STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGBY PLACE	167 CR W 240 S, LAFAYETTE, , 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: April 22 and 23, 2026 Facility number: 004392 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 1, 2026.	R 0000		
R 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2) The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the:	R 0086	Deficiency ID: R_0086 Completion Date: 5/7/2026 On 5/7/2026 The Executive Director (ED) applied and provided payment for renewal of the CLIA Waiver for Digby Place. A confirmation email was received for the submission of renewal from the Program Secretary for the Division of	05/06/2026

	(A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the facility failed to ensure a valid Clinical Laboratory Improvement Amendments (CLIA) waiver was maintained. This deficient practice had the potential to affect 36 of 36 residents who reside in the facility. Findings include: During an observation, on 4/22/26 at 2:49 p.m., the CLIA Waiver had an expiration date of 11/21/24. During an interview, on 4/22/26 at 2:49 p.m., the Executive Director (ED) indicated the CLIA Waiver was expired. There was no policy for CLIA waivers, but the facility followed state regulations.		Acute and Continuing Care. On 4/23/2026, the Regional Director of Operations (RDO) in-serviced the ED on proper procedure for maintaining CLIA waiver renewals. The ED and RDO will track any upcoming renewals for licensures, in addition to the corporate compliance team, to ensure no lapses in licenses and waivers. All waivers and licenses will be discussed in monthly QI meeting to review any upcoming renewals timely. The ED is responsible for compliance. Monitoring will be ongoing.	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2)	R 0092	Deficiency ID: R_0092	05/06/2026

	(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.		Completion date: 4/30/2026 On 4/30/2026 the Lafayette Fire Department (LFD) was invited and attended a fire drill and complete fire system inspection. The Facility Operations Assistant or the ED will conduct monthly fire drills on rotating shifts throughout the year. LFD will be invited every April and October. The ED was retrained by the Regional Director of Facility Operations on the regulations regarding fire safety on 4/30/2026. A monthly audit of fire drills and invitation of the fire department will be conducted by the ED and discussed in the QI meeting monthly to ensure compliance. Audits will continue monthly for 12 months. QI committee will discuss ongoing audits after 12 months of 100% compliance. The ED and Director of Facilties are responsible for compliance. Monitoring will be ongoing.	

	Based on interview and record review, the facility failed to ensure an attempt to hold fire drills in conjunction with the local fire department were held and documented at least every six (6) months. This deficient practice had the potential to affect 36 of 36 residents who resided in the facility. Findings include: On 4/22/26 at 11:43 a.m., the fire drills completed in the most recent twelve-month period were reviewed. There was no documentation to indicate the local fire department were invited or participated in any of the facility fire drills. During an interview, on 4/23/26 at 10:11 a.m., the Executive Director (ED) indicated the facility did not have documentation the local fire department had been contacted and asked to participate in a fire drill for the past twelve months. There should have been an invite for participation sent to the local fire department every six months.			

	During an interview, on 4/23/26 at 10:50 a.m., the Maintenance Supervisor indicated she had not invited the local fire department to come and participate in a fire drill with the facility for the past twelve months. There was no policy provided related to including the local fire department for fire drills.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing	R 0121	Deficiency ID: R_0121 On 4/24/2026, the ED and DON audited all employee files for complete and accurate documentation of TB skin tests. All employees found out of compliance will have a new TB skin test administered by 05/20/2026. On 4/30/2026, a new document to record TB skin tests was initiated to include all information required to maintain compliance, including time administered and read. Any new employees will have a 2 step PPD placed and recorded completely and accurately on the new form.	05/20/2026

	should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure tuberculosis skin test documentation was completed for 5 of 5 employees reviewed for tuberculosis (TB) testing. (CNA 2, RN 3, QMA 4, CNA 5 and CNA 6) Findings include: During a record review, on 4/23/26 at 8:50 a.m., the employee records indicated the following:		On 4/24/2026, the ED and DON were retrained by the Regional Care Specialist on the requirements for accurate PPD administration and documentation. The ED is responsible for compliance. Employee files will be audited monthly and discussed in monthly QI. Monitoring will be ongoing.	

1. CNA 2's TB skin test documentation did not contain a time administered or read for the 1st or 2nd step test.

2. RN 3's TB skin test documentation did not contain a time administered or read for the 1st or 2nd step test.

3. QMA 4's TB skin test documentation did not contain a time administered or read for the 1st or 2nd step test.

4. CNA 5's TB skin test documentation did not contain a time administered or read for the 1st or 2nd step test.

5. CNA 6's TB skin test documentation did not contain a time administered or read for the 1st or 2nd step test.

During an interview, on 4/23/26 at 9:30 a.m., the Director of Nursing (DON) indicated the facility followed the Center for Disease guidelines and state regulation for TB testing. The DON indicated they did not have the documentation completed for TB tests.

A current facility policy, titled "Tuberculosis: Care Staff", dated 6/10/24 provided by the Executive Director (ED) on 4/23/26 at 10:01 a.m., indicated "...Each newly hired care staff member will be screened...TB test must be completed at the

	time of employment...Per the Center for Disease Control and Prevention guidance, test results should be read between forty-eight to seventy two hours...."			

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 SIGNATUREAmber C Shaughnessy	TITLEExecutive Director	(X6) DATE05/14/2026