

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2024	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARYS CIRCLE, HOBART, , 46342					
(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 IN00443613 and IN00443702. Complaint IN00443613 - State deficiencies related to the allegations are cited at R0240. Complaint IN00443702 - State deficiencies related to the allegations are cited at R0240. Survey dates: September 25 and 26, 2024 Facility number: 002627 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/4/24.	R 0000	This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by the regulation.				
R 0030	Residents' Rights - Noncompliance	R 0030	Administrator completed an	10/25/2024			

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410 IAC 16.2-5-1.2(e)(1-6)

(e) Residents have the right to be provided, at the time of admission to the facility, the following:

(1) A copy of his or her admission agreement.

(2) A written notice of the facility ' s basic daily or monthly rates.

(3) A written statement of all facility services (including those offered on an as needed basis).

(4) Information on related charges, admission, readmission, and discharge policies of the facility.

(5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9.

(6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form.

Based on record review and interview, the facility failed to have a current disclosure form for the Alzheimer's/Dementia Special Care Unit. This had the potential to affect all residents residing on the Dementia Care

Alzheimer's and Dementia Special

Care Unit disclosure form and submitted it via US Mail. The administrator was informed that the information

is now submitted online. After completing the Housing Services Unit Disclosure Form, an Alzheimer's/Dementia Special Care Unit form was submitted. The Alzheimer's/Dementia Special Care unit was approved on October 18, 2024.

The Dementia Disclosure form submission shall be monitored by the Administrator at least twice during the year - when auditing the availability of documents needed for the Annual Survey, and again by November 1st of each year, allowing sufficient time to submit any forms needed to assure compliance. This shall be done on an ongoing basis each year, and is a part of the Administrator's routine responsibilities. Dates for review are noted on the calendar of the Administrator.

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unit.

Finding includes:

The Alzheimer's/Dementia Special Care Unit disclosure form was requested on 9/25/24 and was not provided by the facility.

During an interview on 9/26/24 at 1:48 p.m., the Administrator indicated she had filled out a new form as of 9/25/24 and she was unable to locate any previous disclosure forms.

Based on record review and interview, the facility failed to have a current disclosure form for the Alzheimer's/Dementia Special Care Unit. This had the potential to affect all residents residing on the Dementia Care unit.

Finding includes:

The Alzheimer's/Dementia Special Care Unit disclosure form was requested on 9/25/24 and was not provided by the facility.

During an interview on 9/26/24 at 1:48 p.m., the Administrator indicated she had filled out a new form as of 9/25/24 and she was unable to locate any previous disclosure forms.

R 0216	Evaluation - Noncompliance	R 0216	An audit was completed to	10/25/2024
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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 record review and interview, the facility failed to ensure a resident had the ability to self-administer medications for 1 of 1 resident reviewed for self-administration of medications. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident's current Service Plan indicated she was cognitively intact. She could		ensure that all residents that self-administer medications have physicians' orders and self-administration assessments. Self-administration assessments will be completed for each resident that self-administers medications on a monthly basis to ensure that they have the ability to self-administer their medications accurately. All nursing staff in-serviced on self-medication assessments. Self-administration assessments will be completed upon admission for each resident and monthly thereafter. DON or designee will monitor for accuracy and completion of assessments, weekly for 3 months, monthly for 3 months, and then monthly indefinitely to ensure compliance.	
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obtain new prescriptions and refills independently and was independent with self-administration of medications.

The September 2024 Physician's Order Summary (POS) indicated the resident received the following medications: docusate sodium (stool softener) 100 milligram (mg) capsule twice daily as needed, furosemide (diuretic) 20 mg tablet daily, labetalol (treatment for high blood pressure) 100 mg tablet twice daily, lorazepam (anxiolytic) 2 milligram/milliliter (mg/ml) 0.5 ml every four hours as needed, meclizine (anti-nausea medication) 25 mg tablet four times daily, morphine (pain medication) 100 mg/ml 0.25 ml every four hours as needed, ondansetron (anti-nausea medication) 4 mg tablet four times a day as needed, potassium chloride 20 milliequivalents (meq) tablet once daily, and xarelto (blood thinner) 15 mg tablet once daily.

There were no Physician's Orders for self-administration of medications.

A Medication Self-Administration Safety Screen, dated 4/14/24 at 2:05 p.m., indicated the resident was able to safely administer xarelto 15 mg tablet, furosemide 20 mg

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tablet daily, labetalol 50 mg twice daily, potassium chloride 10 meq tablet daily, and ondansetron 4 mg tablet as needed.

There were no Self-Administration Safety Screens related to docusate sodium, lorazepam, meclizine, and morphine.

During an interview on 9/26/24 at 9:52 a.m., the Director of Nursing indicated the resident self-administered all of her medications. There should have been a Physician's Order and the self-administration assessment should have been updated.

Based on record review and interview, the facility failed to ensure a resident had the ability to self-administer medications for 1 of 1 resident reviewed for self-administration of medications. (Resident 5)

Finding includes:

The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure.

The resident's current Service Plan indicated she was cognitively intact. She could obtain new prescriptions and refills independently and was independent with

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self-administration of medications.

The September 2024 Physician's Order Summary (POS) indicated the resident received the following medications: docusate sodium (stool softener) 100 milligram (mg) capsule twice daily as needed, furosemide (diuretic) 20 mg tablet daily, labetalol (treatment for high blood pressure) 100 mg tablet twice daily, lorazepam (anxiolytic) 2 milligram/milliliter (mg/ml) 0.5 ml every four hours as needed, meclizine (anti-nausea medication) 25 mg tablet four times daily, morphine (pain medication) 100 mg/ml 0.25 ml every four hours as needed, ondansetron (anti-nausea medication) 4 mg tablet four times a day as needed, potassium chloride 20 milliequivalents (meq) tablet once daily, and xarelto (blood thinner) 15 mg tablet once daily.

There were no Physician's Orders for self-administration of medications.

A Medication Self-Administration Safety Screen, dated 4/14/24 at 2:05 p.m., indicated the resident was able to safely administer xarelto 15 mg tablet, furosemide 20 mg tablet daily, labetalol 50 mg twice daily, potassium chloride 10 meq tablet daily, and

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	ondansetron 4 mg tablet as needed. There were no Self-Administration Safety Screens related to docusate sodium, lorazepam, meclizine, and morphine. During an interview on 9/26/24 at 9:52 a.m., the Director of Nursing indicated the resident self-administered all of her medications. There should have been a Physician's Order and the self-administration assessment should have been updated.			
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	R 0217	An audit was completed for all resident service plans requiring review, and signatures to ensure compliance. DON or designee will monitor service plans for completion to ensure they are updated, reviewed and signed by Resident/ POA upon admission, any change of condition, and quarterly. A tracking tool will be used to audit service plans, twice a week for one month, once a week for 3 months, and quarterly to ensure compliance.	10/25/2024

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reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors,

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diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required

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orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further

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information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the

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service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was

reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with

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significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the

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resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

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The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment.

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He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated

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8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

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The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind.

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She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at

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night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information

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to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

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2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included,

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but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any

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signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes

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mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents

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reviewed for Service Plans.
(Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage

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renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been

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reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident

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was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen

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use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included,

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but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to

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administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated

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she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24

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at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been

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updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

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A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There

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was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to,

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dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

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6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident

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admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24 at 9:45 a.m., the DON indicated she had no further information to provide.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 7 of 11 residents reviewed for Service Plans. (Residents 2, 6, 8, 10, 7, 3, and 14)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

A Service Plan, dated 11/4/23, indicated the resident had moderate dementia with significant short-term memory and possibly long-term memory loss. The resident was visually impaired and required assistance with bathing and

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medications.

The Service Plan was not signed by the responsible party.

During an interview on 9/25/24 at 3:26 p.m., the Director of Nursing (DON) indicated she was unable to locate a signed Service Plan.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

A Service Plan, dated 8/28/23, indicated the resident was alert and oriented. The resident was legally blind and unable to administer his own medications. The resident required orientation to room and facility and required dialysis for renal failure.

The Service Plan was not signed by the resident. There was no documentation to indicate the Service Plan was read and explained to the resident since he was legally blind.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated

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the Service Plan was not signed because the resident was blind. She could not provide any documentation the Service Plan was explained and read to the resident.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Service Plan was last updated on 4/18/24. There was no signature of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus.

The Service Plan was last updated on 9/3/23. There was no signature of the resident and or responsible party to indicate the Service Plan had been

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reviewed and accepted.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the signed service plans.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any signed service plans. No further information was provided.

5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The Service Plan was last updated on 8/30/24 and was not signed by the resident and/or responsible party.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated the facility staff mailed the service plan to the family a few months ago, but had no documentation of the plan being sent to, received by, or signed by the family member.

6. On 9/27/24 at 1:30 p.m., Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen at 2.5 liters per minute. He indicated he wore the nasal cannula with oxygen all of the time, but sometimes he

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would wake up without it in his nose from moving around at night. He was able to put it back in place independently when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated the resident had oxygen as needed that was ordered from the hospice company and the Service Plan should have been updated.

7. Resident 14's record was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The Service Plan, dated 8/24/24, was not signed by the resident and/or responsible party.

During an interview on 9/25/24

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	at 9:45 a.m., the DON indicated she had no further information to provide.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to assess a resident and notify the Physician and responsible party following a fall, and failed to monitor oxygen use for 2 of 11 residents reviewed. (Residents B and 3) Findings include: 1. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The Service Plan, dated 6/13/23, indicated the resident was at risk for falls related to balance and gait problems. A Progress Note, dated 8/26/24 at 3:30 p.m., indicated the resident was being monitored for fall follow up, was not having any pain or discomfort, and required staff assistance of one	R 0240	An audit was completed to ensure accuracy for all incident reports related to falls. All Nursing staff in-serviced on fall protocol, including assessment and documentation policy, along with proper notifications to include notification of physician and responsible party/ POA. DON or designee will use a tracking tool to audit fall documentation weekly for 3 months, and then monthly indefinitely to ensure compliance. An audit was completed to ensure all residents that require oxygen are entered on service plan and pos orders are entered in PCC. All Nursing staff in-serviced on proper documentation of orders for oxygen use. Clinical documentation will be monitored daily indefinitely by DON or designee to ensure proper documentation is obtained.	10/25/2024

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for activities of daily living (ADLs) and transfers. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

A Progress Note, dated 8/6/24 at 12:46 p.m., indicated the resident was being monitored for fall follow up and was not having any pain or discomfort related to the fall. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

During an interview on 9/26/24 at 3:47 p.m., the Director of Nursing (DON) indicated she would print off the incident reports for the falls.

During an interview on 9/26/24 at 4:41 p.m., QMA 1 indicated the DON was unable to print off the incident reports because the resident had passed away. She had contacted corporate to see if they could help her access the reports. No further information was provided.

2. Upon entrance to Resident 3's room, on 9/27/24 at 1:30 p.m., a sign on the door indicated oxygen was in use.

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Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen set to a flow rate of 2.5 liters per minute. He indicated he kept the oxygen on all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

The September 2024 Physician's Order Summary (POS) lacked any orders for oxygen or monitoring for oxygen use.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing (DON) indicated the resident only had an as needed order for oxygen, but never used oxygen to her knowledge.

A Comfort Kit Order, dated 2/20/24, was provided by the DON on 9/26/24 at 3:30 p.m., which indicated oxygen via

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oxygen concentrator 2-4 liters per nasal cannula as needed.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated oxygen should have been addressed on the Service Plan and it should have been put in the POS for monitoring purposes.

This citation relates to Complaints IN00443613 and IN00443702.

Based on observation, record review, and interview, the facility failed to assess a resident and notify the Physician and responsible party following a fall, and failed to monitor oxygen use for 2 of 11 residents reviewed. (Residents B and 3)

Findings include:

1. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease.

The Service Plan, dated 6/13/23, indicated the resident was at risk for falls related to balance and gait problems.

A Progress Note, dated 8/26/24 at 3:30 p.m., indicated the resident was being monitored for fall follow up, was not having

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any pain or discomfort, and required staff assistance of one for activities of daily living (ADLs) and transfers. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

A Progress Note, dated 8/6/24 at 12:46 p.m., indicated the resident was being monitored for fall follow up and was not having any pain or discomfort related to the fall. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

During an interview on 9/26/24 at 3:47 p.m., the Director of Nursing (DON) indicated she would print off the incident reports for the falls.

During an interview on 9/26/24 at 4:41 p.m., QMA 1 indicated the DON was unable to print off the incident reports because the resident had passed away. She had contacted corporate to see if they could help her access the reports. No further information was provided.

2. Upon entrance to Resident 3's room, on 9/27/24 at 1:30

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p.m., a sign on the door indicated oxygen was in use. Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen set to a flow rate of 2.5 liters per minute. He indicated he kept the oxygen on all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

The September 2024 Physician's Order Summary (POS) lacked any orders for oxygen or monitoring for oxygen use.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing (DON) indicated the resident only had an as needed order for oxygen, but never used oxygen to her knowledge.

A Comfort Kit Order, dated 2/20/24, was provided by the

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DON on 9/26/24 at 3:30 p.m., which indicated oxygen via oxygen concentrator 2-4 liters per nasal cannula as needed.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated oxygen should have been addressed on the Service Plan and it should have been put in the POS for monitoring purposes.

This citation relates to Complaints IN00443613 and IN00443702.

Based on observation, record review, and interview, the facility failed to assess a resident and notify the Physician and responsible party following a fall, and failed to monitor oxygen use for 2 of 11 residents reviewed. (Residents B and 3)

Findings include:

1. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease.

The Service Plan, dated 6/13/23, indicated the resident was at risk for falls related to balance and gait problems.

A Progress Note, dated 8/26/24 at 3:30 p.m., indicated the

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resident was being monitored for fall follow up, was not having any pain or discomfort, and required staff assistance of one for activities of daily living (ADLs) and transfers. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

A Progress Note, dated 8/6/24 at 12:46 p.m., indicated the resident was being monitored for fall follow up and was not having any pain or discomfort related to the fall. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

During an interview on 9/26/24 at 3:47 p.m., the Director of Nursing (DON) indicated she would print off the incident reports for the falls.

During an interview on 9/26/24 at 4:41 p.m., QMA 1 indicated the DON was unable to print off the incident reports because the resident had passed away. She had contacted corporate to see if they could help her access the reports. No further information was provided.

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2. Upon entrance to Resident 3's room, on 9/27/24 at 1:30 p.m., a sign on the door indicated oxygen was in use. Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen set to a flow rate of 2.5 liters per minute. He indicated he kept the oxygen on all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

The September 2024 Physician's Order Summary (POS) lacked any orders for oxygen or monitoring for oxygen use.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing (DON) indicated the resident only had an as needed order for oxygen, but never used oxygen to her knowledge.

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A Comfort Kit Order, dated 2/20/24, was provided by the DON on 9/26/24 at 3:30 p.m., which indicated oxygen via oxygen concentrator 2-4 liters per nasal cannula as needed.

During an interview on 9/26/24 at 9:52 a.m., the DON indicated oxygen should have been addressed on the Service Plan and it should have been put in the POS for monitoring purposes.

This citation relates to Complaints IN00443613 and IN00443702.

Based on observation, record review, and interview, the facility failed to assess a resident and notify the Physician and responsible party following a fall, and failed to monitor oxygen use for 2 of 11 residents reviewed. (Residents B and 3)

Findings include:

1. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease.

The Service Plan, dated 6/13/23, indicated the resident was at risk for falls related to balance and gait problems.

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A Progress Note, dated 8/26/24 at 3:30 p.m., indicated the resident was being monitored for fall follow up, was not having any pain or discomfort, and required staff assistance of one for activities of daily living (ADLs) and transfers. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

A Progress Note, dated 8/6/24 at 12:46 p.m., indicated the resident was being monitored for fall follow up and was not having any pain or discomfort related to the fall. There was a lack of any documentation of when the fall occurred, assessment of the resident at the time of the fall, notification of the Physician, or notification of the resident's responsible party.

During an interview on 9/26/24 at 3:47 p.m., the Director of Nursing (DON) indicated she would print off the incident reports for the falls.

During an interview on 9/26/24 at 4:41 p.m., QMA 1 indicated the DON was unable to print off the incident reports because the resident had passed away. She had contacted corporate to see if they could help her access the reports. No further information

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was provided.

2. Upon entrance to Resident 3's room, on 9/27/24 at 1:30 p.m., a sign on the door indicated oxygen was in use. Resident 3 was observed in a hospital bed in his apartment. He was wearing a nasal cannula with oxygen set to a flow rate of 2.5 liters per minute. He indicated he kept the oxygen on all of the time, but sometimes he would wake up without it in his nose from moving around at night. He was able to put it back in place when needed.

Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease.

A Service Plan was last updated on 9/24/24. The resident signed the Service Plan on 9/20/24. It indicated the resident was cognitively intact. The Service Plan did not address oxygen use.

The September 2024 Physician's Order Summary (POS) lacked any orders for oxygen or monitoring for oxygen use.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing (DON) indicated the resident only had an as needed order for oxygen, but never

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	used oxygen to her knowledge. A Comfort Kit Order, dated 2/20/24, was provided by the DON on 9/26/24 at 3:30 p.m., which indicated oxygen via oxygen concentrator 2-4 liters per nasal cannula as needed. During an interview on 9/26/24 at 9:52 a.m., the DON indicated oxygen should have been addressed on the Service Plan and it should have been put in the POS for monitoring purposes. This citation relates to Complaints IN00443613 and IN00443702.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain proper food sanitation related to unlabeled and undated food. This had the potential to affect the 119 residents who received food from the kitchen.	R 0273	Corrective action All staff have been educated on 10/14/2024 by the food service manager on labeling and dating per facility policy. Measures put in place All staff were educated on 10/14/2024 by the food service manager on labeling and dating per facility and state board of health policy,	10/25/2024

Findings include:

On 9/25/24 at 9:25 a.m., on the initial tour of the kitchen with the Kitchen Manager, the following was observed:

a. In the refrigerator, there was a tray with 11 cups of watermelon, unlabeled and undated. There was an opened, undated bottle of Worcestershire sauce.

b. In the freezer, the following items were opened and undated: a box of diced chicken, a box of chicken nuggets, a box of pork fritters, a box of egg rolls, a box of taco meat, a box of pasta sheets, and 3 large containers of ice cream. There was a tray with 13 serving dishes of sherbet, unlabeled and undated.

During an interview on 9/25/24 at 9:25 a.m., the Kitchen Manager indicated the food items should have been labeled and dated.

A Facility Policy, titled "Food Storage" received as current, indicated, " ...All products should be inspected for safety and quality and be dated upon receipt, when open, and when prepared ..."

Based on observation, interview, and record review, the facility failed to maintain proper food sanitation related to

All food service areas will be monitored daily by the food and service manager/designee x 6 months to assure compliance is maintained.

Corrective actions monitored

Ongoing compliance with corrective action will be monitored via the facility QA program, and a monthly meeting will be held by the food service manager/designee.

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unlabeled and undated food.
This had the potential to affect
the 119 residents who received
food from the kitchen.

Findings include:

On 9/25/24 at 9:25 a.m., on the
initial tour of the kitchen with the
Kitchen Manager, the following
was observed:

a. In the refrigerator, there was
a tray with 11 cups of
watermelon, unlabeled and
undated. There was an opened,
undated bottle of
Worcestershire sauce.

b. In the freezer, the following
items were opened and
undated: a box of diced chicken,
a box of chicken nuggets, a box
of pork fritters, a box of egg
rolls, a box of taco meat, a box
of pasta sheets, and 3 large
containers of ice cream. There
was a tray with 13 serving
dishes of sherbet, unlabeled
and undated.

During an interview on 9/25/24
at 9:25 a.m., the Kitchen
Manager indicated the food
items should have been labeled
and dated.

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	A Facility Policy, titled "Food Storage" received as current, indicated, " ...All products should be inspected for safety and quality and be dated upon receipt, when open, and when prepared ..."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. 6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to,	R 0298	All Pharmacy reviews requiring signatures were submitted to Physicians. Pharmacy reviews will be completed every 60 days and kept in binder, DON or designee will audit pharmacy reviews on a monthly basis indefinitely to ensure completion and accuracy of orders.	10/25/2024

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dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to,

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dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

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5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage

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renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy

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drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60

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days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of

documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every

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60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility

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on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

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9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information

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to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24

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at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24

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at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility

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pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included,

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but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included,

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but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

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During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at

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9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60

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days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information

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to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24

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at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24

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at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility

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pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included,

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but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included,

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but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

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During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at

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9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60

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days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

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9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information

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to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24

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at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24

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at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility

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pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

6. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included,

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but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. The record lacked any pharmacy drug regimen reviews.

During an interview on 9/26/24 at 3:45 p.m., the DON indicated they had no further information to provide at this time.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

3. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included,

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but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

4. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

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During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

5. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

There was a lack of documentation any pharmacy reviews had been completed for 2024.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the pharmacy reviews.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable to find any pharmacy reviews. No further information was provided.

Based on record review and interview, the facility failed to ensure pharmacy drug regimen reviews were completed every 60 days for 9 of 11 residents reviewed for pharmaceutical services. (Residents 6, 4, 8, 10, B, 7, 3, 5, and 11)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at

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9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

7. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60

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days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

8. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.

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	9. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24. The resident received medications through the facility pharmacy. There was a lack of documentation to indicate a pharmacy drug regimen review had been completed every 60 days since admission. During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the pharmacy drug regimen review had been completed every 60 days since the resident's admission.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.	R 0349	Acuity guidelines uploaded on gateway: Nursing staff in-serviced on medication policy, reviews for duplicate orders, and that proper verification of physician orders are entered correctly in MAR. DON or designee will complete medication reviews monthly in PCC on an ongoing basis to ensure medication orders are complete, accurate, and up to date in the MAR indefinitely.	10/25/2024

(4) Systematically organized.

Based on observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to urinary indwelling catheter output documentation, duplicate orders for medications, and a lack of orders for self-administering medications. (Residents 3 and 5)

Findings include:

1. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

The current Service Plan indicated the resident had an indwelling catheter and required assistance with emptying the urine catheter bag.

A Physician's Order, dated 4/29/24, indicated to document urinary catheter output every shift.

The September 2024 Treatment Administration Record indicated the urinary catheter output was not documented on the day shift on 9/9/24, evening shift on 9/9/24 and 9/13/24, and the night shift on 9/1-9/3/24, 9/6/24,

Previous order for catheter output documentation corrected previously in PCC to reflect care is monitored and maintained by third party services and/ or Hospice. Education provided to nursing staff regarding indwelling catheter care and Acuity Guidelines.

Immediate audit completed on residents requiring indwelling catheters to ensure physician orders are followed and are in compliance according to Acuity Guidelines.

Per Acuity Guidelines: resident should be able to perform self-care for indwelling catheters and demonstrate the ability to perform catheter care. If unable to perform self-care, home health or another third-party, service will perform catheter care.

DON or designee will ensure residents requiring indwelling catheters have proper physician orders upon admission and as necessary, and monitor weekly for 3 months, monthly for 3 months and then indefinitely. to ensure proper documentation is followed according to physician orders and acuity guidelines.

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and 9/8-9/10/24.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing had no further information to provide.

2. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The current Service Plan indicated the resident was cognitively intact for daily decision making and self-administered medications.

The September 2024 Physician's Order Summary (POS) indicated morphine 100 milligrams per milliliter (mg/ml) 0.25 ml every four hours as needed was ordered twice on 7/27/24 and 8/13/24.

There were no Physician's Orders for self-administration of medications.

A Medication Self-Administration Safety Screen, dated 4/14/24 at 2:05 p.m., indicated the resident was able to safely administer xarelto (blood thinner) 15 mg tablet , furosemide (diuretic) 20 mg tablet daily, labetalol (treatment for high blood pressure) 50 mg twice daily, potassium chloride 10 meq tablet daily, and

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ondansetron (anti-nausea medication) 4 mg tablet as needed.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing indicated the resident self-administered all of her medications and there should have been a Physician's Order in the POS. When pharmacy refilled the medications, they put in a new order in the POS, but they did not discontinue the old order as they should have.

Based on observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to urinary indwelling catheter output documentation, duplicate orders for medications, and a lack of orders for self-administering medications. (Residents 3 and 5)

Findings include:

1. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

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The current Service Plan indicated the resident had an indwelling catheter and required assistance with emptying the urine catheter bag.

A Physician's Order, dated 4/29/24, indicated to document urinary catheter output every shift.

The September 2024 Treatment Administration Record indicated the urinary catheter output was not documented on the day shift on 9/9/24, evening shift on 9/9/24 and 9/13/24, and the night shift on 9/1-9/3/24, 9/6/24, and 9/8-9/10/24.

During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing had no further information to provide.

2. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The current Service Plan indicated the resident was cognitively intact for daily decision making and self-administered medications.

The September 2024 Physician's Order Summary (POS) indicated morphine 100 milligrams per milliliter (mg/ml) 0.25 ml every four hours as

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	needed was ordered twice on 7/27/24 and 8/13/24. There were no Physician's Orders for self-administration of medications. A Medication Self-Administration Safety Screen, dated 4/14/24 at 2:05 p.m., indicated the resident was able to safely administer xarelto (blood thinner) 15 mg tablet , furosemide (diuretic) 20 mg tablet daily, labetalol (treatment for high blood pressure) 50 mg twice daily, potassium chloride 10 meq tablet daily, and ondansetron (anti-nausea medication) 4 mg tablet as needed. During an interview on 9/25/24 at 9:45 a.m., the Director of Nursing indicated the resident self-administered all of her medications and there should have been a Physician's Order in the POS. When pharmacy refilled the medications, they put in a new order in the POS, but they did not discontinue the old order as they should have.			
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data.	R 0354	Nursing staff in-serviced on Transfer/ Discharge policy including the completion of the transfer/ discharge form. DON or designee will maintain a binder created to	10/25/2024

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(2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 11 resident records reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on		include each resident hospital discharge/ transfer form and ensure that proper documentation is completed in PCC for each resident transfer or discharge. DON or designee will monitor this binder each month indefinitely.	
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5/1/23.

A Nurse's Note, dated 9/23/24, indicated the resident returned to the facility from the hospital.

Previous Nurse's Notes lacked documentation of the resident going to the hospital.

There was no documentation of a transfer/discharge assessment or instructions completed for the resident.

During an interview on 9/26/24 at 4:10 p.m., the Director of Nursing indicated the facility should have completed a transfer/discharge form, but they missed it.

Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 11 resident records reviewed. (Resident 7)

Finding includes:

Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

A Nurse's Note, dated 9/23/24, indicated the resident returned to the facility from the hospital.

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	Previous Nurse's Notes lacked documentation of the resident going to the hospital. There was no documentation of a transfer/discharge assessment or instructions completed for the resident. During an interview on 9/26/24 at 4:10 p.m., the Director of Nursing indicated the facility should have completed a transfer/discharge form, but they missed it.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or	R 0356	An audit of the emergency binder was completed to determine which residents required hospital preference documentation. DON or designee will ensure hospital preferences are listed for new and existing residents. DON or designee will complete audits on emergency binder for new and existing resident's biweekly for 2 months, weekly for 2months, then monthly indefinitely to ensure accuracy and compliance.	10/25/2024

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death.

(6) Information on any known allergies.

(7) A photograph (for identification of the resident).

(8) Copy of advance directives, if available.

Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 8 of 8 residents reviewed.
(Residents 2, 3, 4, 5, 6, 7, 8, 11)

Findings include:

The emergency file binder was reviewed on 9/26/2024 at 11:45 a.m.

The file did not have a hospital preference documented for Residents 2, 3, 4, 5, 6, 7, 8, and 11.

During an interview on 9/26/24 at 3:45 p.m., the Administrator indicated they did not document resident hospital preferences.

Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 8 of 8 residents reviewed.
(Residents 2, 3, 4, 5, 6, 7, 8, 11)

Findings include:

The emergency file binder was

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	reviewed on 9/26/2024 at 11:45 a.m. The file did not have a hospital preference documented for Residents 2, 3, 4, 5, 6, 7, 8, and 11. During an interview on 9/26/24 at 3:45 p.m., the Administrator indicated they did not document resident hospital preferences.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23. There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed. During an interview on 9/26/24	R 0409	An audit was conducted to determine each resident requiring a signed annual health statement stating resident is free of communicable disease. DON or designee will ensure each new and existing resident has a signed annual health statement indicating they are free of communicable disease upon admission and annually as required per regulations and will be monitored monthly indefinitely to ensure compliance.	10/25/2024

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at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

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The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any

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documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from

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communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

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The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but

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were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

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7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to

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indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included,

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but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

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5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health

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statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

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Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was

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free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked

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any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and

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chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

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9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

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Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure,

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diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24

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at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

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During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of

communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases

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had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24

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at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating

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the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The

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resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included,

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but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases

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had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney

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disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses

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included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated

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she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she

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could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of 11 residents reviewed for annual health statements. (Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma,

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legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was

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free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24.

The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

8. Resident 3's record was reviewed on 9/25/24 at 1:26 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and chronic kidney disease. The resident admitted to the facility on 5/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

9. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart

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failure and high blood pressure.
The resident admitted to the facility on 10/31/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

7. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was admitted to the facility on 5/1/23.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she could not find documentation that the resident was free of communicable diseases.

Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 9 of

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11 residents reviewed for annual health statements.
(Residents 2, 6, 4, 8, 10, B, 7, 3, 5)

Findings include:

1. Record review for Resident 2 was completed on 9/25/24 at 10:32 a.m. Diagnoses included, but were not limited to, dementia with behaviors, diabetes mellitus, glaucoma, legal blindness, hypertension and heart failure. The resident was admitted to the facility on 11/1/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

2. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on

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8/30/23.

There was no documentation to indicate an annual health statement that the resident was free of communicable diseases had been completed.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation an annual health statement that the resident was free of communicable diseases had been completed.

3. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

4. The record for Resident 8 was reviewed on 9/26/24 at 1:20 p.m. Diagnoses included, but were not limited to,

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dementia, anxiety disorder, and hyperlipidemia.

The Physician's Order Summary (POS), dated 9/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

5. The closed record for Resident 10 was reviewed on 9/26/24 at 9:04 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and type 2 diabetes mellitus. The resident passed away on 7/11/24.

The Physician's Order Summary (POS), dated 7/2024, lacked any health statement indicating the resident was free from communicable disease.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

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	6. The closed record for Resident B was reviewed on 9/26/24 at 10:36 a.m. Diagnoses included, but were not limited to, hypertension and chronic obstructive pulmonary disease. The resident passed away on 8/28/24. The Physician's Order Summary (POS), dated 8/2024, lacked any health statement indicating the resident was free from communicable disease. During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for annual health statement. During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing	R 0410	An audit was completed to ensure all residents requiring their initial TB/chest x-ray/ yearly screening were completed. All new and existing residents will have their first and second step TB administered upon admission or prior to admission. The two step TB test will be administered, and education will be provided. TB test will be documented in PCC and will flag to notify when TB test or screenings are due. DON or	10/25/2024

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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.

3. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

4. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident

designee will run immunization report weekly indefinitely to ensure compliance.

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admitted to the facility on 5/25/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

5. The record was Resident 14 was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to,

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hypertension, type 2 diabetes mellitus, and chronic kidney disease. The resident was admitted to the facility on 11/10/23.

A Physician's Order, dated 11/11/23, indicated aplisol (solution used in Mantoux testing) intradermal solution for TB (tuberculosis) screening.

The Medication Administration Record (MAR), dated 11/2023, indicated the sign off for the aplisol administration on 11/11/23 was left blank. There was lack of documentation a two-step Mantoux test was completed upon admission.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the TB testing.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 5 of 11 residents reviewed. (Residents 6, 4, 5, 11, and 14)

Findings include:

1. Record review for Resident 6

was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

3. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she

could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

4. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

5. The record was Resident 14 was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease. The resident was admitted to the facility on 11/10/23.

A Physician's Order, dated 11/11/23, indicated aplisol (solution used in Mantoux testing) intradermal solution for TB (tuberculosis) screening.

The Medication Administration Record (MAR), dated 11/2023, indicated the sign off for the aplisol administration on 11/11/23 was left blank. There was lack of documentation a two-step Mantoux test was completed upon admission.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the TB testing.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

Based on record review and

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interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 5 of 11 residents reviewed. (Residents 6, 4, 5, 11, and 14)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

3. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure.

The resident admitted to the facility on 10/31/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

4. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

5. The record was Resident 14 was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included,

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but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease. The resident was admitted to the facility on 11/10/23.

A Physician's Order, dated 11/11/23, indicated aplisol (solution used in Mantoux testing) intradermal solution for TB (tuberculosis) screening.

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The Medication Administration Record (MAR), dated 11/2023, indicated the sign off for the aplisol administration on 11/11/23 was left blank. There was lack of documentation a two-step Mantoux test was completed upon admission.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the TB testing.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 5 of 11 residents reviewed. (Residents 6, 4, 5, 11, and 14)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

3. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

4. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident

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admitted to the facility on 5/25/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

5. The record was Resident 14 was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to,

hypertension, type 2 diabetes mellitus, and chronic kidney disease. The resident was admitted to the facility on 11/10/23.

A Physician's Order, dated 11/11/23, indicated aplisol (solution used in Mantoux testing) intradermal solution for TB (tuberculosis) screening.

The Medication Administration Record (MAR), dated 11/2023, indicated the sign off for the aplisol administration on 11/11/23 was left blank. There was lack of documentation a two-step Mantoux test was completed upon admission.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the TB testing.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 5 of 11 residents reviewed. (Residents 6, 4, 5, 11, and 14)

Findings include:

1. Record review for Resident 6

was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

3. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure. The resident admitted to the facility on 10/31/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she

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could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

4. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

5. The record was Resident 14 was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

2. The record for Resident 4 was reviewed on 9/25/24 at 2:16 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney disease. The resident was admitted to the facility on 11/10/23.

A Physician's Order, dated 11/11/23, indicated aplisol (solution used in Mantoux testing) intradermal solution for TB (tuberculosis) screening.

The Medication Administration Record (MAR), dated 11/2023, indicated the sign off for the aplisol administration on 11/11/23 was left blank. There was lack of documentation a two-step Mantoux test was completed upon admission.

During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the TB testing.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

Based on record review and

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interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 5 of 11 residents reviewed. (Residents 6, 4, 5, 11, and 14)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

3. The record for Resident 5 was reviewed on 9/25/24 at 2:55 p.m. Diagnoses included, but were not limited to, heart failure and high blood pressure.

The resident admitted to the facility on 10/31/23.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when she was admitted.

4. The record for Resident 11 was reviewed on 9/26/24 at 10:21 a.m. Diagnoses included, but were not limited to, dementia, depression, and anxiety disorder. The resident admitted to the facility on 5/25/24.

The record lacked any documentation a TB test had been completed on or prior to the resident's admission to the facility.

During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

5. The record was Resident 14 was reviewed on 9/25/24 at 9:55 a.m. Diagnoses included,

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but were not limited to, dementia, Parkinson's disease, and an enlarged heart. The resident admitted to the facility on 8/24/24.

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A Physician's Order, dated 11/11/23, indicated aplisol (solution used in Mantoux testing) intradermal solution for TB (tuberculosis) screening.

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During an interview on 9/26/24 at 9:45 a.m., the DON indicated she would look for the TB testing.

During an interview on 9/26/24 at 4:10 p.m., the DON indicated she was unable provided any further information.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 5 of 11 residents reviewed. (Residents 6, 4, 5, 11, and 14)

Findings include:

1. Record review for Resident 6 was completed on 9/26/24 at 9:36 a.m. Diagnosis included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to the facility on 8/30/23.

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During an interview on 9/26/24 at 3:50 p.m., the Director of Nursing (DON) indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.

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