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
KEYSTONE WOODS	2335 N MADISON AVE, ANDERSON, , 46011

(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 & 23, 2026 Facility number: 010409 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 1, 2026.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Keystone Woods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the	

			intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. • Whatcorrectiveaction(s) willbeaccomplishedfor thoseresidentsfoundto havebeenaffectedbythe deficientpractice; • Howthefacilitywillidentify otherresidentshavingthe potentialtobeaffectedby thesamedeficientpractice andwhatcorrectiveaction willbetaken; • Whatmeasureswillbeput intoplaceorwhatsystemic changesthefacilitywill maketoensurethatthe deficientpracticedoesnot recur; • Howthecorrective action(s)willbemonitored toensurethedeficient practicewillnotrecur,i.e. whatqualityassurance programwillbeputinto place?;and • By thedatethe systemic	

			changes will be completed.	
R 0351	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(c)(d) (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation, record review, and interview, the facility failed to ensure confidential resident records were kept in a secure location and accessible only to authorized persons for 53 of 53 residents residing in the facility. Findings include: During a random observation of a facility laundry room, across from the nurse's station, on 4/22/26 at 11:23 a.m., two large white binders were located on top of a base cabinet against the wall. The two large white binders were labeled, "Resident Care Plans" and "Resident Vitals". The "care plan" binder included every residents' care plan with a photo of each	R 0351	R 351 1. The binders labeled “Resident Care Plans” and “Resident Vitals” were immediately removed from the unsecured laundry room and relocated to a secured, locked area at the nurse’s station. All staff were immediately re-educated on proper storage, handling, and protection of confidential resident information in accordance with Community policy. 2. TheCommunityreviewed each resident’s recordto determinewhich residents, if any,could be affected by the alleged deficient practice. 3. All resident records (paper and electronic) will be stored in secure, locked locations when not in use. A designated access system has been implemented to ensure staff can access necessary information without compromising confidentiality. All staff have been re-educated on HIPAA and Community privacy	05/11/2026

	person. The care plan indicated the levels of care a resident required for activities of daily living (ADLs) such as ambulation, showering, and toileting. The "vitals" binder contained pages labeled for each resident and handwritten information for each vital sign, such blood pressure and temperature. There were no staff members present in the laundry room. The laundry room was unlocked. During an interview, on 4/22/26 at 11:30 a.m., the Director of Nursing (DON) indicated the "Resident Care Plans" binder and the "Resident Vitals" binder, each containing specific resident information, were routinely kept in the laundry room for staff to access and review. The laundry room remained unlocked. On 4/23/26 at 8:00 a.m., Qualified Medication Aide (QMA) 3 indicated the "Resident Care Plans" binder and the "Resident Vitals" binder which contain specific resident information were routinely kept in the laundry room for staff to access and review. The Certified Nursing Assistants (CNAs) needed access to these binders regularly. The binders weren't kept in the medication carts or at the nurse's station since those locations remained		policies, with ongoing education to occur upon hire and annually. 4. The Executive Director or designee will conduct twice weekly environmental rounds for 2 weeks, then Weekly audits for 4 weeks, and then monthly audits for 2 months. Audits will ensure no PHI is left unsecured and that proper storage procedures are followed. Results will be reviewed, and corrective action will be taken as needed. 5. Completion Date: 5/11/26	

	locked and not all staff had a key. On 4/23/26 at 12:15 p.m., CNA 4 was in the laundry room. The CNA indicated the "Resident Care Plans" binder, and the "Resident Vitals" binder were sometimes kept in the laundry room. Staff members would review the information in the binders and place them on top of the base cabinet in the corner as they completed laundry tasks. The binders contained resident-specific information for the type of care needed, for instance, how the resident took a shower or moved around. Sometimes, the binders were in the medication carts and sometimes they were at the nurse's station. Sometimes the staff would need to look around to locate them. During an interview, on 4/23/26 at 1:35 p.m., the DON indicated the facility's standard of practice was to ensure all resident records were secured and locked up. The "Resident Care Plans" binder and the "Resident Vitals" binders should be stored at the nurse's station and returned by the staff after using or updating the information. A current facility policy, revised 2024 and titled, "Protected Health Information Privacy and Security Policies", provided by			

	the Administrator on 4/23/26 at 12:07 p.m., indicated the following: "... 1. Premises and Workstations. The Facility shall physically secure all premises and provide physical Access to Facility premises and physical/electronic access to Workstations, and other Electronic Medical and other devices only to authorized Workforce... All Workstations, Electronic Media and other devices storing e-PHI shall be used in a secure environment at all times, subject to the supervisions of authorized Facility Workforce, and maintained in a locked office or other storage container when not in use..."			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities.	R 0383	Tag: R383 1. Resident 35's service plan was immediately reviewed and updated by the Wellness Director/Director of Nursing to include Documented mental health diagnoses and current psychiatric services. Resident-centered psychosocial interventions and supportive services are available within the community. Recreational,	05/06/2026

	(B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to coordinate service plans related to mental health needs with the resident's mental health care provider for 1 of 1 resident reviewed for mental health services. (Resident 35) Findings include: Resident 35's clinical record was reviewed on 4/23/26 at 9:15 a.m. Diagnoses included adjustment disorder with mixed anxiety, dementia, and schizophrenia. The resident was admitted to the facility on 9/27/23. The resident received Medicaid services. The resident received psychiatric services from an outside mental health service provider. A 12/4/25, "Pharmacist Report to Nursing", indicated Resident 35 had progress notes indicating she was being followed by a psychiatric provider but there were no psychiatric notes in the clinical record. Please clarify the resident was being followed by		socialization, and activity-based interventions tailored to the residents' preferences and needs. Monitoring parameters related to mood, behaviors, and psychiatric symptoms. The Community contacted the residents outside psychiatric provider to request collaboration and obtain documentation necessary for care coordination. The provider declined to release information or collaborate with the Community due to the resident's confidentiality preferences and the absence of authorization for communication. The resident was educated regarding the importance of coordination between the Community and outside psychiatric providers to support continuity of care and regulatory compliance. The resident was offered the opportunity to sign a release of information; however, participation remains voluntary in accordance with resident rights. Documentation of the facility's outreach efforts, resident education, and resident preferences has been added to the clinical record. 2. TheCommunityreviewed each resident's recordto determinewhich	

	a psychiatric provider and add psychiatric notes to the clinical record. Resident 35's psychiatric medications were due for dosage reduction evaluations. Please evaluate current orders and psychiatric symptoms and determine if trail reductions of any of the medications would be appropriate. If orders continue, please document rationale. The facility response was as follows: "had requested multiple times". A 1/29/25, mental health service care plan indicated Resident 35 had diagnoses of schizophrenia, a mood disorder, and anxiety. Mental health services were consulted, and she was currently being seen by an outside provider. Interventions included to encourage the resident to participate in activities, redirect as needed, and notify MD as needed (1/29/25). The care plan lacked documentation indicating input and/or cooperation from the mental health care provider. A current, 2/3/26, signed "Service Plan" indicated Resident 35 had needs under "disposition and behaviors". Resident 35 was under doctors' care for depression and was prescribed anti-depressant as well as anti-anxiety and anti-psychotic medications. The		residents, if any,could be affected by the alleged deficient practice. 3. The Community has revised its process for residents receiving outside psychiatric or mental health services to ensure appropriate coordination while respecting resident rights and confidentiality. The following measures were implemented upon admission and during service plan reviews, residents receiving outside mental health services will be identified. The Community will request resident consent to communicate with outside psychiatric and mental health providers through a signed Release of Information form. When consent is granted, the Wellness Director/designee will request visit notes, recommendations, and treatment plans from the provider. Coordinate incorporation of recommendations into the resident’s service plan. Document all communication attempts and received information in the clinical record. When a resident declines	

	objectives were to monitor for changes in condition and conduct a reappraisal as appropriate, encourage family support, and involve the resident in activity planning to meet needs and preferences. The resident's service plan lacked a plan of care developed in cooperation with their mental health services provider which included: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. The clinical record lacked notes and/or documentation from the outside mental health provider. During an interview on 4/23/26 at 10:47 a.m., the DON indicated Resident 35 saw an outside provider for her		authorization for communication the refusal will be documented in the clinical record. The residents will be educated regarding the benefits of coordinated care. Community staff will continue to monitor the residents' condition, behaviors, psychosocial needs, and participation in activities through internal assessments and observations. The facility updated education for licensed nursing staff and management regarding requirements under 410 IAC 16.2-5-11.1(g)(1-2) Documentation expectations for outside mental health coordination Resident rights related to confidentiality and self-direction. Required documentation of communication attempts and refusals 4. The Executive Director and/or Wellness Director will complete monthly audits for 3 months of residents receiving outside mental health services to ensure appropriate releases of information are obtained	

psychiatric services. The resident never brought any documentation or paperwork to the clinical staff. The DON indicated the facility had not reached out to the provider about the resident's care.

On 4/23/26 at 12:07 p.m., the Administrator indicated Resident 35's psychiatric provider advised her that the resident would need to provide them with any information or documentation. The resident printed up her last appointment notes and gave a copy to the Administrator.

During a follow-up interview, on 4/23/26 at 1:35 p.m., the DON indicated the standard of practice for the facility was to allow residents and/or resident representatives to handle all appointments, care, and treatment provided by an outside doctor. This resident had been leaving the facility to attend her psychiatric visits and was not bringing any documentation back to the facility for them to add to her care plans. The DON indicated Resident 35 did not have a mental health service plan that had been completed with the resident's mental health service provider.

A current facility policy, dated 8/23, titled, "Special Behaviors Operations Manual", provided

or refusals documented. Outreach to providers is documented when authorized. Service plans include individualized psychosocial and activity interventions. Documentation from outside providers, when available, is maintained in the clinical record. Audit findings will be reviewed during IDT meetings and additional corrective action will be implemented as needed to ensure ongoing compliance.

5. Completion Date: The systematic changes will be completed by 5/11/26

	by the Administrator on 4/23/26 at 12:07 p.m., indicated the following: "... 6. The Wellness Director and/or ED or designee should assist Residents, as needed, in coordinating access to appropriate providers for evaluation and/or treatment (e.g. psychologist, psychiatrist, social worker). Document such assistance in the Resident's Service Notes..."			

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 SIGNATUREKristin Johnson	TITLEExecutive Director	(X6) DATE05/13/2026