STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/18/2024

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. This visit included the Investigation of Complaints IN00435348, IN00436750 & IN00438385. Complaint IN00435348 - No deficiencies related to the allegations are cited. Complaint: IN00436750 - State deficiency related to the allegations is cited at R0247. Complaint IN00438385 - No deficiencies related to the allegations are cited. Survey dates: July 16, 17 & 18, 2024 Facility number: 001148 Residential Census: 62 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on	R 0000		

	8/2/2024.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal	R 0090	The facility will report allegation of abuse to the IDOH per requirements. The incident identified during the State visit was reported while the State was in the building. Follow up has been completed with no new issues noted. The Administrator has been in-serviced on reporting guidelines of reporting to the State Department of Health. 24-hour reports, complaints, grievances and nurses' documentation will be reviewed to ensure that any incident that meets criteria is reported to the state in a timely manner. Audits will continue until problem is considered resolved Problem is considered resolved after three months of no new issues identified.	08/31/2024

representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana Department of Health for 1 of 1 allegations of abuse reviewed. (Residents 6 and 9)

Finding includes:

During an interview on

	7/17/2024 at 11:00 A.M., Resident 7 indicated he had witnessed an altercation between Resident 9 and Resident 6 on 7/13/2024 around 1:00 P.M. During the altercation, Resident 9 had been drinking and was cursing, and threatening to assault Resident 6. Resident 9's behavior made Resident 7 uncomfortable and Resident 7 worried about his own safety, as well as the safety of other residents. He felt the behavior exhibited by Resident 9 was verbal abuse and intimidation but he did not talk to any of the staff about it. Resident 7 provided a video of the altercation. The video appeared to show the end of the altercation, after staff had already intervened and had assisted both Residents 6 and 9. QMA 2 could be seen taking Resident 6 out of the Activities Room and LPN 3 stayed with Resident 9. "Shut the f--- up" and "f--- you" could be heard on the video, but neither Residents 6 or 9 were facing the recording, and it could not be determined which resident was using foul language or who the foul language was directed at. No threats of physical violence was heard on the video. During an interview on 7/17/2024 at 11:00 P.M., Resident 8 indicated she had witnessed Resident 9 drunk on 7/13/2024 and threatening			

	Resident 6 in the Activities Room around 1:00 P.M. Resident 9 called Resident 6 names and threatened to "beat him up". Resident 8 was scared and considered what she witnessed to be abuse, but she did not report the incident or her concerns to staff. She indicated she did not feel comfortable being in the common areas of the facility because of Resident 9 and on looking was hoping to move out of the facility. During an interview on 7/17/2024 at 12:30 P.M., the Executive Director (ED) indicated he had been made aware of an incident on 7/13/2024 between Residents 6 and 9 in the Activities Room. He believed it was a verbal altercation resolved by staff and he did not receive any reports of threats of violence or name calling between any of the residents. The ED informed about the verbal abuse, but he thought the verbal abuse was directed toward staff and not other residents. He had followed up, on 7/14/2024, by visiting both Resident 6 and 9. Resident 6 did not express any concerns of being abused and did not tell the ED Resident 9 threatened him with physical violence. During an interview on 7/17/2024 at 12:50 P.M., LPN 3 indicated she was alerted to an incident in the Activities Room			

	where Residents 9 and 6 were having an altercation on 7/13/2024. She witnessed Resident 9 slurring his speech and antagonizing other residents. Resident 9 called Resident 6 a "punk" and threatened to "beat him up" Resident 6. Resident 6 asked Resident 9 to leave him alone. Another staff member assisted Resident 6 while she was assisted Resident 9. She called the ED and reported the incident but did not tell him she witnessed threats of physical harm or verbal abuse. She defined verbal abuse as, "Threatening another person with harm, calling someone a name or anything that could be considered derogatory." She indicated did not feel the altercation between Residents 6 and 9 met the criteria of abuse. During an interview on 7/17/2024 at 1:02 P.M., QMA 2 indicated she had witnessed an incident in the Activities Room on 7/13/2024. She believed Resident 9 was drunk and described his behavior as belligerent. She heard Resident 9 tell Resident 6, "You can walk punk, I can't", but denied hearing Resident 9 threaten Resident 6. Resident 6 was upset and had cried, but she felt he was crying out of frustration and not fear. She did not speak to the ED about the event. She defined verbal abuse as, "Name			

	calling, making threats, or intimidating another resident." She did not consider the incident she witnessed to have been abuse. During an interview on 7/17/2024 at 1:25 P.M., Resident 6 indicated he was involved in an incident that happened on 7/13/2024 in the Activities Room. While sitting in the Activities Room, Resident 9 came in and was drunk. Resident 9 started yelling at Resident 6 and when Resident 6 asked Resident 9 to leave him alone, Resident 9 called him a "punk" and threatened to "beat him up" He was not sure why Resident 9 was upset with him. Resident 6 confirmed he was upset and had cried about the situation due to his frustration of not being able to handle the situation himself. The ED had visited Resident 6 the next day, but he did not express any concerns of abuse to the ED and felt the situation had been handled. He was unsure of whether he told the ED Resident 9 called him a name or threatened him. An attempt to interview Resident 9 was made on 7/17/2024 at 1:40 P.M., but the resident declined to be interviewed. Resident 9's record review was completed on 7/17/2024 at 2:05 P.M. A Nursing Progress Note,			

	dated 7/13/2024 at 1:59 P.M., indicated Resident 9 was cursing at staff and residents. The resident documented to have been crying, starting fights with other residents, and using vulgar words toward other residents. Resident 6's record review was completed on 7/17/2024 at 2:30 P.M. Resident 6's record lacked any documentation to indicate the resident had been in an altercation with another resident or had experienced any emotional distress related to an altercation. During an interview on 7/18/2024 at 11:38 A.M., the ED indicated he had not reported an incident of abuse through the state reporting system because he was never made aware of any allegations of abuse. He was not aware of the Nurse's Note on 7/13/2024 at 1:59 P.M. When he followed up with Residents 6 and 9 on 7/14/2024, both residents were happy and wanted to move forward from the incident. He was not aware there were witnesses to the incident and had not heard anything about Resident 7 or Resident 8 being scared or having witnessed the abuse. If he had been aware of the name calling or threats to Resident 6, he would have reported the incident.			

	On 7/17/2024 at 2:30 P.M., the ED provided a policy dated, 9/8/2023 at 2:30 P.M., titled, "Abuse, Neglect, Exploitation & Misappropriation of Resident Property", and identified it as the policy currently used by the facility. The policy indicated, " ...Facility staff should immediately report all such allegations to the Administrator/designee and to the Indiana Department of Health in accordance with the procedures in this policy ... A. Abuse. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ... It includes verbal abuse, sexual abuse, physical abuse, and mental abuse ...." Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana Department of Health for 1 of 1 allegations of abuse reviewed. (Residents 6 and 9) Finding includes: During an interview on 7/17/2024 at 11:00 A.M., Resident 7 indicated he had witnessed an altercation between Resident 9 and Resident 6 on 7/13/2024 around 1:00 P.M. During the altercation, Resident 9 had been drinking and was cursing, and			

	threatening to assault Resident 6. Resident 9's behavior made Resident 7 uncomfortable and Resident 7 worried about his own safety, as well as the safety of other residents. He felt the behavior exhibited by Resident 9 was verbal abuse and intimidation but he did not talk to any of the staff about it. Resident 7 provided a video of the altercation. The video appeared to show the end of the altercation, after staff had already intervened and had assisted both Residents 6 and 9. QMA 2 could be seen taking Resident 6 out of the Activities Room and LPN 3 stayed with Resident 9. "Shut the f--- up" and "f--- you" could be heard on the video, but neither Residents 6 or 9 were facing the recording, and it could not be determined which resident was using foul language or who the foul language was directed at. No threats of physical violence was heard on the video. During an interview on 7/17/2024 at 11:00 P.M., Resident 8 indicated she had witnessed Resident 9 drunk on 7/13/2024 and threatening Resident 6 in the Activities Room around 1:00 P.M. Resident 9 called Resident 6 names and threatened to "beat him up". Resident 8 was scared and considered what she witnessed to be abuse, but she did not report the incident or her			

concerns to staff. She indicated she did not feel comfortable being in the common areas of the facility because of Resident 9 and on looking was hoping to move out of the facility.

During an interview on 7/17/2024 at 12:30 P.M., the Executive Director (ED) indicated he had been made aware of an incident on 7/13/2024 between Residents 6 and 9 in the Activities Room. He believed it was a verbal altercation resolved by staff and he did not receive any reports of threats of violence or name calling between any of the residents. The ED informed about the verbal abuse, but he thought the verbal abuse was directed toward staff and not other residents. He had followed up, on 7/14/2024, by visiting both Resident 6 and 9. Resident 6 did not express any concerns of being abused and did not tell the ED Resident 9 threatened him with physical violence.

During an interview on 7/17/2024 at 12:50 P.M., LPN 3 indicated she was alerted to an incident in the Activities Room where Residents 9 and 6 were having an altercation on 7/13/2024. She witnessed Resident 9 slurring his speech and antagonizing other residents. Resident 9 called Resident 6 a "punk" and threatened to "beat him up"

	Resident 6. Resident 6 asked Resident 9 to leave him alone. Another staff member assisted Resident 6 while she was assisted Resident 9. She called the ED and reported the incident but did not tell him she witnessed threats of physical harm or verbal abuse. She defined verbal abuse as, "Threatening another person with harm, calling someone a name or anything that could be considered derogatory." She indicated did not feel the altercation between Residents 6 and 9 met the criteria of abuse. During an interview on 7/17/2024 at 1:02 P.M., QMA 2 indicated she had witnessed an incident in the Activities Room on 7/13/2024. She believed Resident 9 was drunk and described his behavior as belligerent. She heard Resident 9 tell Resident 6, "You can walk punk, I can't", but denied hearing Resident 9 threaten Resident 6. Resident 6 was upset and had cried, but she felt he was crying out of frustration and not fear. She did not speak to the ED about the event. She defined verbal abuse as, "Name calling, making threats, or intimidating another resident." She did not consider the incident she witnessed to have been abuse. During an interview on 7/17/2024 at 1:25 P.M.,			

	Resident 6 indicated he was involved in an incident that happened on 7/13/2024 in the Activities Room. While sitting in the Activities Room, Resident 9 came in and was drunk. Resident 9 started yelling at Resident 6 and when Resident 6 asked Resident 9 to leave him alone, Resident 9 called him a "punk" and threatened to "beat him up" He was not sure why Resident 9 was upset with him. Resident 6 confirmed he was upset and had cried about the situation due to his frustration of not being able to handle the situation himself. The ED had visited Resident 6 the next day, but he did not express any concerns of abuse to the ED and felt the situation had been handled. He was unsure of whether he told the ED Resident 9 called him a name or threatened him. An attempt to interview Resident 9 was made on 7/17/2024 at 1:40 P.M., but the resident declined to be interviewed.			

	Resident 9's record review was completed on 7/17/2024 at 2:05 P.M. A Nursing Progress Note, dated 7/13/2024 at 1:59 P.M., indicated Resident 9 was cursing at staff and residents. The resident documented to have been crying, starting fights with other residents, and using vulgar words toward other residents. Resident 6's record review was completed on 7/17/2024 at 2:30 P.M. Resident 6's record lacked any documentation to indicate the resident had been in an altercation with another resident or had experienced any emotional distress related to an altercation. During an interview on 7/18/2024 at 11:38 A.M., the ED indicated he had not reported an incident of abuse through the state reporting system because he was never made aware of any allegations of abuse. He was not aware of the Nurse's Note on 7/13/2024 at 1:59 P.M. When he followed up with Residents 6 and 9 on 7/14/2024, both residents were happy and wanted to move forward from the incident. He was not aware there were witnesses to the incident and had not heard anything about Resident 7 or Resident 8 being scared or having witnessed the abuse. If he had been aware of the name calling or threats to			

	Resident 6, he would have reported the incident. On 7/17/2024 at 2:30 P.M., the ED provided a policy dated, 9/8/2023 at 2:30 P.M., titled, "Abuse, Neglect, Exploitation & Misappropriation of Resident Property", and identified it as the policy currently used by the facility. The policy indicated, " ...Facility staff should immediately report all such allegations to the Administrator/designee and to the Indiana Department of Health in accordance with the procedures in this policy ... A. Abuse. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ... It includes verbal abuse, sexual abuse, physical abuse, and mental abuse ...."			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of	R 0092	The facility will conduct fire drills in conjunction with the local fire department unless requests to participate are declined. The local fire department has been contacted to attend a disaster drill scheduled to be conducted before the end of the month. / Facility is awaiting a response to the request. Update: Drill is scheduled for Thursday, / This practice does not affect other	09/15/2024

	nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review the facility failed to attempt to conduct fire drills every six months in conjunction with the local fire department. Finding includes: Review of the Fire Drill Education/Inservices for the past year (2023/2024) indicated there was no record the facility had attempted to conduct a fire drill in conjunction with the local fire department. During an interview on 7/18/2024 at 11:38 A.M., the Executive Director (ED) indicated the fire department had not been involved in any fire drills in the past year and		elements of the fire drill. 1pm. The Maintenance Department has been in-serviced on requesting participation from the local fire department. Requests for local fire department participation has been added to TELS and is scheduled for twice per year. TELS auditing will be reviewed on a monthly basis to ensure compliance with this regulation.	

	the facility and they did not have any documentation of communication requesting their involvement. There was no facility policy regarding fire drills. Based on interview and record review the facility failed to attempt to conduct fire drills every six months in conjunction with the local fire department. Finding includes: Review of the Fire Drill Education/Inservices for the past year (2023/2024) indicated there was no record the facility had attempted to conduct a fire drill in conjunction with the local fire department. During an interview on 7/18/2024 at 11:38 A.M., the Executive Director (ED) indicated the fire department had not been involved in any fire drills in the past year and the facility and they did not have any documentation of communication requesting their involvement. There was no facility policy regarding fire drills.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled	R 0117	Teh facility will ensure that there are qualified personnel in CPR and First Aide on all shifts. Review has indicated that staff were available on all shifts who are certified in CPR. The facility has acquired of the cards since the	09/15/2024

	and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview,the facility failed to ensure there was at least one awake staff member, certified in CPR (Cardio-pulmonary Recessitation) and First Aide training for 4 of 9 nursing shifts reviewed. This had the potential to affect all 62 residents in the facility. Finding includes: On 7/18/2024 at 1:00 P.M., a review of the nursing staffing schedules, as worked, for both		survey. Teh schedule for the nursing department has been updated to include who is certified in CPR and First Aide for continued monitoring. The DON, BOM, scheduler and/or designee have been in-serviced in the requirement to have CPR personnel on all shifts. Schedules will be reviewed by the DON or designee will review all schedules when initiated to ensure that the facility is compliant with this regulation. Monthly schedules will be reviewed by the QA Team to ensure continued compliance.	

day and night shifts, from 7/14/2024 through 7/18/2024 indicated were not covered with personnel certified in CPR and First Aid. Nursing staffing schedules, dated 7/17/2024 night shift and 7/14/2024 night shift and 7/16/2024 both day and night shifts did not have qualified staff working.

During an interview on 7/18/2024 at 11:00 A.M.. the ED indicated not all nursing shifts were covered with CPR and First Aide certified staff.

On 7/18/2024 at 1:56 P.M., the DON indicated the facility did not have a policy regarding CPR and First Aide staff requirements but followed state regulations.

Based on record review and interview,the facility failed to ensure there was at least one awake staff member, certified in CPR (Cardio-pulmonary Recessitation) and First Aide training for 4 of 9 nursing shifts reviewed. This had the potential to affect all 62 residents in the facility.

Finding includes:

On 7/18/2024 at 1:00 P.M., a review of the nursing staffing schedules, as worked, for both day and night shifts, from 7/14/2024 through 7/18/2024 indicated were not covered with personnel certified in CPR and

	First Aid. Nursing staffing schedules, dated 7/17/2024 night shift and 7/14/2024 night shift and 7/16/2024 both day and night shifts did not have qualified staff working. During an interview on 7/18/2024 at 11:00 A.M.. the ED indicated not all nursing shifts were covered with CPR and First Aide certified staff. On 7/18/2024 at 1:56 P.M., the DON indicated the facility did not have a policy regarding CPR and First Aide staff requirements but followed state regulations.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at	R 0120	The facility will ensure that staff members receive annual dementia training per regulations. Employees identified during the survey have been scheduled for dementia training prior to 09/15/2024. Other employees are required to complete their training before 09/15/2024. All training will be completed via Relias. Relias has been established for the use of the staff to complete training per requirements. Personnel files will be audited monthly for completion of dementia training.	09/15/2024

	least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff members received annual dementia education/training for 2 of 5 employee files reviewed. (Housekeeper 6 & Dietary Aide 5)		Results of audits will be reviewed monthly by the QA Team to ensure continued compliance. Audits will continue until the problem is considered resolved. The problem will be resolved after three months of no new issues noted.	

	Finding includes: On 7/17/2024 at 9:25 A.M., a review of the employee records was completed. The employee records for Housekeeper 6 and Dietary Aide 5 lacked documentation of annual dementia training/education. During an interview, on 7/17/2024 at 9:59 A.M., the DON indicated she had not provided staff members with a annual dementia training/education as required. On 7/17/2024 at 10:21 A.M., a policy for dementia training was requested but one was not provided prior to the survey exit. Based on record review and interview, the facility failed to ensure staff members received annual dementia education/training for 2 of 5 employee files reviewed. (Housekeeper 6 & Dietary Aide 5) Finding includes: On 7/17/2024 at 9:25 A.M., a review of the employee records was completed. The employee records for Housekeeper 6 and Dietary Aide 5 lacked documentation of annual dementia training/education. During an interview, on 7/17/2024 at 9:59 A.M., the DON indicated she had not			

	provided staff members with a annual dementia training/education as required. On 7/17/2024 at 10:21 A.M., a policy for dementia training was requested but one was not provided prior to the survey exit.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be 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	R 0121	The facility will be compliant with TB/employee screening requirements. New Employees will receive first and second TB test upon hire. Records have been reviewed and all staff will have new screenings by the end of the month. Employees will have their files signed off by the Administrator/DON or designee prior to beginning work to ensure compliance with this regulation. A new hire check list has been added to all personnel to ensure that all areas of pre-employment prior to hire. Results of audits will be reported to the QA team to ensure continued compliance until this problem is resolved. This problem is considered resolved after 3 months of no new issues noted.	09/15/2024

	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. (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 ensure second step tuberculin testing was completed for new employees for 3 out of 5 employee records reviewed. (DON (Director of Nursing), CNA 4 and QMA 7) Findings includes: Employee records were reviewed on 7/16/2024 at 10:00 A.M. New employees, hired within 2024, did not have documentation of a completed second step tuberculin kin test having been completed. -DON start date of 4/26/2024			

	-CNA 4 start date of 4/8/2024 -QMA 7 start date of 5/30/2024 During an interview, on 7/18/2024 at 10:19 A.M., the DON indicated the employees had a first step completed with a local health facility, but they should have had a second step tuberculin skin test performed.. She did not have a policy regarding the facility's Tuberculin prevention program and requirements. Based on record review and interview, the facility failed to ensure second step tuberculin testing was completed for new employees for 3 out of 5 employee records reviewed. (DON (Director of Nursing), CNA 4 and QMA 7) Findings includes: Employee records were reviewed on 7/16/2024 at 10:00 A.M. New employees, hired within 2024, did not have documentation of a completed second step tuberculin kin test having been completed. -DON start date of 4/26/2024 -CNA 4 start date of 4/8/2024 -QMA 7 start date of 5/30/2024 During an interview, on 7/18/2024 at 10:19 A.M., the DON indicated the employees			

	had a first step completed with a local health facility, but they should have had a second step tuberculin skin test performed.. She did not have a policy regarding the facility's Tuberculin prevention program and requirements.			
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	R 0123	The facility will ensure employees receive general and specific orientation upon hire. Employees identified during the survey and other employees are scheduled to complete general and specific orientation prior to 09/15/2024. Personnel files will be audited a least monthly to ensure all employees have received general and specific orientation. Audits will be submitted to the QA Team to ensure continued compliance. Monthly audits will continue until the problem is considered resolved. Problem will be considered resolved after three months of audits with no new issues noted.	09/15/2024

	accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure employee records included general and specific orientation documentation for 3 of 3 employee records reviewed. (DON (Director of Nursing), CNA 4 and QMA 7) Findings include: Employee records were reviewed on 7/16/2024 at 10:00 A.M. The following was missing from the files: -DON, CNA 4, QMA 7 were missing general and specific orientation. -DON start date of 4/26/2024 -CNA 4 start date of 4/8/2024 -QMA 7 start date of 5/30/2024 During an interview on 7/16/2024 at 10:45 A.M., the Business Office Manager indicated she did not have documentation of any general or specific orientation for the employee's files to provide. A policy regarding general and job specific orientation for new employees was requested , on			

	7/16/2024 at 10:46 A.M., but one was not provided prior to the survey exit date. Based on record review and interview, the facility failed to ensure employee records included general and specific orientation documentation for 3 of 3 employee records reviewed. (DON (Director of Nursing), CNA 4 and QMA 7) Findings include: Employee records were reviewed on 7/16/2024 at 10:00 A.M. The following was missing from the files: -DON, CNA 4, QMA 7 were missing general and specific orientation. -DON start date of 4/26/2024 -CNA 4 start date of 4/8/2024 -QMA 7 start date of 5/30/2024 During an interview on 7/16/2024 at 10:45 A.M., the Business Office Manager indicated she did not have documentation of any general or specific orientation for the employee's files to provide. A policy regarding general and job specific orientation for new employees was requested , on 7/16/2024 at 10:46 A.M., but			

	one was not provided prior to the survey exit date.			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observations and interviews, the facility failed to ensure the building was maintained in a clean and safe manner related to the walls, ceilings, vents and handrails for 2 of 2 floors, including the	R 0148	The facility will maintain the building in a clean and safe manner. The walls, ceilings, vents, handrails, ceiling tiles have all be updated in TELS for weekly follow up. Most of these areas have been completed. The work is on-going. In addition to the areas identified by the State, other areas with the same problems have been identified. The tracking of these items on TELS ensures that each area is addressed. TELS reports will be report to the QA Teams to ensure continued compliance with this regulation. The reports will continue to be reported to the QA Team on a permanent basis to ensure that the facility is maintained in a safe and clean environment.	09/15/2024

	outside and common areas. This had the potential to affect 62 of 62 residents in the facility. Findings include: 1. During an observation on 7/16/2024 at 9:50 A.M., with the Maintenance Director, the Housekeeping Closet was found unlocked. The door had a "Hazard" sign on it. Another room labeled Equipment was unlocked and the resident laundry room, which was under remodel, was unlocked and had various tools on a table on the second floor. During an observation and interview on 7/16/2024 at 10:42 A.M., the Maintenance Director indicated the Housekeeping Closet, Equipment Room, and Resident Laundry Room should have been locked. 2. During an observation with the Executive Director (ED) and the Housekeeping Supervisor on 7/18/2024 at 10:20 A.M., the following was observed: - A cold air return vent in the dining room was dusty. - There was mold on the ceiling vent and ceiling tiles with water stains in the hallway outside of the Activity Room. - There was unpainted plaster on the walls in the hallways outside of rooms 107, 109, and		The Director of Maintenance or designee will be responsible for touring the building at least weekly to identify problems that may occur. His tours should ensure that the deficient practice doesn't reoccur. Results of will be reported to the QA Team for continued monitoring.	

	115. -The handrails in all hallways, on both the first and second floors had areas where the paint was scraped off. -The ceiling vent in the hall between rooms 105 and 107 was rusty and had mold. -Numerous apartment doors, on both the first and second floors, were were scratched and scuffed. -There was a cracked ceiling tile outside of the resident laundry on the 1st floor. -Both elevators had wood paneling that was chipped. -The heating/air conditioning register cover in the small lounge next to room 235 was falling off. -The facility laundry room, on the second floor had stained and missing floor tiles and the walls needed repaired. -A balcony on the front of the building was missing siding and the wood underneath was rotted.			

During an interview on 7/18/2024 at 11:41 A.M., the ED indicated there was no policy regarding building maintenance and there was no preventative maintenance program.

Based on observations and interviews, the facility failed to ensure the building was maintained in a clean and safe manner related to the walls, ceilings, vents and handrails for 2 of 2 floors, including the outside and common areas. This had the potential to affect 62 of 62 residents in the facility.

Findings include:

1. During an observation on 7/16/2024 at 9:50 A.M., with the Maintenance Director, the Housekeeping Closet was found unlocked. The door had a "Hazard" sign on it. Another room labeled Equipment was unlocked and the resident laundry room, which was under remodel, was unlocked and had various tools on a table on the second floor.

During an observation and interview on 7/16/2024 at 10:42 A.M., the Maintenance Director indicated the Housekeeping Closet, Equipment Room, and Resident Laundry Room should have been locked.

2. During an observation with the Executive Director (ED) and the Housekeeping Supervisor

	on 7/18/2024 at 10:20 A.M., the following was observed: - A cold air return vent in the dining room was dusty. - There was mold on the ceiling vent and ceiling tiles with water stains in the hallway outside of the Activity Room. - There was unpainted plaster on the walls in the hallways outside of rooms 107, 109, and 115. -The handrails in all hallways, on both the first and second floors had areas where the paint was scraped off. -The ceiling vent in the hall between rooms 105 and 107 was rusty and had mold. -Numerous apartment doors, on both the first and second floors, were were scratched and scuffed. -There was a cracked ceiling tile outside of the resident laundry on the 1st floor. -Both elevators had wood paneling that was chipped. -The heating/air conditioning register cover in the small lounge next to room 235 was falling off. -The facility laundry room, on the second floor had stained			

	and missing floor tiles and the walls needed repaired. -A balcony on the front of the building was missing siding and the wood underneath was rotted. During an interview on 7/18/2024 at 11:41 A.M., the ED indicated there was no policy regarding building maintenance and there was no preventative maintenance program.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food and dishes were appropriately stored and protected from contaminants in 1 of 1 kitchens. This had the potential to affect 62 of 62 residents receiving food from the kitchen. Findings include: During an initial kitchen tour,on 7/16/2024 at 9:33 A.M. with the Dietary Manager, the following	R 0154	The facility will ensure that foods and dishes are stored and protected from contaminants. All items sited during the survey were corrected during the survey. The kitchen staff has been in serviced on proper storage of food items and dishes. Scoops, dating of foods, and bowls/plates have been addressed during in-services. Proper techniques have been demonstrated. An audit sheet has been developed for these items to be monitored on a daily basis by the Dietary Manager or designee. The audit sheets will be reported to the QA team to ensure continued	09/15/2024

	was observed: a. An ice scoop was on top of the ice machine uncovered. b. Bulk storage bins for flour and brown sugar had food scoops inside them on top of the food and a 25 pound box of sugar was not sealed. c. Ham sandwiches, madarin oranges and cut up melon were not labeled and milk was not dated in the refrigerator. d. In the freezer, sausage and pepperoni were opened and not labeled. A veggie burger was not sealed and dated. e. In the dry storage, an opened cake mix and bag of coconut were not sealed and dated. An opened bag of flour was undated. bf. Salad bowls and dessert plates were not stored inverted or covered. During an interview on 7/16/2024 at 9:50 A.M. the Dietary Manager indicated all food should be covered and dated, bulk bin items should be sealed without scoops inside them, dishes should be inverted when stored and the ice scoop should be covered. On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, "Food Storage,"		compliance. This process will continue until this problem is considered resolved. This problem will be considered resolved after 3 months of no new findings.	

	and indicated the policy was the one currently used by the facility. The policy indicated "... 6. Scoops are not to be stored in the food containers, but are kept covered in a protected area near the containers. 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. 17. Freezer Temperatures e. Rewrap packages of frozen food which have been opened. This prevents freezer burns and spoilage. g. To freeze leftovers food, package in small airtight units for quick freezing, label and date....." On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, "Sanitation of Ice Machine," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "1. Place scoop in dish rack and sanitize in dish machine. 2. Allow to air dry. 3. Place in clean plastic container for storage....." On 7/18/2024 at 9:30 A.M., the Dietary Manger indicated the facility did not have a policy regarding dish storage. Based on observation and interview, the facility failed to ensure food and dishes were appropriately stored and protected from contaminants in			

	1 of 1 kitchens. This had the potential to affect 62 of 62 residents receiving food from the kitchen. Findings include: During an initial kitchen tour,on 7/16/2024 at 9:33 A.M. with the Dietary Manager, the following was observed: a. An ice scoop was on top of the ice machine uncovered. b. Bulk storage bins for flour and brown sugar had food scoops inside them on top of the food and a 25 pound box of sugar was not sealed. c. Ham sandwiches, madarin oranges and cut up melon were not labeled and milk was not dated in the refrigerator. d. In the freezer, sausage and pepperoni were opened and not labeled. A veggie burger was not sealed and dated. e. In the dry storage, an opened cake mix and bag of coconut were not sealed and dated. An opened bag of flour was undated. bf. Salad bowls and dessert plates were not stored inverted or covered. During an interview on 7/16/2024 at 9:50 A.M. the Dietary Manager indicated all			

	food should be covered and dated, bulk bin items should be sealed without scoops inside them, dishes should be inverted when stored and the ice scoop should be covered. On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, "Food Storage," and indicated the policy was the one currently used by the facility. The policy indicated "... 6. Scoops are not to be stored in the food containers, but are kept covered in a protected area near the containers. 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. 17. Freezer Temperatures e. Rewrap packages of frozen food which have been opened. This prevents freezer burns and spoilage. g. To freeze leftovers food, package in small airtight units for quick freezing, label and date....." On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, "Sanitation of Ice Machine," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "1. Place scoop in dish rack and sanitize in dish machine. 2. Allow to air dry. 3. Place in clean plastic container for storage....."			

	On 7/18/2024 at 9:30 A.M., the Dietary Manger indicated the facility did not have a policy regarding dish storage.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interviews, the facility felled to ensure semiannual evaluations were completed for 5 of 7 residents reviewed. (Resident B, C, 3, 4 and 5) Findings include: 1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension. The Electronic Medical Record (EMR) had no documentation a semi-annual assessment had been completed for Resident C. During an interview, on 7/18/2024 at 10:07 A.M., the	R 0214	All residents will receive semi-annual evaluations per regulatory requirements. All residents have had a review of their records and those who did not have a semiannual assessment or weight has had his/her record updated to include assessments. DON or designee will be in-serviced on completing assessments in a timely manner. Residents will receive semiannual assessments along with service plans which are completed on semiannual basis. Services plans upon completion will be reviewed by the QA Team to ensure semiannual assessments are completed until this problem is considered resolved. This problem will be considered resolved after three months of review by the QA Team with any additional findings.	09/15/2024

	DON indicated residents should have a semi-annual evaluation and service plan review. 2. 2. Resident B's record review was completed on 7/16/2024 at 3:05 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked the documentation he had received a semiannual evaluation. 3. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The record lacked a semi-annual evaluation. The most recent evaluation was completed in June of 2023. There was no evaluations for December of 2023 or June of 2024. 4. A record review for Resident 5 was completed on 7/17/2024 at 3:10 P.M. The resident was admitted to the facility on 4/29/2022 and still resided in the facility. Resident 5's record lacked documentation of a semi-annual evaluation having been completed since admission. 5, A closed record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of a			

	semi-annual evaluation. On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual assessments, semi-annual weights, or admission weights and they follow the State regulations Based on record review and interviews, the facility felled to ensure semiannual evaluations were completed for 5 of 7 residents reviewed. (Resident B, C, 3, 4 and 5) Findings include: 1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension. The Electronic Medical Record (EMR) had no documentation a semi-annual assessment had been completed for Resident C. During an interview, on 7/18/2024 at 10:07 A.M., the DON indicated residents should have a semi-annual evaluation and service plan review. 2. 2. Resident B's record review was completed on 7/16/2024 at 3:05 P.M. Resident B was admitted to the facility on 11/26/2021.			

	Resident B's record lacked the documentation he had received a semiannual evaluation. 3. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The record lacked a semi-annual evaluation. The most recent evaluation was completed in June of 2023. There was no evaluations for December of 2023 or June of 2024. 4. A record review for Resident 5 was completed on 7/17/2024 at 3:10 P.M. The resident was admitted to the facility on 4/29/2022 and still resided in the facility. Resident 5's record lacked documentation of a semi-annual evaluation having been completed since admission. 5, A closed record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of a semi-annual evaluation. On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual assessments, semi-annual weights, or admission weights and they follow the State regulations			

R 0215	Evaluation - Deficiency 410 IAC 16.2-5-2(b) (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on record review and interview, the facility failed to ensure residents had an evaluation prior to admission for 2 of 7 residents reviewed. (Residents 2 and 3) Finding includes: 1. A record review for Resident 2 was completed on 7/17/2024 at 2:11 P.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/19/2024. The record lacked documentation of an evaluation completed prior to 12/8/2023. 2. A record review for Resident 3 was completed on 7/17/2024 at 2:36 P.M. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked	R 0215	The facility will ensure that all residents receive an evaluation prior to admission. All residents' files have been reviewed for assessment prior to admission. If a file did not have an assessment prior to admissions, that file has been updated with a current assessment. Inservice completed on having assessment completed by a nurse prior to admission. All new residents are assessed prior to admissions. Resident files will be audited at least monthly or until problem is considered resolved. The problem will be considered resolved after three months of no new issues noted.	09/15/2024

documentation of an evaluation completed prior to 11/20/2023.

During an interview on 7/18/024 at 10:07 A.M., the DON indicated the residents had not had an evaluation completed prior to admission.

During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding completing pre-admission evaluations but followed state regulations.

Based on record review and interview, the facility failed to ensure residents had an evaluation prior to admission for 2 of 7 residents reviewed. (Residents 2 and 3)

Finding includes:

1. A record review for Resident 2 was completed on 7/17/2024 at 2:11 P.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/19/2024. The record lacked documentation of an evaluation completed prior to 12/8/2023.

2. A record review for Resident 3 was completed on 7/17/2024 at 2:36 P.M. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of an evaluation

	completed prior to 11/20/2023. During an interview on 7/18/024 at 10:07 A.M., the DON indicated the residents had not had an evaluation completed prior to admission. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding completing pre-admission evaluations but followed state regulations.			

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure a self-administration of medication assessment was completed timely for 1 of 7 resident records reviewed, failed to obtain semiannual weights for 2 of 7 resident records reviewed and failed to ensure a weight was obtained upon admission for 1 of 7 residents reviewed. (Residents C, D and 3) Findings include: 1. A record review was completed on 7/16/2024 at 2	R 0216	The facility will ensure that all residents who are classified as self-administration of medications are assessed quarterly or upon change in condition. DON and/or designee has been in-serviced on completing self-administration assessments. All files have been reviewed and all residents currently have medication assessments if the resident is classified as self-administration of medications. The count is 14 of 58. Resident files will be audited at least monthly to ensure that orders and assessments are completed for medication administration. Audits will continue until problem is considered resolved This problem will be considered resolved after three months of no new issues noted. Semi-annual and admissions are to be completed upon admission or a change in condition. The facility is currently obtaining weights from residents on a monthly basis. Files will be reviewed during semi -annual service plans to ensure that each resident has received at least one weight within the prior six-month period. Results of audits	09/15/2024

	P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension. The Electronic Medical Record (EMR) for Resident C indicated the last self-medication assessment was completed on 6/29/2023. During an interview on 7/17/2024 at 10:00 A.M., the Director of Nursing (DON) indicated an administration of medication assessment should have been completed quarterly for Resident C. 2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had been weighed semiannually 3. A record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of an admission weight. On 7/17/2024 at 10:20 A.M., the DON provided a policy titled, "Self-Administration of Medication, "dated 2023, and		will be reported to the QA Team for continued monitoring and compliance.	

indicated the policy is the one currently used by the facility. The policy indicated, "A skills assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. The skills assessment is repeated on a quarterly basis or when there is a significant change in condition....."

On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual weights or admission weights, but the facility followed State regulations.

Based on interview and record review, the facility failed to ensure a self-administration of medication assessment was completed timely for 1 of 7 resident records reviewed, failed to obtain semiannual weights for 2 of 7 resident records reviewed and failed to ensure a weight was obtained upon admission for 1 of 7 residents reviewed. (Residents C, D and 3)

Findings include:

1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension.

	The Electronic Medical Record (EMR) for Resident C indicated the last self-medication assessment was completed on 6/29/2023. During an interview on 7/17/2024 at 10:00 A.M., the Director of Nursing (DON) indicated an administration of medication assessment should have been completed quarterly for Resident C. 2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had been weighed semiannually 3. A record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of an admission weight. On 7/17/2024 at 10:20 A.M., the DON provided a policy titled, "Self-Administration of Medication, "dated 2023, and indicated the policy is the one currently used by the facility. The policy indicated, "A skills assessment is conducted by the interdisciplinary team of the resident's cognitive, physical,			

	and visual ability to carry out this responsibility during the care planning process. The skills assessment is repeated on a quarterly basis or when there is a significant change in condition....." On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual weights or admission weights, but the facility followed State regulations. Based on interview and record review, the facility failed to ensure a self-administration of medication assessment was completed timely for 1 of 7 resident records reviewed, failed to obtain semiannual weights for 2 of 7 resident records reviewed and failed to ensure a weight was obtained upon admission for 1 of 7 residents reviewed. (Residents C, D and 3) Findings include: 1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension. The Electronic Medical Record (EMR) for Resident C indicated the last self-medication assessment was completed on 6/29/2023.			

	During an interview on 7/17/2024 at 10:00 A.M., the Director of Nursing (DON) indicated an administration of medication assessment should have been completed quarterly for Resident C. 2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had been weighed semiannually 3. A record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of an admission weight. On 7/17/2024 at 10:20 A.M., the DON provided a policy titled, "Self-Administration of Medication, "dated 2023, and indicated the policy is the one currently used by the facility. The policy indicated, "A skills assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. The skills assessment is repeated on a quarterly basis or when there			

	is a significant change in condition....." On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual weights or admission weights, but the facility followed State regulations. Based on interview and record review, the facility failed to ensure a self-administration of medication assessment was completed timely for 1 of 7 resident records reviewed, failed to obtain semiannual weights for 2 of 7 resident records reviewed and failed to ensure a weight was obtained upon admission for 1 of 7 residents reviewed. (Residents C, D and 3) Findings include: 1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension. The Electronic Medical Record (EMR) for Resident C indicated the last self-medication assessment was completed on 6/29/2023. During an interview on 7/17/2024 at 10:00 A.M., the Director of Nursing (DON) indicated an administration of medication assessment should			

have been completed quarterly for Resident C.

2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022.

Resident D's record lacked the documentation indicating he had been weighed semiannually

3. A record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of an admission weight.

On 7/17/2024 at 10:20 A.M., the DON provided a policy titled, "Self-Administration of Medication, "dated 2023, and indicated the policy is the one currently used by the facility. The policy indicated, "A skills assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. The skills assessment is repeated on a quarterly basis or when there is a significant change in condition....."

On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual weights

	or admission weights, but the facility followed State regulations.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations	R 0217	The facility will ensure that all Service Plans are completed in a timely manner. The DON and designees have updated all Service Plans. The Service Plans are in the process of being signed by the residents and/or representatives. The Nursing Department has been in-serviced on the regulatory requirements to complete services plans on a semi-annual basis. Service Planss will be reviewed on a monthly basis to ensure all are completed. This will be audited by the DON or designee. Results of the audits will be reported to the QA Team on a monthly basis for monitoring continued compliance. QA Team Audit will continue until this problem is considered resolved. It is resolved after 3 months of clean audits.	09/15/2024

	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. 5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan. 6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan. 7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but			

	followed the State regulations. 2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension. Resident C's record indicated a service plan was not completed during the past year. 3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked documentation indicating he had signed a Service Plan. 4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had signed a Service Plan. Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by			

	the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5) Findings include: 1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident. During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff. 5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan. 6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan.			

	7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations. 2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension. Resident C's record indicated a service plan was not completed during the past year. 3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked documentation indicating he had signed a Service Plan.			

	4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had signed a Service Plan. Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5) Findings include: 1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident. During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff. 5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The			

record lacked documentation of a signed Service Plan.

6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan.

7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan.

During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations.

2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension.

Resident C's record indicated a service plan was not completed during the past year.

3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on

	11/26/2021. Resident B's record lacked documentation indicating he had signed a Service Plan. 4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had signed a Service Plan. Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5) Findings include: 1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident. During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.			

	5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan. 6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan. 7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations. 2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension. Resident C's record indicated a service plan was not completed			

during the past year.

3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021.

Resident B's record lacked documentation indicating he had signed a Service Plan.

4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant.

Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022.

Resident D's record lacked the documentation indicating he had signed a Service Plan.

Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5)

Findings include:

1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident.

During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.

5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan.

6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan.

7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan.

During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations.

2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to:

type 2 diabetes, major depressive disorder, and hypertension.

Resident C's record indicated a service plan was not completed during the past year.

3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021.

Resident B's record lacked documentation indicating he had signed a Service Plan.

4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant.

Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022.

Resident D's record lacked the documentation indicating he had signed a Service Plan.

Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5)

Findings include:

1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident.

During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.

5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan.

6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan.

7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan.

During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding

	Service Plan requirements, but followed the State regulations. 2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension. Resident C's record indicated a service plan was not completed during the past year. 3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked documentation indicating he had signed a Service Plan. 4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had signed a Service Plan. Based on record review and interview the facility failed to ensure Service Plans were			

provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5)

Findings include:

1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident.

During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.

5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan.

6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan.

7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed

Service Plan.

During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations.

2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension.

Resident C's record indicated a service plan was not completed during the past year.

3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021.

Resident B's record lacked documentation indicating he had signed a Service Plan.

4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant.

Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022.

Resident D's record lacked the

documentation indicating he had signed a Service Plan.

Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5)

Findings include:

1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident.

During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.

5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan.

6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan.

7. A record review for Resident

	5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations. 2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension. Resident C's record indicated a service plan was not completed during the past year. 3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked documentation indicating he had signed a Service Plan. 4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant.			

	Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had signed a Service Plan. Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5) Findings include: 1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident. During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.	R 0247	The facility will notify physicians when there are abnormal readings for blood sugars. The physician was notified about the b/s for resident B. No new orders noted. Nursing staff has been in-serviced on notification with b/s or other	09/15/2024

	Based on record review and interview, the facility failed to notify a Physician about a resident's high blood glucose levels for 1 of 1 resident who was reviewed for insulin use. (Resident B) Finding includes: A record review for Resident B was completed 7/16/2024 at 3:05 P.M. Diagnoses included, but were not limited to, type 2 diabetes mellitus, schizoaffective disorder, epilepsy and hypertension. A Physicians Order for Resident B, dated, 7/5/2023, indicated the Physician was to be notified if the resident's blood glucose level was 390 milligram (mg) per deciliter (dL) or higher. The Electronic Medical Record (EMR) for Resident B indicated the following blood glucose levels: -7/16/2024 at 7:51 A.M. resident's blood glucose was 390 mg/dL. -7/14/2024 at 4:09 P.M. resident's blood glucose was 427 mg/dL. -7/14/2024 at 7:32 A.M. resident's blood glucose was 403 mg/dL. -7/11/2024 at 11:23 A.M. resident's blood glucose was		vitals are not within normal ranges per physicians. Other areas of notification have been reviewed. Change in conditions will require notification of physician. All notification will be documented in the EMAR to ensure tracking of physician communication. 24-report will be monitored by the DON to ensure continued compliance with notification. Audit of 24-hour reports will be reported to the QA Team for continued monitoring. This will continue until this problem is considered resolved. This problem is considered resolved after 3 month of no new issues.	

	420 mg/dL. -7/5/2024 at 11:55 A.M. resident's blood glucose was 393 mg/dL. -6/20/2024 at 3:56 P.M. resident's blood glucose was 426 mg/dL. -6/19/2024 at 12:03 P.M. resident's blood glucose was 400 mg/dL. -6/16/2024 at 11:48 A.M. resident's blood glucose was 425 mg/dL. -6/15/2024 at 9:00 A.M. resident's blood glucose was 420 mg/dL. -6/14/2024 at 11:16 A.M. resident's blood glucose was 422 mg/dL. -6/10/2024 at 3:50 P.M. resident's blood glucose was 427 mg/dL. -6/3/2024 at 11:15 A.M. resident's blood glucose was 410 mg/dL. -6/2/2024 at 7:33 A.M. resident's blood glucose was 427 mg/dL. -5/21/2024 at 4:21 P.M. resident's blood glucose was 401 mg/dL. -5/18/2024 at 12:12 P.M. resident's blood glucose was			

525 mg/dL.

-5/16/2024 at 4:00 P.M. resident's blood glucose was 519 mg/dL.

-5/14/2024 at 6:18 P.M. resident's blood glucose was 520 mg/dL.

Resident B's record lacked the documentation indicating a Physician was notified about high blood glucose levels for any of the dates listed above.

During an interview on 7/17/2024 at 3:30 P.M., the Director of Nursing (DON) indicated the staff were to notify the Physician through a text application but she could not locate any documentation the Physician had been notified about Resident B's high blood glucose levels. Staff were also to document in the Electronic Medical Record (EMR) when a Physician has been contacted.

The DON indicated the facility did not have a policy regarding following Physician Orders because following Physician Orders was a standard of care and following the standards of care was what the facility did.

This citation relates to complaint IN00436750.

Based on record review and interview, the facility failed to notify a Physician about a

resident's high blood glucose levels for 1 of 1 resident who was reviewed for insulin use. (Resident B)

Finding includes:

A record review for Resident B was completed 7/16/2024 at 3:05 P.M. Diagnoses included, but were not limited to, type 2 diabetes mellitus, schizoaffective disorder, epilepsy and hypertension.

A Physicians Order for Resident B, dated, 7/5/2023, indicated the Physician was to be notified if the resident's blood glucose level was 390 milligram (mg) per deciliter (dL) or higher.

The Electronic Medical Record (EMR) for Resident B indicated the following blood glucose levels:

-7/16/2024 at 7:51 A.M. resident's blood glucose was 390 mg/dL.

-7/14/2024 at 4:09 P.M. resident's blood glucose was 427 mg/dL.

-7/14/2024 at 7:32 A.M. resident's blood glucose was 403 mg/dL.

-7/11/2024 at 11:23 A.M. resident's blood glucose was 420 mg/dL.

-7/5/2024 at 11:55 A.M.

	resident's blood glucose was 393 mg/dL. -6/20/2024 at 3:56 P.M. resident's blood glucose was 426 mg/dL. -6/19/2024 at 12:03 P.M. resident's blood glucose was 400 mg/dL. -6/16/2024 at 11:48 A.M. resident's blood glucose was 425 mg/dL. -6/15/2024 at 9:00 A.M. resident's blood glucose was 420 mg/dL. -6/14/2024 at 11:16 A.M. resident's blood glucose was 422 mg/dL. -6/10/2024 at 3:50 P.M. resident's blood glucose was 427 mg/dL. -6/3/2024 at 11:15 A.M. resident's blood glucose was 410 mg/dL. -6/2/2024 at 7:33 A.M. resident's blood glucose was 427 mg/dL. -5/21/2024 at 4:21 P.M. resident's blood glucose was 401 mg/dL. -5/18/2024 at 12:12 P.M. resident's blood glucose was 525 mg/dL. -5/16/2024 at 4:00 P.M.			

	resident's blood glucose was 519 mg/dL. -5/14/2024 at 6:18 P.M. resident's blood glucose was 520 mg/dL. Resident B's record lacked the documentation indicating a Physician was notified about high blood glucose levels for any of the dates listed above. During an interview on 7/17/2024 at 3:30 P.M., the Director of Nursing (DON) indicated the staff were to notify the Physician through a text application but she could not locate any documentation the Physician had been notified about Resident B's high blood glucose levels. Staff were also to document in the Electronic Medical Record (EMR) when a Physician has been contacted. The DON indicated the facility did not have a policy regarding following Physician Orders because following Physician Orders was a standard of care and following the standards of care was what the facility did. This citation relates to complaint IN00436750.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f)	R 0273	The employees of the dietary department will wear hairnets at all times while in the kitchen.	09/15/2024

	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to serve and prepare food under sanitary conditions related to hair nets not being worn and mean no defrosted appropriately. This had the potential to affect 62 out of 62 residents receiving food from the kitchen. Findings include: During an initial kitchen observation tour, conducted on 7/16/2024 at 9:33 A.M. with the Dietary Manager, the following was observed: a. In the refrigerator uncooked chicken was thawing above pork and beef. b. Hair nets were not worn by three kitchen staff working and preparing food. During an interview on 7/16/2024 at 9:55 A.M., the Dietary Manager indicated the chicken should not be thawing out above the beef and the pork, and hair nets should be worn by the staff when working in the kitchen. On 7/16/2024 at 1:59 P.M., the		The dietary department has been in-serviced on wearing hairnets at all times while in the kitchen. The dietary manager is currently auditing compliance of this issue. So far, no new issues noted. Foods will be thawed in the kitchen per regulatory protocol. The dietary department has been in-serviced on the proper handling of foods that are being thawed. "Chicken always goes on the bottom". All audits will be reported to the QA Team for monitoring of continue compliance. The audits will be reported to the QA for 3 months or until this problem is considered resolved. This problem will be considered resolved after 3 months of no new issues noted. Audits will be completed by the Dietary Manager or designee at least weekly. Results of audits will be reported to the QA Team to ensure continued compliance.	

	Dietary Manager provided a policy titled, " Food Storage," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 17. Freezer Temperatures: c. Holding temperatures for frozen foods is 0 degrees or below 0. Frozen meats must be defrosted in a refrigerator on a tray on a lower shelf....." On 7/17/2024 at 10:10 A.M., the Dietary Manager provided a policy titled, " Personal Hygiene," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 1. If hair is long and not covered properly with a cap, a hair net must be worn. Hair spray is not an authorized substitute for a hair net....." Based on observation, record review and interview, the facility failed to serve and prepare food under sanitary conditions related to hair nets not being worn and mean no defrosted appropriately. This had the potential to affect 62 out of 62 residents receiving food from the kitchen. Findings include: During an initial kitchen observation tour, conducted on 7/16/2024 at 9:33 A.M. with the Dietary Manager, the following			

was observed:

a. In the refrigerator uncooked chicken was thawing above pork and beef.

b. Hair nets were not worn by three kitchen staff working and preparing food.

During an interview on 7/16/2024 at 9:55 A.M., the Dietary Manager indicated the chicken should not be thawing out above the beef and the pork, and hair nets should be worn by the staff when working in the kitchen.

On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, " Food Storage," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 17. Freezer Temperatures: c. Holding temperatures for frozen foods is 0 degrees or below 0. Frozen meats must be defrosted in a refrigerator on a tray on a lower shelf....."

On 7/17/2024 at 10:10 A.M., the Dietary Manager provided a policy titled, " Personal Hygiene," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 1. If hair is long and not covered properly with a cap, a hair net must be worn. Hair spray is not an authorized substitute for a

	hair net....."			
R 0275	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(h) (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview the facility failed to ensure residents had a Physician's diet order for 2 of 7 residents reviewed. (Residents 3 & B) Findings include: 1. A record review for Resident 3 was completed on 7/17/2024 at 1:31 P.M. Resident 3's diagnoses included, but were not limited to gastroesophageal reflux disease and hypercholesterolemia. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. There was no diet order for Resident 3.. 2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypertension, heart failure and stage 3 chronic	R 0275	The facility will ensure that all residents have a diet order on file. The DON and designees have reviewed all residents and have found them to have diet orders per physician orders. Nursing department has been in-serviced on having an order for new and current residents. All have been updated. Audits will be completed by the DON and/or designee on a monthly basis to ensure continued compliance. Results of audits will be reported to the QA Team for review and monitoring. This will continue until this problem is considered resolved which will be 3 months with no new issues noted.	09/15/2024

kidney disease.

Resident D's record lacked the documentation indicating he had a Physician's order for a diet.

During an interview on 7/18/2024 at 1:30 P.M., the Director of Nursing indicated residents should have a diet order prescribed from a physician. The facility did not have a policy regarding diet orders but followed State regulations.

Based on record review and interview the facility failed to ensure residents had a Physician's diet order for 2 of 7 residents reviewed. (Residents 3 & B)

Findings include:

1. A record review for Resident 3 was completed on 7/17/2024 at 1:31 P.M. Resident 3's diagnoses included, but were not limited to gastroesophageal reflux disease and hypercholesterolemia. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. There was no diet order for Resident 3..

2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Diagnoses included,

	but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypertension, heart failure and stage 3 chronic kidney disease. Resident D's record lacked the documentation indicating he had a Physician's order for a diet. During an interview on 7/18/2024 at 1:30 P.M., the Director of Nursing indicated residents should have a diet order prescribed from a physician. The facility did not have a policy regarding diet orders but followed State regulations. Based on record review and interview the facility failed to ensure residents had a Physician's diet order for 2 of 7 residents reviewed. (Residents 3 & B) Findings include: 1. A record review for Resident 3 was completed on 7/17/2024 at 1:31 P.M. Resident 3's diagnoses included, but were not limited to gastroesophageal reflux disease and hypercholesterolemia. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. There was no diet order for Resident 3.. 2. Resident D's record review			

	was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypertension, heart failure and stage 3 chronic kidney disease. Resident D's record lacked the documentation indicating he had a Physician's order for a diet. During an interview on 7/18/2024 at 1:30 P.M., the Director of Nursing indicated residents should have a diet order prescribed from a physician. The facility did not have a policy regarding diet orders but followed State regulations. Based on record review and interview the facility failed to ensure residents had a Physician's diet order for 2 of 7 residents reviewed. (Residents 3 & B) Findings include: 1. A record review for Resident 3 was completed on 7/17/2024 at 1:31 P.M. Resident 3's diagnoses included, but were not limited to gastroesophageal reflux disease and hypercholesterolemia. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024.			

	There was no diet order for Resident 3.. 2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypertension, heart failure and stage 3 chronic kidney disease. Resident D's record lacked the documentation indicating he had a Physician's order for a diet. During an interview on 7/18/2024 at 1:30 P.M., the Director of Nursing indicated residents should have a diet order prescribed from a physician. The facility did not have a policy regarding diet orders but followed State regulations.			
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 and interview the facility failed to ensure medications, for	R 0295	All residents who are self-administering medications will have a lockbox for safety and storage of their medications. The DON and/or designee will ensure that every resident who has an order for self-administration has a lockbox for the safeguarding of the medications. Residents who are	09/15/2024

	residents who self-administer, were stored secured from other residents. Finding includes: A record review completed on 7/16/2024 at 2:00 P.M., indicated Resident 4 had an order, dated 5/17/2024, to self-administer his medications. An assessment for self administering medications was completed on 5/14/2024 and indicated the resident was capable of handling his own medications. During an interview, on 7/17/2024 at 9:08 A.M., Resident 4 indicated he handled his own medications and did not have them locked up. He kept them in the top drawer of his dresser. During an observation on 7/17/2024 at 9:08 A.M., Resident 4's medications were kept in the top drawer of his dresser. The resident shared the room with a roommate. During an interview on 7/18/2024 at 9:23 A.M., the DON indicated medications should be secured and she did not know Resident 4 did not have his medications locked up. On 7/18/2024 at 9:37 A.M., the DON provided a current policy, dated 2023, titled, "Self-Administration of		self-administering medications will be monitored and assessed for proper use of lockbox to secure medications when not in use. These assessments will be reported to the QA Team to ensure continued compliance with the use of the lock boxes. This process will continue until this issue is considered resolved. This issue will be resolved after three months of no new issues noted. Residents will be monitored by DON or designee (Nurses/QMA's) to ensure that residents who self-administer medications store them properly. Storage of medications will be audited at least weekly until this problem is considered resolved. Problem will be considered resolved at 3 months of no new issues noted.	

Medications." The policy indicated, "...The following condition are met for beside storage to occur: The manner of storage prevents access by other residents...."

Based on observation and interview the facility failed to ensure medications, for residents who self-administer, were stored secured from other residents.

Finding includes:

A record review completed on 7/16/2024 at 2:00 P.M., indicated Resident 4 had an order, dated 5/17/2024, to self-administer his medications. An assessment for self administering medications was completed on 5/14/2024 and indicated the resident was capable of handling his own medications.

During an interview, on 7/17/2024 at 9:08 A.M., Resident 4 indicated he handled his own medications and did not have them locked up. He kept them in the top drawer of his dresser.

During an observation on 7/17/2024 at 9:08 A.M., Resident 4's medications were kept in the top drawer of his dresser. The resident shared the room with a roommate.

During an interview on

	7/18/2024 at 9:23 A.M., the DON indicated medications should be secured and she did not know Resident 4 did not have his medications locked up. On 7/18/2024 at 9:37 A.M., the DON provided a current policy, dated 2023, titled, "Self-Administration of Medications." The policy indicated, "...The following condition are met for beside storage to occur: The manner of storage prevents access by other residents...."			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to	R 0407	The facility will maintain a log for tracking infections throughout the facility. The log has been initiated by the DON or designee as a tool to monitor infections throughout the facility. The log will include urinary and respiratory infections. The nursing department has been in-services on tracking infections and the logs that will be used for tracking infections. Medications will be crossed referenced with infections to ensure all infections are noted. This will include a 24-hour report review to further compliance. Results of audits will be reported to	09/15/2024

	establish an infection control program that included, but was not limited to, a system that enabled the facility to analyze patterns of known infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect 62 of 62 residents who reside in the facility. Finding includes: During an interview on 7/17/2024 at 9:54 A.M., the Infection Prevention Nurse was unable to provide an infection control log book showing surveillance of infections throughout the facility. She indicated the facility did have a section in the EMR system, called clinical overview, that identified urinary tract and respiratory infections. However, they did not have a staff member assigned to monitor and carry out an infection control program. On 7/17/2024 at 10:11 A.M., a policy was requested but one was not provided prior to the survey exit. Based on record review and interview, the facility failed to establish an infection control program that included, but was not limited to, a system that enabled the facility to analyze		the QA to ensure continued compliance. This will continue unit this problem is considered resolved. This problem will be considered resolved after 3 months of no new issues noted. Auditing of the Infection Control problem will be conducted by the DON, Regional Nurse or designee. Audits will be conducted at least monthly or until problem is considered resolved. Problem will be considered resolved after three months of no new issues noted.	

	patterns of known infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect 62 of 62 residents who reside in the facility. Finding includes: During an interview on 7/17/2024 at 9:54 A.M., the Infection Prevention Nurse was unable to provide an infection control log book showing surveillance of infections throughout the facility. She indicated the facility did have a section in the EMR system, called clinical overview, that identified urinary tract and respiratory infections. However, they did not have a staff member assigned to monitor and carry out an infection control program. On 7/17/2024 at 10:11 A.M., a policy was requested but one was not provided prior to the survey exit.			
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	R 0409	All residents will receive an annual health statement per regulations.	09/15/2024

	no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement. 7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement. During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record. During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations. Based on record review and interview, the facility failed to ensure annual health statements were obtained for 7 of 7 residents reviewed. (Residents 2, 3, 5, C, 4, B, D) Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of		All files have been reviewed for annual health statements. Files found not to have an annual health statement are in the process of being updated and should be completed by 09/15/2024. DON /Nursing Department in serviced on maintaining an annual health statement for each resident in the facility. Filles will be reviewed with service plans to ensure continued compliance. Results of audits will be reported to the QA Team to ensure continued compliance. Audits will continue until the problem i considered resolved. The problem will be considered resolved with three months of no new issues noted. Service Plan requirements will be reviewed by the DON or designee. Reviews will occur at least monthly to ensure all service plans are completed per regulatory requirements. Results of reviews will be reported to the QA Team on a monthly basis for continued monitoring and compliance.	

an annual health statement.

2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement.

3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement.

4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the documentation of an annual health statement

5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the documentation of an annual health statement.

6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement.

7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement.

During an interview on 7/18/2024 at 10:18 A.M., the

	Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record. During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations. Based on record review and interview, the facility failed to ensure annual health statements were obtained for 7 of 7 residents reviewed. (Residents 2, 3, 5, C, 4, B, D) Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement. 2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement. 4. A record review was completed on 7/16/2024 at 2			

P.M. for Resident C. The resident's record lacked the documentation of an annual health statement

5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the documentation of an annual health statement.

6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement.

7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement.

During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record.

During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations.

Based on record review and interview, the facility failed to ensure annual health statements were obtained for 7 of 7 residents reviewed.

	(Residents 2, 3, 5, C, 4, B, D) Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement. 2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement. 4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the documentation of an annual health statement 5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the documentation of an annual health statement. 6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement.			

	7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement. During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record. During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations. Based on record review and interview, the facility failed to ensure annual health statements were obtained for 7 of 7 residents reviewed. (Residents 2, 3, 5, C, 4, B, D) Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement. 2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident			

	5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement. 4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the documentation of an annual health statement 5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the documentation of an annual health statement. 6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement. 7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement. During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record. During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding			

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health statement.

6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement.

7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement.

During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record.

During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations.

Based on record review and interview, the facility failed to ensure annual health statements were obtained for 7 of 7 residents reviewed. (Residents 2, 3, 5, C, 4, B, D)

Findings include:

1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement.

	2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement. 4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the documentation of an annual health statement 5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the documentation of an annual health statement. 6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement. 7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement. During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should			

	have an Annual Health Statement from a physician in their Electronic Medical Record. During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations. Based on record review and interview, the facility failed to ensure annual health statements were obtained for 7 of 7 residents reviewed. (Residents 2, 3, 5, C, 4, B, D) Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement. 2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement. 4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the			

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	Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement. 2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement. 4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the documentation of an annual health statement 5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the 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	R 0410	The facility will be compliant with TB/resident screening requirements. New admissions will receive first and second TB test upon	09/15/2024

	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 ensure residents had a 1st and 2nd step tuberculosis test (TB) upon admission for 2 of 7 residents reviewed for TB tests. (Resident 3 & 5) Findings include:		Admission. Inservice will be conducted for the nursing department on 1st & 2nd step TB for residents and staff. Records have been reviewing and all residents will have new screenings by the end of the month. All residents will have 1st steps completed, pending for 2nd steps per protocol. Admissions packets will be reviewed/audited to ensure process is completed. This will be audited by the DON and/or designee. Results of audits will be reported to the QA team to ensure continued compliance. The audit process will continue until there have been 3 months with no new issues noted	

1. A record review for Resident 3 was completed on 7/17/2024 at 1:07 P.M. Resident 3 was admitted to the facility on 11/20/2023. The record lacked documentation of a 1st and 2nd TB test upon admission to the facility.

2. A record review for Resident 5 was completed on 7/17/2024 at 3:01 P.M. Resident 5 was admitted to the facility on 4/29/2023. The record lacked documentation of a 1st and 2nd step TB test upon admission.

During an interview on 7/18/024 at 10:07 A.M., the DON indicated the residents did not have their 1st and 2nd step TB tests completed on or prior to admission.

During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy but followed the State regulations

Based on record review and interview the facility failed to ensure residents had a 1st and 2nd step tuberculosis test (TB) upon admission for 2 of 7 residents reviewed for TB tests. (Resident 3 & 5)

Findings include:

1. A record review for Resident 3 was completed on 7/17/2024 at 1:07 P.M. Resident 3 was admitted to the facility on

	11/20/2023. The record lacked documentation of a 1st and 2nd TB test upon admission to the facility. 2. A record review for Resident 5 was completed on 7/17/2024 at 3:01 P.M. Resident 5 was admitted to the facility on 4/29/2023. The record lacked documentation of a 1st and 2nd step TB test upon admission. During an interview on 7/18/024 at 10:07 A.M., the DON indicated the residents did not have their 1st and 2nd step TB tests completed on or prior to admission. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy but followed the State regulations			

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

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