| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 05/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKDALE CARMEL | 301 EXECUTIVE DR, CARMEL, , 46032 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 467380.<br><br>Intake 467380-No deficiencies related to the allegations are cited.<br><br>Survey dates: May 1 and 4, 2026<br><br>Facility number: 010416<br><br>Residential Census: 29<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on May 7, 2026. | R 0000 | please see POC for annual survey | |
| R 0117 | Personnel - Deficiency<br><br>410 IAC 16.2-5-1.4(b)<br><br>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state | R 0117 | R117 | 05/20/2026 |

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| | laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.<br><br>Based on record review and interview, the facility failed to ensure staff on duty met the requirements of Cardiopulmonary Resuscitation (CPR) and first aid training for 19 of 21 shifts reviewed.<br><br>Findings include:<br><br>During a review of the staffing schedule and employee records on 5/4/25, the following shifts | | **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>No residents were adversely affected by the alleged deficiency.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken;**<br><br>All residents have the potential to be affected.<br><br>Health and Wellness Director and Executive Director personnel will be in-serviced on R 117 personnel- requirement that the facility will have one awake staff member at all times with CPR and first aid certificates.<br><br>**What measures will be put into place or what systemic changes that facility will make to ensure that the deficient practice does not recur;**<br><br>An audit will be conducted by HWD and ED to identify which employees are currently CPR and first aid certified, this audit will be compared to the schedule weekly to ensure compliance with this rule.<br><br>**How the corrective actions(s)** | |

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| | did not have appropriate CPR and/or first aid coverage:<br><br>On 4/26/26, the facility was unable to provide CPR certifications for the staff who had worked the night shift and was unable to provide first aid certification for the staff who had worked the day, evening and night shift.<br><br>On 4/27/26, the facility was unable to provide CPR certifications for the staff who had worked the night shift and was unable to provide first aid certification for the staff who had worked the day, evening and night shift.<br><br>On 4/28/26, the facility was unable to provide CPR certifications for the staff who had worked the day and evening shift and were unable to provide first aid certification for the staff who had worked the day, evening and night shift.<br><br>On 4/29/26, the facility was unable to provide CPR certifications for the staff who had worked the night shift and was unable to provide first aid certification for the staff who had worked the day, evening and night shift.<br><br>On 4/30/26, the facility was unable to provide CPR certifications for the staff who had worked the day, evening | | **will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>Audits will be conducted by HR director biweekly for 3 months then monthly for 3 months and reviewed during the community safety meeting to ensure compliance with scheduling staff that are CPR and first aid certified.<br><br>Completion Date: 5-20-2026 | |

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| | and night shift and were unable to provide first aid certification for the staff who had worked the day, evening and night shift.<br><br>On 5/1/26, the facility was unable to provide CPR certifications for the staff who had worked the day, evening and night shift and were unable to provide first aid certification for the staff who had worked the day and evening shift.<br><br>On 5/2/26, the facility was unable to provide CPR certifications for the staff who had worked the day, evening and night shift and were unable to provide first aid certifications for the staff who had worked the day and evening shift.<br><br>During an interview, on 5/4/26 at 11:49 a.m., the Executive Director indicated Human Resources did not obtain copies of all first aid cards. The employees were to take them to the facility. He indicated the facility followed the State of Indiana regulations and he had no other first aid cards to provide.<br><br>During an interview, on 5/4/26 at 12:03 p.m., the Executive Director indicated he did not have any other CPR cards to provide.<br><br>A current facility policy, titled "CPR Policy-States Requiring | | | |

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| | Certification RR-7", dated as last reviewed 4/26 and received from Receptionist 5 on 5/4/26 at 12:24 p.m., indicated "...An associate certified in cardiopulmonary resuscitation (CPR) will perform CPR...." The policy indicated Indiana was a state which required certification in CPR.<br><br>During the exit conference, on 5/4/26 beginning at 1:54 p.m., the Executive Director indicated he did not have any other policies to provide. | | | |
| R 0118 | Personnel - Deficiency<br><br>410 IAC 16.2-5-1.4(c)<br><br>(c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.<br><br>Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had a valid certification for 1 of 34 employees reviewed for a | R 0118 | **R118**<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>No residents were adversely affected by the alleged deficiency<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken;**<br><br>All residents have the potential to be affected.<br><br>Health and Wellness Director and Human Resource Director | 05/20/2026 |

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| | license or certification. (CNA 8)<br><br>Findings include:<br><br>The employee records were reviewed on 5/4/26 at 8:15 a.m. The facility also provided a binder which included all the staff licensures and certifications.<br><br>CNA 8's certified nursing assistant certification expired on 12/3/25.<br><br>CNA 8's timecard, from 12/3/25 to 12/30/25, indicated CNA 8 had worked 18 shifts as a CNA with an expired certification.<br><br>During an interview, on 5/4/26 at 11:56 a.m., the Director of Nursing (DON) indicated all nursing staff required an active state license or certification. The DON reviewed CNA 8's certification and indicated she was not aware it had expired.<br><br>During an interview, on 5/4/26 at 12:18 p.m., the Executive Director (ED) indicated CNA 8 had been on leave from work since 12/31/25 after a foot injury and had been on light duty since returning to work. The ED asked the receptionist if CNA 8 had clocked in and worked as a CNA from 12/3/25 to 12/30/25. The receptionist stated, "according to the timecard, yes." The ED pointed to the receptionist when asked who | | will be in-serviced by ED on R118 Personnel- to ensure all license and certifications are valid and current to meet the requirement and any personnel who do not have current license and or certification will not be put on schedule to work.<br><br>**What measures will be put into place or what systemic changes that facility will make to ensure that the deficient practice does not recur;**<br><br>An audit is being conducted by HR director to identify that all license and certifications are current and any personnel who does not have valid license or certification will not be put on schedule to work.<br><br>**How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>Audits will be conducted monthly by HR director for 6 months with all results will be reviewed by ED and HWD discussed monthly in the quality assurance meeting.<br><br>Completion Date: 5-20-2026 | |

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| | was responsible for ensuring licenses and certifications were not expired.<br><br>During an interview, on 5/4/26 at 12:20 p.m., the receptionist indicated nursing would inform her when a license would be expiring. She would inform the employee to renew their license/certification before the expiration date, but most of the time, the employee would renew the license without needing to be notified.<br><br>During an interview, on 5/4/26 at 11:49 a.m., the Executive Director indicated the facility followed all state regulations.<br><br>A facility document, titled "Certified Nursing Assistant (CNA)," dated 11/2014 and received from the receptionist on 5/4/26 at 11:24 a.m., indicated "...Provides direct care to residents...Promotes quality services within community standards, State and Federal Regulations...Certification of completing an approved Certified Nursing Assistant is required...Successful completion of State C.N.A. course...." | | | |
| R 0119 | Personnel - Noncompliance<br><br>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- | R 0119 | R119<br><br>**What corrective action(s) will be accomplished for those** | 05/20/2026 |

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| | (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:<br><br>(1) Instructions on the needs of the specialized populations:<br><br>(A) aged;<br><br>(B) developmentally disabled;<br><br>(C) mentally ill;<br><br>(D) dementia; or<br><br>(E) children;<br><br>served in the facility.<br><br>(2) A review of the facility's policy manual and applicable procedures, including:<br><br>(A) organization chart;<br><br>(B) personnel policies;<br><br>(C) appearance and grooming policies for employees; and<br><br>(D) residents' rights.<br><br>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.<br><br>(4) Review of ethical considerations and confidentiality in resident care and records.<br><br>(5) For direct care staff, personal | | **residents found to be affected by the deficient practice;**<br><br>No residents were adversely affected by the alleged deficiency<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken;**<br><br>All residents have the potential to be affected.<br><br>Health and Wellness Director and Human Director will be in-service by ED on R119 personnel- on ensuring job orientation specific are being completed with documentation and kept in employee files to meet the requirement.<br><br>**What measures will be put into place or what systemic changes that facility will make to ensure that the deficient practice does not recur;**<br><br>Business office manager and Health and Wellness director will audit will be done ensure compliance is obtained on making sure LPN orientation and CNA orientation job specific check list is done to meet requirements.<br><br>**How the corrective actions(s) will be monitored to ensure** | |

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| | introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.<br><br>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.<br><br>Based on interview and record review, the facility failed to ensure job specific orientations were completed and documented in the employee's file for 2 of 5 employee's reviewed for employee records. (CNA 6 and LPN 7)<br><br>Findings include:<br><br>The employee records were reviewed on 5/4/26 at 8:15 a.m.<br><br>1. Certified Nursing Assistant (CNA) 6 was hired on 1/16/26. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire.<br><br>2. Licenses Practical Nurse (LPN) 7 was hired on 2/10/26. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire.<br><br>During an interview, on 5/4/26 at 10:15 a.m., the receptionist indicated all employees should | | **the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>ED, HWD with review compliance based on monthly audits monthly for 6 months ,Compliance will be reviewed during monthly QA meetings.<br><br>Completion Date: 5-20-2026 | |

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| | have a job specific orientation on file. The facility was unable to find CNA 6's or LPN 7's job specific orientation documents.<br><br>During an interview, on 5/4/26 at 11:49 a.m., the Executive Director indicated the facility followed all state regulations.<br><br>A current facility policy, titled "Training-New Hire and Annual," last revised 5/2025 and received from the receptionist on 5/4/26 at 12:25 p.m., did not include instruction on job specific orientation. | | | |
| R 0121 | Personnel - Noncompliance<br><br>410 IAC 16.2-5-1.4(f)(1-4)<br><br>(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:<br><br>(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 | R 0121 | R121<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>No residents were adversely affected by the alleged deficiency<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice**; All residents have the potential to be affected<br><br>Health and Wellness Director and Human Resource Director, | 05/20/2026 |

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| | prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br><br>(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.<br><br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.<br><br>(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.<br><br>Based on interview and record review, the facility failed to ensure employees received a second-step tuberculosis (TB) test and failed to include the time the tests were administered and read for 2 of 5 employees reviewed for health screenings. (CNA 6 and LPN 7) | | will be in-service by ED on R121- on ensuring all employees received second-step TB test with time test and documentation provided to meet requirements with regulations.<br><br>**What measures will be put into place or what systemic changes that facility will make to ensure that the deficient practice does not recur;**<br><br>Audits are being done by Health and Wellness Director and Human Resource director on all employee files and those identified during the survey to ensure the facility meets requirement and compliance on the TB first and second steps with documentation.<br><br>**How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>HWD and HR director will audit employee files monthly for 6 months, and reviewed during monthly QA meetings to ensure compliance is maintained.<br><br>Completion Date: 5-20-2026 | |

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| | Findings include:<br><br>The employee records were reviewed on 5/4/26 at 8:15 a.m.<br><br>1. Certified Nursing Assistant (CNA) 6 was hired on 1/16/26.<br><br>An associate health record, dated 1/15/26, indicated CNA 6 received a first and second step tuberculosis test. The documentation for the administration did not include a time the tests were administered or read.<br><br>2. License Practical Nurse (LPN) 7 was hired on 2/10/26.<br><br>An associate health record, dated 2/10/26, indicated LPN 7 received a first step tuberculosis test. The documentation for the administration did not include a time the test was administered or read. The document did not include a second step test.<br><br>During an interview, on 5/4/26 at 9:25 a.m., the receptionist indicated the facility only completed one tuberculosis test when an employee was hired.<br><br>During an interview, on 5/4/26 at 11:42 a.m., the Director of Nursing (DON) indicated she administered the tuberculosis tests for employees. The tests would be read 48 to 72 hours after being administered. She would need to review the | | | |

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| | facility's policy to determine if an employee would need to have a second step test.<br><br>During an interview, on 5/4/26 at 11:49 a.m., the Executive Director indicated the facility followed all state regulations.<br><br>A current facility policy, titled "Tuberculosis /Health Screening," last revised 4/2025 and received from the receptionist on 5/4/26 at 12:25 p.m., indicated "...The agency should ensure that direct care workers/associates, prior to client/consumer contact, provide documentation that the individual has been screened for and is free from active mycobacterium tuberculosis [(TB)]. The screening should be conducted in accordance with Centers for Disease Control [(CDC)] guidelines for preventing the transmission of TB in health care settings. The documentation should indicate the date of the screening which may not be more than one [(1)] year prior to the individual's start date...TB screenings for settings classified as low risk include...receiving a baseline TB tine test upon hire...using a two-step Tuberculin Skin Test [(TST)]...If using the two step TST test, a worker whose first test result is negative may begin to work immediately, but the second Purified Protein | | | |

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| | Derivative [(PPD)] should be administered between one [(1)] an three [(3)] weeks after the first PPD to continue working...." | | | |
| R 0214 | Evaluation - Deficiency<br><br>410 IAC 16.2-5-2(a)<br><br>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.<br><br>Based on interview and record review, the facility failed to ensure an evaluation of the individual needs of the residents was completed prior to admission and updated semiannually for 1 of 7 residents reviewed for evaluations. (Resident 70).<br><br>Findings include:<br><br>The clinical record for Resident 70 was reviewed on 5/1/26 at 1:15 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and pneumonia. | R 0214 | R214<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>R70 is no longer a resident at the community<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>All residents have the potential to be affected<br><br>HWD will be in-service by ED on R214 regulation to ensure compliance is maintained and pre-admission evaluations are done on all new resident's needs.<br><br>**What measures will be put into place or what systemic changes that facility will make to ensure that the deficient practice does not recur;**<br><br>Audits will be done by HWD and ED to ensure all new resident's pre-evaluations and documented are done for new admissions. | 05/20/2026 |

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| | Resident 70 was admitted on 1/7/25 and discharged on 2/15/26.<br><br>The medical record did not include a pre-admission evaluation, admission evaluation, or semi-annual evaluation of the resident. All resident evaluations were requested on 5/1/26 and 5/4/26.<br><br>During an interview, on 5/4/26 at 9:45 a.m., the Executive Director (ED) indicated the facility was unable to find most of the paper chart for Resident 70.<br><br>During an interview, on 5/4/26 at 1:05 p.m., the Director of Nursing (DON) indicated she was unable to provide any evaluations for Resident 70. The facility should evaluate all residents and document in the medical record.<br><br>A current facility policy, titled "Admission Move in Review Criteria Policy," dated 9/2021 and provided by the Executive Director on 5/4/26 at 11:54 a.m., indicated "...the pre-admission review process...should occur as soon as possible after the referral has been received so a timely and prompt decision can be made...."<br><br>A current facility policy, titled "Evaluation Process Policy," dated 3/2026 and provided by | | **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>Audits will be done by HWD and ED weekly for 1 month and biweekly for 2 months, and monthly for 3 months. All results will be reviewed monthly for compliance in QA meetings.<br><br>Completion Date: 5-20-2026 | |

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| | the Receptionist on 5/4/26 at 12:25 p.m., indicated "...should complete an evaluation...at move-in, within 14-30 days after move-in, every 6 months...the original forms signed by...responsible party. The signed forms should be placed in the resident record...resident evaluations should be stored and retained...." | | | |
| R 0216 | Evaluation - Noncompliance<br><br>410 IAC 16.2-5-2(c)(1-4)(d)<br><br>(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:<br><br>(1) The resident ' s physical, cognitive, and mental status.<br><br>(2) The resident ' s independence in the activities of daily living.<br><br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br><br>(4) If applicable, the resident ' s ability to self-administer medications.<br><br>(d) The evaluation shall be documented in writing and kept in the facility.<br><br>Based on interview and record review, the facility failed to | R 0216 | R216<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>R70 is no longer a resident at the community<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>All residents have the potential to be affected.<br><br>HWD will be in-serviced by ED on R216 regulation to ensure compliance is maintained on new admissions evaluations and semi-annually with documentation are done on new residents.<br><br>**What measures will be put into place or what systemic** | 05/20/2026 |

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| | ensure a resident's status was evaluated at admission and semi-annually and the assessment was documented in writing and kept in the facility medical record for 1 of 7 residents reviewed resident assessments. (Resident 70)<br><br>Findings include:<br><br>The clinical record for Resident 70 was reviewed on 5/1/26 at 1:15 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and pneumonia.<br><br>Resident 70 was admitted on 1/7/25 and discharged on 2/15/26.<br><br>The medical record did not include an admission evaluation, or semi-annual evaluation of the resident's physical, mental, or emotional function status. All resident evaluations were requested on 5/1/26 and 5/4/26.<br><br>During an interview, on 5/4/26 at 9:45 a.m., the Executive Director indicated the facility was unable to find most of the paper chart for Resident 70.<br><br>During an interview, on 5/4/26 at 1:05 p.m., the Director of Nursing indicated she was unable to provide any evaluations for Resident 70 and the facility should evaluate all | | **changes that facility will make to ensure that the deficient practice does not recur;**<br><br>An audit HWD and ED will be done to ensure all new resident's assessments are done upon admissions and semi-annually.<br><br>**How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>Audits will be done weekly by HWD and ED for 1 month, then biweekly for 2 months, then for 3 months. All results will be reviewed monthly for compliance in QA meetings.<br><br>Completion Date: 5-20-2026 | |

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| | residents and document in the medical record.<br><br>A current facility policy, titled "Evaluation Process Policy," dated 3/2026 and provided by the Receptionist on 5/4/26 at 12:25 p.m., indicated "...should complete an evaluation...at move-in, within 14-30 days after move-in, every 6 months...the original forms signed by...responsible party. The signed forms should be placed in the resident record...resident evaluations should be stored and retained...." | | | |
| R 0217 | Evaluation - Deficiency<br><br>410 IAC 16.2-5-2(e)(1-5)<br><br>(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:<br><br>(1) The services offered to the individual resident shall be appropriate to the:<br><br>(A) scope;<br><br>(B) frequency;<br><br>(C) need; and<br><br>(D) preference;<br><br>of the resident.<br><br>(2) The services offered shall be | R 0217 | R217<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>Resident 60 and 70 no longer residents at the community. Resident 40 service plan was signed.<br><br>**What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice;**<br><br>All residents have the potential to be affected<br><br>HWD will be in-serviced by ED on R217 on ensuring this practice is followed to ensure compliance is maintained per | 05/20/2026 |

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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.<br><br>(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.<br><br>(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.<br><br>(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.<br><br>2. The clinical record for Resident 70 was reviewed on 5/1/26 at 1:15 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and pneumonia.<br><br>Resident 70 was admitted on 1/7/25 and discharged on 2/15/26.<br><br>The medical record did not include a signed service plan. A service plan was requested on 5/1/26 and 5/4/26. | | the regulation and all service plans are signed by resident and or resident's representative.<br><br>**What measures will be put into place or what systemic changes that facility will make to ensure that the deficient practice does not recur;**<br><br>Audit will be done by HWD and ED to ensure the most current service plans have signatures.<br><br>**How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place;**<br><br>Audits will be done weekly for 1 month, then biweekly for 2 months and then monthly for 3 months by HWD and ED. All results will be reviewed monthly for compliance in QA meetings.<br><br>Completion Date: 5-20-2026 | |

During an interview, on 5/4/26 at 9:45 a.m., the Executive Director indicated the facility was unable to find most of the paper chart for Resident 70.

3. The clinical record for Resident 60 was reviewed on 5/1/26 at 10:45 a.m. The diagnoses included, but were not limited to, mild dementia with behavioral disturbance, anxiety disorder, and chronic obstructive pulmonary disorder (COPD).

The medical record did not include a signed service plan. A service plan was requested on 5/1/26 and 5/4/26.

During an interview, on 5/4/26 at 1:05 p.m., the DON indicated she was unable to provide any service plan for the residents and the facility needed to complete service plans for all residents.

A current facility policy, titled "Service Plan Process Policy," dated 3/2026 and provided by the Receptionist on 5/4/26 at 12:25 p.m., indicated "...An initial service plan should be developed...on move in/ admission...The service plan should be reviewed and revised as necessary...as required by state regulations...copies of the service plan should be stored and retained...."

Based on interview and record review, the facility failed to ensure service plans were signed by the resident or the resident's representative for 3 of 7 residents reviewed for service plans. (Resident 40, 70 and 60)

Findings include:

1. The clinical record for Resident 40 was reviewed on 5/1/26 at 11:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease (a progressive condition affecting memory and cognition), essential hypertension, and major depressive disorder.

A service plan, dated 1/5/26, was present in the clinical record, but was not signed or dated by the resident or the resident's representative.

During an interview, on 5/4/26 at 10:11 a.m., the Director of Nursing (DON) indicated she could not find the signed service plan and the resident or resident representative should have signed it.

During an interview, on 5/4/26 at 11:30 a.m., the DON indicated she still could not locate the signed service plan.

| | | |
|---|---|---|
| instructions.) | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURERick | TITLEWalworth | (X6) DATE05/26/2026 |