMAs without prior approval from a nurse. QMA 7 had administered ondansetron, without a nurse's prior approval, on 6/28/2025 at 9:38 P.M. QMA 3 had administered ondansetron, without a nurse's prior approval, on 6/11/2025 at 9:02 A.M. and on 6/29/2025 at 9:02 A.M. A Physician's Order, dated 5/20/2025, indicated Glucose Oral 40% (Dextrose) give 15 milligrams by mouth every 15 minutes as needed for hypoglycemia (low blood sugar). A review of the June MAR indicated Resident 5 had received Glucose Oral 40% administered by a QMA without prior approval from a nurse. QMA 7 had administered Glucose Oral 40% on 6/24/2025 at 12:44 A.M. There was no blood sugar level documented at the time the Glucose Oral 40 % medication had been administered. During an interview, on 7/2/2025 at 8:40 A.M., the Director of Nursing indicated the QMAs knew they were to get permission from the nurse prior to administering an as needed			

	(PRN) medications and the QMAs should have asked permission prior to administering the as needed medications. A policy for QMA administration of as needed medications was requested, on 7/2/2025 at 11:23 A.M. On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for QMA administration of as needed medications. The Director of Nursing indicated the facility followed state regulation regarding QMA administration of as needed medications. Based on record review and interview, the facility failed to ensure staff obtained a nurse's permission to administer an as needed (PRN) medications provided by a qualified medication assistant (QMA) for 1 of 7 residents reviewed. (Resident 5) Finding includes: A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus type 2. A Physician's Order, dated 5/20/2025, indicated Morphine Sulfate ER (extended release)			

	oral tablet 15 milligrams every 12 hours as needed for pain. A review of the June Medication Administration Record (MAR) indicated Resident 5 had received Morphine Sulfate ER administered by QMAs without prior approval from a nurse. QMA 7 had administered Morphine Sulfate ER, without a nurse's prior approval, on the following days: 6/1/2025 at 8:30 P.M., 6/10/2025 at 8:39 P.M., 6/14/3035 at 9:08 P.M., 6/24/2025 at 8:00 P.M. and 6/28/2025 at 9:00 P.M. QMA 3 had administered Morphine Sulfate ER, without a nurse's prior approval, on the following days: 6/11/2025 at 9:00 A.M., 6/12/2025 at 9:30 A.M., and 6/25/2025 at 8:07 A.M. QMA 8 had administered Morphine Sulfate ER, without a nurse's prior approval, on 6/13/2025 at 10:37 P.M. A Physician's Order, dated 5/20/2025, indicated ondansetron (Zofran) 4 milligram tablet every 6 hours as needed (PRN) for nausea and vomiting.			

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	(PRN) medications and the QMAs should have asked permission prior to administering the as needed medications. A policy for QMA administration of as needed medications was requested, on 7/2/2025 at 11:23 A.M. On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for QMA administration of as needed medications. The Director of Nursing indicated the facility followed state regulation regarding QMA administration of as needed medications.			
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. 3. During the dining observation, in the main dining room, on 7/1/2025 from 11:39 A.M. through 12:21 P.M., CNA 6 was observed serving the residents requested drinks prior to food service. The following was observed:	R 0273	The facility will ensure that foods are stored per policy and that utensils are handled in a way to ensure sanitation and safety. The items identified by the State have been cleaned, discarded or replaced as needed per findings. The kitchen storage and refrigerators have been inspected to ensure no other issues are present. No findings in addition to the State findings. The kitchen personnel and CNA's will be in serviced on proper and handling of foods while be distributed. Proper handling on	08/06/2025

	-At 11:41 A.M., CNA 6 was observed serving a resident a coffee cup with her hand cupped over the top of the coffee cup, touching the drinking rim of the cup. -At 11:44 A.M., CNA 6 was observed serving a resident a cup of chocolate milk with her hand cupped over the top of the glassware, touching the drinking rim of the cup. -At 11:51 A.M., CNA 6 was observed handling glassware with her hand cupped over the top of the glassware when placing the glassware on the beverage cart. -At 11:53 A.M., CNA 6 was observed serving a resident two cups of cranberry juice with her hands cupped over the top of the glassware, touching the drinking rim of the glasses. -At 12:03 P.M., CNA 6 was observed serving a resident two cups of milk with her hands cupped over the top of the glassware, touching the drinking rims of the cups. -At 12:07 P.M., CNA 6 was observed serving a resident two cups of water with her hands cupped over the top of the glassware, touching the drinking rims of the glasses. -At 12:14 P.M., CNA 6 was observed serving a resident a		utensils when storing after cleaning. A thorough review the policy and dating a labeling of items that have been opened or used. The kitchen to include refrigerator, freezer and storage area will be audited daily by the Dietary Manager or designee. The audits will be conducted daily x 1 month, the weekly x 1 month or until problem is considered resolved. Any negative findings will add an additional month of auditing until 100% compliance is achieved. The results of the inspections/audits will be reported to the management team on a monthly basis to ensure continued compliance.	

	coffee cup with her hand cupped over the top of the coffee cup, touching the drinking rim of the cup. -At 12:21 P.M., CNA 6 was observed handling glassware with her hand cupped over the top of the glassware when placing the glassware on the beverage cart. During an interview, on 7/1/2025 at 12:21 P.M., CNA 6 indicated she should handle the coffee cups and glassware from the sides and not over the tops of the coffee cups and glassware. On 7/1/2025 at 12:25 P.M., the Dietary manager provided the policy titled, "Food Storage" undated, and indicated thee policy was the one currently used by the facility. The policy indicated "...4. Metal or plastic containers with tight fitting covers must be used for storing cereals, cereal products... dried vegetables... 10. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods... 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated deforming refrigerated. Leftover food is used within 48 hours or discarded... 17. g. To freeze leftover food, package in small airtight units for quick			

	freezing, label and date...." On 7/2/2025 at 10:52 A.M., the Dietary manager provided the policy titled, "Sanitation/Infection Control ", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... 2. i. Leftover foods are placed in shallow containers, dated, labeled and chilled rapidly... 4. e. All food surfaces including plates and kitchenware and surfaces of all equipment are washed, rinsed, and sanitized after each use to prevent cross-contamination... 5. All equipment is cleaned as needed. a. After each use, the designated staff member clean the... pots and pans...." On 7/2/2025 at 10:52 A.M., the Dietary Manager provided the policy titled, "Pot and Pan Washing", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Pots and pan must be air dries on the drain board... After pot and pans are dry, they must be inspected and then stored in a clean, dry, protected area... Procedure for washing pots and pans... 8. Clean underneath pot and pan area daily...." A policy for beverage service was requested, on 7/2/2025 at 11:23 A.M. On 7/2/2025 at 1:37 P.M., the Director of Nursing			

indicated a policy was not available for dining service. The Director of Nursing indicated the facility followed state regulation for dining services.

Based on observation, interview and record review, the facility failed to ensure foods were stored, prepared and served in a sanitary manner in 1 of 1 kitchens and 1 of 1 dining rooms. This deficient practice potentially affected 55 of 55 residents in the building who consumed food from the kitchen.

Findings include:

1. During the initial tour of the kitchen, on 7/1/2025 at 9:25 A.M. with the Dietary Manager, the following was observed:

A. In the dry storage area:

- an opened bag of oat cereal with an expiration date of 6/16/2025.

- an opened bag of shredded coconut with no opened date.

- an opened bag of vanilla wafers (cookies) with no opened date.

- an opened and unsealed 1 lb. bag of cocoa powder with no opened date

- an opened tub of vanilla icing with an expiration date of

	5/23/2025. - a bag of pasta with a use by date of 9/12/2024. - an opened, unsealed and undated bag of dried peas B. In the walk in cooler: - an opened plastic container of lobster base with black specs around the lid and on the container. - an opened container of coffee creamer with no open and or use by date. - an opened gallon of Honey Dijon mustard with black specs around the lid and on the container. - an opened bottle of 1000 Island dressing with specs of a black substance on the top lid and around the bottle with an opened date of 1/8/2025. - an opened 1/2 gallon bottle of Sweet-N-Sour sauce with an opened date of 9/16/2024 with black specs around the rim of the lid. - an opened bottle of lemon juice with black specs around the lid and on the container itself. - an opened and undated container of Asian Ginger sauce with black specs all around the			

	circumference of the lid and on the entire label. - an opened container of mandarin oranges, with an open date of 5/6/2025, with black specs along the lid and on the label. - an opened and undated container of Hoisin Sauce with black specs on the lid and on the label. - an opened gallon of prune juice with black specs on the lid rim and covering the container. - an opened container of Miracle Whip with a use by date of 2/14/2023. - an opened and undated container of basil pesto sauce. - an opened container of horseradish with a use by date of 6/20/2025. C. In the walk in freezer: - 2 unsealed opened bags of ravioli. - a metal steam table pan, partially covered with plastic wrap, holding chicken breasts with visible freezer burn and undated. - an opened bag of broccoli, dated 6/2022. - an opened bag of diced celery			

not sealed.

2. During a follow up observation of the kitchen, on 7/2/2025 at 9:18 A.M., the following was observed:

- cooking utensils of spatulas, ice cream scoop, food peeler, spoodles and tongues had been put away as clean with dried food substances.

- a cooking utensil drawer had diced potato pieces in it and other food debris.

- two small and one large pots with specs of black on the cooking surfaces and a dirty greasy debris along the handles.

- two small skillets with missing Teflon coating and a build up of grease along the rims of the skillets.

- three steam table pans, put away as clean, were visibly wet and had dried food substances.

- fruit bowls put away as clean were visibly wet and had dried specs of food.

During an interview, on 7/1/2025 at 9:59 A.M., the Dietary Manager indicated the black substance noted on several of the refrigerated food/condiment items looked like mold. She indicated the foods should have had open and use by dates;

should have been sealed appropriately; the expired items should have been removed and the foods with the black specs that looked like mold should have been thrown away.

During an interview, on 7/2/25 at 9:28 A.M., the Dietary manager indicated the cooking utensils were not cleaned and should have been clean prior to putting them away. In addition, the pots should not have been put away wet and the drawers and utensil bins should have been free of food debris. Finally, she indicated the skillets should have not been used.

3. During the dining observation, in the main dining room, on 7/1/2025 from 11:39 A.M. through 12:21 P.M., CNA 6 was observed serving the residents requested drinks prior to food service.

The following was observed:

-At 11:41 A.M., CNA 6 was observed serving a resident a coffee cup with her hand cupped over the top of the coffee cup, touching the drinking rim of the cup.

-At 11:44 A.M., CNA 6 was observed serving a resident a cup of chocolate milk with her hand cupped over the top of the glassware, touching the drinking rim of the cup.

	-At 11:51 A.M., CNA 6 was observed handling glassware with her hand cupped over the top of the glassware when placing the glassware on the beverage cart. -At 11:53 A.M., CNA 6 was observed serving a resident two cups of cranberry juice with her hands cupped over the top of the glassware, touching the drinking rim of the glasses. -At 12:03 P.M., CNA 6 was observed serving a resident two cups of milk with her hands cupped over the top of the glassware, touching the drinking rims of the cups. -At 12:07 P.M., CNA 6 was observed serving a resident two cups of water with her hands cupped over the top of the glassware, touching the drinking rims of the glasses. -At 12:14 P.M., CNA 6 was observed serving a resident a coffee cup with her hand cupped over the top of the coffee cup, touching the drinking rim of the cup. -At 12:21 P.M., CNA 6 was observed handling glassware with her hand cupped over the top of the glassware when placing the glassware on the beverage cart. During an interview, on 7/1/2025 at 12:21 P.M., CNA 6 indicated			

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	used by the facility. The policy indicated "...4. Metal or plastic containers with tight fitting covers must be used for storing cereals, cereal products... dried vegetables... 10. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods... 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated deforming refrigerated. Leftover food is used within 48 hours or discarded... 17. g. To freeze leftover food, package in small airtight units for quick freezing, label and date...." On 7/2/2025 at 10:52 A.M., the Dietary manager provided the policy titled, "Sanitation/Infection Control ", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... 2. i. Leftover foods are placed in shallow containers, dated, labeled and chilled rapidly... 4. e. All food surfaces including plates and kitchenware and surfaces of all equipment are washed, rinsed, and sanitized after each use to prevent cross-contamination... 5. All equipment is cleaned as needed. a. After each use, the designated staff member clean the... pots and pans...." On 7/2/2025 at 10:52 A.M., the			

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Based on observation, interview and record review, the facility failed to ensure foods were stored, prepared and served in a sanitary manner in 1 of 1 kitchens and 1 of 1 dining rooms. This deficient practice potentially affected 55 of 55 residents in the building who consumed food from the kitchen.

Findings include:

1. During the initial tour of the kitchen, on 7/1/2025 at 9:25 A.M. with the Dietary Manager, the following was observed:

	A. In the dry storage area: - an opened bag of oat cereal with an expiration date of 6/16/2025. - an opened bag of shredded coconut with no opened date. - an opened bag of vanilla wafers (cookies) with no opened date. - an opened and unsealed 1 lb. bag of cocoa powder with no opened date - an opened tub of vanilla icing with an expiration date of 5/23/2025. - a bag of pasta with a use by date of 9/12/2024. - an opened, unsealed and undated bag of dried peas B. In the walk in cooler: - an opened plastic container of lobster base with black specs around the lid and on the container. - an opened container of coffee creamer with no open and or use by date. - an opened gallon of Honey Dijon mustard with black specs around the lid and on the container. - an opened bottle of 1000			

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During an interview, on 7/2/25 at 9:28 A.M., the Dietary manager indicated the cooking utensils were not cleaned and should have been clean prior to putting them away. In addition, the pots should not have been put away wet and the drawers and utensil bins should have been free of food debris. Finally, she indicated the skillets should have not been used.

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R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure medications were secured appropriately in a resident's room for 1 of 1 resident who was reviewed for self-administration of medication. (Resident 7) Finding includes: During an observation, on 7/1/2025 at 10:45 A. M. various medications in a weekly pill holder, an inhaler and other bottles of medications were noted on a table in Resident 7's apartment, beside her recliner.	R 0295	The facility will ensure all residents who are self-administration store medications in a safe manner. Resident who was identified during the survey has been in-serviced on keeping medications in her lock box when not in use. All other residents who are self-administration have been checked and in-serviced on proper storage of medications. No new issues noted. Resident who are not compliant will be subject to loss of self-administration privileges.	08/05/2025

	A large drawer was observed by the kitchen area with a key lock along the upper side of the drawer. During an interview, on 7/1/2025 at 10:50 A.M., Resident 7 indicated she self-administered all of her medications and did not lock her medications up in the locked drawer in her apartment. Resident 7 indicated when she left her apartment, she only locked her hall door. When questioned if anyone else possessed keys for her room, she indicated the housekeepers, the aides, nurses and management staff. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's current medications included, but were not limited to: Duloxetine (anti-depressant) Gabapentin (anti-convulsant), Hydrocodone (narcotic), Lidocaine patch (analgesic), Trazadone (anti-depressant) and Ubrelvy (migraine medication). During an interview, on 7/2/2025 at 10:50 A.M., the Director of Nursing confirm Resident 7 did not always lock up her medications and "she should have them locked up especially		The DON or designee will audit medication storage for all residents who are self-administration at least weekly x 4 weeks, and then monthly or until problem is considered to be resolved. Problem is resolved at the end of 4 weeks if no new issues are noted. Any negative findings will add an additional month of auditing until 100% compliance is achieved. Results of audits will be reported to the management team on a monthly basis to ensure continued compliance	

	if there is a narcotic." A policy for self administration of medications storage was requested on 7/2/2025, During an interview, on 7/2/2025 at 11:51 P.M., the Director of Nursing indicated a facility policy regarding medication storage for self administration of medications was not available. Based on observation, interview and record review, the facility failed to ensure medications were secured appropriately in a resident's room for 1 of 1 resident who was reviewed for self-administration of medication. (Resident 7) Finding includes: During an observation, on 7/1/2025 at 10:45 A. M. various medications in a weekly pill holder, an inhaler and other bottles of medications were noted on a table in Resident 7's apartment, beside her recliner. A large drawer was observed by the kitchen area with a key lock along the upper side of the drawer. During an interview, on 7/1/2025 at 10:50 A.M., Resident 7 indicated she self-administered all of her medications and did not lock her medications up in the locked drawer in her apartment. Resident 7 indicated when she left her apartment,			

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R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major	R 0356	The facility will maintain an emergency binder that is complete with information for residents in case of emergency. The binder has been reviewed and updated with pictures and additional information needed for residents in case of an emergency. The DON or designee will ensure that new residents' information is added to the emergency binder. The binder will be audited on a monthly basis by the DON or designee to ensure all facesheets and additional information is updated for all residents. The results of the auditing will be reported to the management team on a monthly basis or until problem is considered resolved to ensure continued compliance. The problem will be considered resolved after 3 months of no new issues.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	08/05/2025

depressive disorder, anxiety and chronic pain. Resident was admitted on 5/8/2024.

The emergency information file did not have a hospital preference listed or a picture posted on the provided face sheet for Resident 6.

During an interview, on 11:49 A.M., the Director of Nursing indicated the face sheet lacked a picture of the resident and should have had the hospital preference listed.

Based on record review and interview the facility failed to ensure information in the emergency binder was complete for 4 of 7 residents reviewed for emergency binder information (Resident 2, 5, 6 & 8).

Findings include:

1. A review of the emergency binder was completed on 7/2/2025 at 10:10 A.M., and indicated the emergency binder lacked all required documentation for Resident 2.

3. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus type 2.

A review of the emergency information file was completed,

on 7/1/2025 at 2:32 P.M. The emergency information file did not have any documents for Resident 5.

During an interview, on 7/2/2025 at 8:35 A.M., the Director of Nursing indicated there were copies of Resident 5's face sheet and medication list at the nurse's station, but those documents had not been placed in the emergency information file.

A policy for emergency information files was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 12:15 P.M., the Director of Nursing provided a paper titled, "Policy Adding New Admissions to Emergency File". The paper indicated, " ...All residents that move into the facility should have face sheets added to the emergency file. File should be updated monthly ...."

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for emergency information files and the facility followed the state regulation.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was

admitted on 5/8/2024.

The emergency information file did not have a hospital preference listed or a picture posted on the provided face sheet for Resident 6.

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Based on record review and interview the facility failed to ensure information in the emergency binder was complete for 4 of 7 residents reviewed for emergency binder information (Resident 2, 5, 6 & 8).

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A policy for emergency information files was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 12:15 P.M., the Director of Nursing provided a paper titled, "Policy Adding New Admissions to Emergency File". The paper indicated, " ...All residents that move into the facility should have face sheets added to the emergency file. File should be updated monthly ...."

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for emergency information files and the facility followed the state regulation.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was admitted on 5/8/2024.

	The emergency information file did not have a hospital preference listed or a picture posted on the provided face sheet for Resident 6. During an interview, on 11:49 A.M., the Director of Nursing indicated the face sheet lacked a picture of the resident and should have had the hospital preference listed. Based on record review and interview the facility failed to ensure information in the emergency binder was complete for 4 of 7 residents reviewed for emergency binder information (Resident 2, 5, 6 & 8). Findings include: 1. A review of the emergency binder was completed on 7/2/2025 at 10:10 A.M., and indicated the emergency binder lacked all required documentation for Resident 2. 3. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus type 2.			

A review of the emergency information file was completed, on 7/1/2025 at 2:32 P.M. The emergency information file did not have any documents for Resident 5.

During an interview, on 7/2/2025 at 8:35 A.M., the Director of Nursing indicated there were copies of Resident 5's face sheet and medication list at the nurse's station, but those documents had not been placed in the emergency information file.

A policy for emergency information files was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 12:15 P.M., the Director of Nursing provided a paper titled, "Policy Adding New Admissions to Emergency File". The paper indicated, " ...All residents that move into the facility should have face sheets added to the emergency file. File should be updated monthly ...."

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for emergency information files and the facility followed the state regulation.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major

depressive disorder, anxiety and chronic pain. Resident was admitted on 5/8/2024.

The emergency information file did not have a hospital preference listed or a picture posted on the provided face sheet for Resident 6.

During an interview, on 11:49 A.M., the Director of Nursing indicated the face sheet lacked a picture of the resident and should have had the hospital preference listed.

Based on record review and interview the facility failed to ensure information in the emergency binder was complete for 4 of 7 residents reviewed for emergency binder information (Resident 2, 5, 6 & 8).

Findings include:

1. A review of the emergency binder was completed on 7/2/2025 at 10:10 A.M., and indicated the emergency binder lacked all required documentation for Resident 2.

3. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus type 2.

A review of the emergency information file was completed,

on 7/1/2025 at 2:32 P.M. The emergency information file did not have any documents for Resident 5.

During an interview, on 7/2/2025 at 8:35 A.M., the Director of Nursing indicated there were copies of Resident 5's face sheet and medication list at the nurse's station, but those documents had not been placed in the emergency information file.

A policy for emergency information files was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 12:15 P.M., the Director of Nursing provided a paper titled, "Policy Adding New Admissions to Emergency File". The paper indicated, " ...All residents that move into the facility should have face sheets added to the emergency file. File should be updated monthly ...."

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for emergency information files and the facility followed the state regulation.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was

admitted on 5/8/2024.

The emergency information file did not have a hospital preference listed or a picture posted on the provided face sheet for Resident 6.

During an interview, on 11:49 A.M., the Director of Nursing indicated the face sheet lacked a picture of the resident and should have had the hospital preference listed.

Based on record review and interview the facility failed to ensure information in the emergency binder was complete for 4 of 7 residents reviewed for emergency binder information (Resident 2, 5, 6 & 8).

Findings include:

1. A review of the emergency binder was completed on 7/2/2025 at 10:10 A.M., and indicated the emergency binder lacked all required documentation for Resident 2.

3. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus type 2.

A review of the emergency information file was completed, on 7/1/2025 at 2:32 P.M. The emergency information file did

not have any documents for Resident 5.

During an interview, on 7/2/2025 at 8:35 A.M., the Director of Nursing indicated there were copies of Resident 5's face sheet and medication list at the nurse's station, but those documents had not been placed in the emergency information file.

A policy for emergency information files was requested, on 7/2/2025 at 11:23 A.M.

On 7/2/2025 at 12:15 P.M., the Director of Nursing provided a paper titled, "Policy Adding New Admissions to Emergency File". The paper indicated, " ...All residents that move into the facility should have face sheets added to the emergency file. File should be updated monthly ...."

On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for emergency information files and the facility followed the state regulation.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was admitted on 5/8/2024.

	The emergency information file did not have a hospital preference listed or a picture posted on the provided face sheet for Resident 6. During an interview, on 11:49 A.M., the Director of Nursing indicated the face sheet lacked a picture of the resident and should have had the hospital preference listed. Based on record review and interview the facility failed to ensure information in the emergency binder was complete for 4 of 7 residents reviewed for emergency binder information (Resident 2, 5, 6 & 8). Findings include: 1. A review of the emergency binder was completed on 7/2/2025 at 10:10 A.M., and indicated the emergency binder lacked all required documentation for Resident 2. 3. A record review for Resident 5 was completed, on 7/1/2025 at 1:47 P.M. Diagnoses included, but were not limited to: bipolar disorder, seizures, blindness in one eye and diabetes mellitus type 2.			

	A review of the emergency information file was completed, on 7/1/2025 at 2:32 P.M. The emergency information file did not have any documents for Resident 5. During an interview, on 7/2/2025 at 8:35 A.M., the Director of Nursing indicated there were copies of Resident 5's face sheet and medication list at the nurse's station, but those documents had not been placed in the emergency information file. A policy for emergency information files was requested, on 7/2/2025 at 11:23 A.M. On 7/2/2025 at 12:15 P.M., the Director of Nursing provided a paper titled, "Policy Adding New Admissions to Emergency File". The paper indicated, " ...All residents that move into the facility should have face sheets added to the emergency file. File should be updated monthly ...." On 7/2/2025 at 1:37 P.M., the Director of Nursing indicated a policy was not available for emergency information files and the facility followed the state regulation.			
R 0378	Mental Health Screening-Deficiency 410 IAC	R 0378	All residents with a mental health diagnosis will receive a mental health screening.	08/05/2025

	16.2-5-11.1(b)(1)(A-H)(2-3) (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual.		Residents identified during the State Survey are in the process of having their screenings updated. All other residents with a mental health diagnosis will have their screenings updated as well. Once completed, all residents with a mental health diagnosis will have their charts reviewed on a monthly basis to ensure compliance with this regulation. Results of audits will be reported to the management team for review and continued compliance. This will be an on-going monthly audit.	

R 0382	Mental Health Screening - Noncompliance 410 IAC 16.2-5-11.1(f) (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to ensure a Comprehensive Care Plan was developed in coordination with a Mental Health Provider for residents with major mental illness for 4 of 7 residents reviewed for major mental illness (Resident 4, 6, 7 & 8). Findings include: 1. A record review was completed for Resident 4 on 7/1/2025 at 1:48 P.M. Diagnoses included, but were not limited to: schizoaffective disorder and major depressive disorder. Resident 4's record lacked documentation that a Care Plan had been developed in coordination with a Mental Health Provider. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major	R 0382	All residents with a mental health diagnosis will receive a mental health screening and care planning in coordination with their mental health screenings. . Residents identified during the State Survey are in the process of having their screenings updated. All other residents with a mental health diagnosis will have mental health care plans in coordination with their screenings updated as well. Once completed, all residents with a mental health diagnosis will have their charts reviewed on a monthly basis to ensure compliance with having updated mental health care plans. Results of audits will be reported to the management team for review and continued compliance. This will be an on-going monthly audit.	08/05/2025

depressive disorder, anxiety and chronic pain. Resident had been admitted on 5/8/2024.

A comprehensive care plan related to mental health was not available and there were no indications Resident 6 had been seen by a mental health professional to assist in the development of a plan of care.

3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia.

Current medications included but were not limited to: duloxetine (antidepressant) 30 mg (milligrams) 1 capsule at bedtime for depression, and trazadone (antidepressant) 150 mg 1 tablet at bedtime related to anxiety disorder and major depressive disorder.

There was no care plan addressing the resident's major depressive disorder developed in conjunction with a mental health care provider.

4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, insomnia, dementia and major depressive disorder.

Current medications included,

but were not limited to trazadone (antidepressant) 100 mg 1 tablet at bedtime for insomnia.

A comprehensive care plan related to mental health was not available and there were no indications that Resident 8 had been evaluated by a mental health professional to assist in the development of a plan of care.

During an interview, on 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the residents did not have comprehensive care plans addressing their mental heath issues and should have had them. In addition, she indicated there were no facility policies available regarding mental health issues and care plans.

Based on record review and interview, the facility failed to ensure a Comprehensive Care Plan was developed in coordination with a Mental Health Provider for residents with major mental illness for 4 of 7 residents reviewed for major mental illness (Resident 4, 6, 7 & 8).

Findings include:

1. A record review was completed for Resident 4 on 7/1/2025 at 1:48 P.M. Diagnoses included, but were not limited to: schizoaffective

disorder and major depressive disorder.

Resident 4's record lacked documentation that a Care Plan had been developed in coordination with a Mental Health Provider.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident had been admitted on 5/8/2024.

A comprehensive care plan related to mental health was not available and there were no indications Resident 6 had been seen by a mental health professional to assist in the development of a plan of care.

3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia.

Current medications included but were not limited to: duloxetine (antidepressant) 30 mg (milligrams) 1 capsule at bedtime for depression, and trazadone (antidepressant) 150 mg 1 tablet at bedtime related to anxiety disorder and major depressive disorder.

There was no care plan

addressing the resident's major depressive disorder developed in conjunction with a mental health care provider.

4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, insomnia, dementia and major depressive disorder.

Current medications included, but were not limited to trazadone (antidepressant) 100 mg 1 tablet at bedtime for insomnia.

A comprehensive care plan related to mental health was not available and there were no indications that Resident 8 had been evaluated by a mental health professional to assist in the development of a plan of care.

During an interview, on 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the residents did not have comprehensive care plans addressing their mental heath issues and should have had them. In addition, she indicated there were no facility policies available regarding mental health issues and care plans.

Based on record review and interview, the facility failed to ensure a Comprehensive Care Plan was developed in

coordination with a Mental Health Provider for residents with major mental illness for 4 of 7 residents reviewed for major mental illness (Resident 4, 6, 7 & 8).

Findings include:

1. A record review was completed for Resident 4 on 7/1/2025 at 1:48 P.M. Diagnoses included, but were not limited to: schizoaffective disorder and major depressive disorder.

Resident 4's record lacked documentation that a Care Plan had been developed in coordination with a Mental Health Provider.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident had been admitted on 5/8/2024.

A comprehensive care plan related to mental health was not available and there were no indications Resident 6 had been seen by a mental health professional to assist in the development of a plan of care.

3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety,

chronic pain, major depressive disorder and insomnia.

Current medications included but were not limited to: duloxetine (antidepressant) 30 mg (milligrams) 1 capsule at bedtime for depression, and trazadone (antidepressant) 150 mg 1 tablet at bedtime related to anxiety disorder and major depressive disorder.

There was no care plan addressing the resident's major depressive disorder developed in conjunction with a mental health care provider.

4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, insomnia, dementia and major depressive disorder.

Current medications included, but were not limited to trazadone (antidepressant) 100 mg 1 tablet at bedtime for insomnia.

A comprehensive care plan related to mental health was not available and there were no indications that Resident 8 had been evaluated by a mental health professional to assist in the development of a plan of care.

During an interview, on 7/2/2025 at 1:19 P.M., the Director of

	Nursing indicated the residents did not have comprehensive care plans addressing their mental heath issues and should have had them. In addition, she indicated there were no facility policies available regarding mental health issues and care plans. Based on record review and interview, the facility failed to ensure a Comprehensive Care Plan was developed in coordination with a Mental Health Provider for residents with major mental illness for 4 of 7 residents reviewed for major mental illness (Resident 4, 6, 7 & 8). Findings include: 1. A record review was completed for Resident 4 on 7/1/2025 at 1:48 P.M. Diagnoses included, but were not limited to: schizoaffective disorder and major depressive disorder. Resident 4's record lacked documentation that a Care Plan had been developed in coordination with a Mental Health Provider. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident had been			

admitted on 5/8/2024.

A comprehensive care plan related to mental health was not available and there were no indications Resident 6 had been seen by a mental health professional to assist in the development of a plan of care.

3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia.

Current medications included but were not limited to: duloxetine (antidepressant) 30 mg (milligrams) 1 capsule at bedtime for depression, and trazadone (antidepressant) 150 mg 1 tablet at bedtime related to anxiety disorder and major depressive disorder.

There was no care plan addressing the resident's major depressive disorder developed in conjunction with a mental health care provider.

4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, insomnia, dementia and major depressive disorder.

Current medications included, but were not limited to trazadone (antidepressant) 100

	mg 1 tablet at bedtime for insomnia. A comprehensive care plan related to mental health was not available and there were no indications that Resident 8 had been evaluated by a mental health professional to assist in the development of a plan of care. During an interview, on 7/2/2025 at 1:19 P.M., the Director of Nursing indicated the residents did not have comprehensive care plans addressing their mental heath issues and should have had them. In addition, she indicated there were no facility policies available regarding mental health issues and care plans.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major	R 0409	Medical Records for all residents will include a health care statement. Medical records identified are being updated with health care statements. All records will be audited for Health Care Statements. Any found to be out of compliance will be updated. Medical records will be audited monthly for Health Care Statements. This will be an	08/05/2025

	depressive disorder, anxiety and chronic pain. Resident was admitted to the facility on 5/8/2024. Resident 6's clinical record lacked the documentation of an annual health statement including a statement indicating the resident was free from tuberculosis in an infectious state. 3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state 4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, dementia, insomnia and major depressive disorder. Resident 8's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state.		on-going process. Results of audits will be reported to the Managment Team to ensure continued compliance.	

	On 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding annual health statements was not available. Based on record review and interview, the facility failed to ensure resident records included annual health statements for 4 of 7 records reviewed for annual health statements (Resident 2, 6, 7 & 8). Findings include: 1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on 6/20/2025. Resident 2's record lacked documentation of an annual health statement. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was admitted to the facility on 5/8/2024. Resident 6's clinical record lacked the documentation of an annual health statement including a statement indicating the resident was free from tuberculosis in an infectious			

state.

3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia.

Resident 7's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state

4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, dementia, insomnia and major depressive disorder.

Resident 8's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state.

On 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding annual health statements was not available.

Based on record review and interview, the facility failed to ensure resident records included annual health statements for 4 of 7 records

	reviewed for annual health statements (Resident 2, 6, 7 & 8). Findings include: 1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on 6/20/2025. Resident 2's record lacked documentation of an annual health statement. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was admitted to the facility on 5/8/2024. Resident 6's clinical record lacked the documentation of an annual health statement including a statement indicating the resident was free from tuberculosis in an infectious state. 3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's clinical record lacked the documentation of an			

annual health statement, including a statement that the resident was free from tuberculosis in an infectious state

4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease, dementia, insomnia and major depressive disorder.

Resident 8's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state.

On 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding annual health statements was not available.

Based on record review and interview, the facility failed to ensure resident records included annual health statements for 4 of 7 records reviewed for annual health statements (Resident 2, 6, 7 & 8).

Findings include:

1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on

	6/20/2025. Resident 2's record lacked documentation of an annual health statement. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident was admitted to the facility on 5/8/2024. Resident 6's clinical record lacked the documentation of an annual health statement including a statement indicating the resident was free from tuberculosis in an infectious state. 3. The record for Resident 7 was completed on 7/1/2025 at 1:43 P.M. Diagnoses included, but were not limited to anxiety, chronic pain, major depressive disorder and insomnia. Resident 7's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state 4. The record for Resident 8 was completed on 7/2/2025 at 11:10 A.M. Diagnose included, but were not limited to sleep apnea, chronic kidney disease,			

	dementia, insomnia and major depressive disorder. Resident 8's clinical record lacked the documentation of an annual health statement, including a statement that the resident was free from tuberculosis in an infectious state. On 7/2/2025 at 11:51 A.M., the Director of Nursing indicated a facility policy regarding annual health statements was not available. Based on record review and interview, the facility failed to ensure resident records included annual health statements for 4 of 7 records reviewed for annual health statements (Resident 2, 6, 7 & 8). Findings include: 1. A record review was completed for Resident 2 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on 6/20/2025. Resident 2's record lacked documentation of an annual health statement.			

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. (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 complete a first and second step tuberculosis (TB) test for 2 of 7 records reviewed for TB tests. (Residents 3 & 6) Findings include: 1. A record review was completed for Resident 3 on 7/1/2025 at 11:27 A.M. and	R 0410	The facility will ensure that all residents receive 1st and 2nd steps TB Tests per regulatory requirement. Resident #3 has expired. Resident #6 received Mantoux test, and his file has been updated. All other residents in the facility charts have been audited for compliance. All have been found have received 1st and 2nd step or chest x-rays to verify residents are free of TB. Residents upon admission will receive 1st and 2nd step in accordance with State Regulations and facility policy. The DON or designee will audit for TB testing for all residents. Any resident that is unable to have TB status verified will be denied admission until the process can be initiated or completed. Audits of charts will be reported to the management team for review on a monthly basis x 3 months or until the problem is considered resolved. The problem will be considered resolved when there are no new issues noted after 3 months.Any negative findings will add an additional month of auditing until 100% compliance is achieved.	08/05/2025

indicated the resident had been admitted to the facility on 6/20/2025.

The record lacked documentation Resident 3 had received a first and second step TB test upon admission.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident 6 was admitted to the facility on 5/8/2024.

An immunization tab in the clinical record indicated Resident 6 had received a mantoux (tuberculin test) on 8/26/2024, 5 months after admission but only one mantoux test was documented.

During an interview, 7/2/2025 at 11:20 A.M., the Director of Nursing indicated the resident should have received a Mantoux Tuberculin skin test upon their admission to the facility.

During an interview, on 7/2/2025 at 11:54 A.M., the Director of Nursing indicated a facility policy regarding admission tuberculin skin tests was not available.

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Based on record review and

	interview, the facility failed to complete a first and second step tuberculosis (TB) test for 2 of 7 records reviewed for TB tests. (Residents 3 & 6) Findings include: 1. A record review was completed for Resident 3 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on 6/20/2025. The record lacked documentation Resident 3 had received a first and second step TB test upon admission. 2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident 6 was admitted to the facility on 5/8/2024. An immunization tab in the clinical record indicated Resident 6 had received a mantoux (tuberculin test) on 8/26/2024, 5 months after admission but only one mantoux test was documented.			

During an interview, 7/2/2025 at 11:20 A.M., the Director of Nursing indicated the resident should have received a Mantoux Tuberculin skin test upon their admission to the facility.

During an interview, on 7/2/2025 at 11:54 A.M., the Director of Nursing indicated a facility policy regarding admission tuberculin skin tests was not available.

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Based on record review and interview, the facility failed to complete a first and second step tuberculosis (TB) test for 2 of 7 records reviewed for TB tests. (Residents 3 & 6)

Findings include:

1. A record review was completed for Resident 3 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on 6/20/2025.

The record lacked documentation Resident 3 had received a first and second step TB test upon admission.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident 6 was

admitted to the facility on 5/8/2024.

An immunization tab in the clinical record indicated Resident 6 had received a mantoux (tuberculin test) on 8/26/2024, 5 months after admission but only one mantoux test was documented.

During an interview, 7/2/2025 at 11:20 A.M., the Director of Nursing indicated the resident should have received a Mantoux Tuberculin skin test upon their admission to the facility.

During an interview, on 7/2/2025 at 11:54 A.M., the Director of Nursing indicated a facility policy regarding admission tuberculin skin tests was not available.

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Based on record review and interview, the facility failed to complete a first and second step tuberculosis (TB) test for 2 of 7 records reviewed for TB tests. (Residents 3 & 6)

Findings include:

1. A record review was completed for Resident 3 on 7/1/2025 at 11:27 A.M. and indicated the resident had been admitted to the facility on 6/20/2025.

The record lacked

documentation Resident 3 had received a first and second step TB test upon admission.

2. The record for Resident 6 was completed on 7/2/2025 at 9:49 A.M. Diagnoses included, but were not limited to chronic kidney disease, major depressive disorder, anxiety and chronic pain. Resident 6 was admitted to the facility on 5/8/2024.

An immunization tab in the clinical record indicated Resident 6 had received a mantoux (tuberculin test) on 8/26/2024, 5 months after admission but only one mantoux test was documented.

During an interview, 7/2/2025 at 11:20 A.M., the Director of Nursing indicated the resident should have received a Mantoux Tuberculin skin test upon their admission to the facility.

During an interview, on 7/2/2025 at 11:54 A.M., the Director of Nursing indicated a facility policy regarding admission tuberculin skin tests was not available.

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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	TITLE	(X6) DATE

SIGNATURE		