STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF MARION, LLC	2452 W KEM RD, MARION, , 46952

(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: June 11 and 12, 2026 Facility number: 010682 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 19, 2026.	R 0000		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on	R 0117	R117- Personnel Deficiency CPR/First Aide • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Facility immediately made corrections to the schedule to ensure that the facility had a	06/23/2026

	skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure first-aid certified staff were on site for eight of forty-two shifts reviewed for staffing. Findings include: A review of staffing scheduled for the prior seven days, provided by the Administrator, was completed on 6/11/26 and indicated the following: On 6/4/26, no first-aid certified staff were present for first shift. On 6/5/26, no first-aid certified		minimum of one (1) awake staff person, with current CPR and first aid certificates, on site at all times. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to have been affected by the alleged deficient practice. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Facility scheduled a CPR/First Aide class for all nursing personnel. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. A CPR/First Aide Audit Tool has been created to ensure that facility will monitor nursing personnel CPR/First Aide expirations, so that this deficient practice will not occur again. The audit tool with be monitored monthly ongoing.	

	staff were present for first shift. On 6/6/26, no first-aid certified staff were present for first shift. On 6/7/26, no first-aid certified staff were present for first shift. On 6/8/26, no first-aid certified staff were present for first or third shift. On 6/9/26, no first-aid certified staff were present for first shift. On 6/10/26, no first-aid certified staff were present for first shift. During an interview, on 6/12/26 at 10:50 a.m., the Administrator indicated that due to staff turnover, not every shift was covered with a certified first-aid staff member. A current facility policy, undated, titled "Cardiopulmonary Resuscitation (CPR) and First Aid Certification Policy," provided by the DON on 6/12/26 at 1:28 p.m., indicated the following: " ...The facility shall ensure that at least one (1) awake staff member with current certification in Cardiopulmonary Resuscitation (CPR) and First Aid is on duty and physically present within the facility twenty-four (24) hours per day, seven (7) days per week ...."		• By what date the systemic changes will be completed. 7/13/26	

R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat 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.	R 0121	R121- Personnel Deficiency Noncompliance of TB • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this deficient practice. The 3 employees found to not have TB documentation on file, a TB test was administered and TB symptom questionnaire was completed and added to the file. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No residents were affected by this deficient practice. However, facility educated administrative staff on the TB policy regarding new hire TB monitoring procedures. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Effective immediately all administrative staff/HR staff were educated on TB policy to ensure this deficient practice does not happen again.	06/23/2026

	(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 accurately document the administration and results of mandatory tuberculin skin tests (TST) performed on 3 of 5 new employee files reviewed. (LPN 4, CNA 5, LPN 6) Findings include: Employee records were reviewed on 6/11/26 3:30 p.m. and indicated the following: A "Mantoux Tuberculin Skin Test Record" form for LPN 4 indicated a first step tuberculin (TB) test was read on 1/7/26. A second step TB test was administered on 2/2/26. The record reflected the second step TB test was administered after the 7-21-day timeframe. A "Mantoux Tuberculin Skin Test Record" form for CNA 5 indicated a second step TB test was administered on 2/2/26 and		• How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A Tuberculosis audit tool has been created to ensure all new hires receive the administration and results of the mandatory tuberculin skin tests. The Audit tool will be monitored monthly ongoing. • By what date the systemic changes will be completed. 7/1/26	

	the results were zero millimeters. The record lacked the date and time the TB test was read. A "Mantoux Tuberculin Skin Test Record" form for LPN 6 indicated a second step TB test was administered on 2/17/26. The record lacked documented results for date, time, and induration. During an interview, on 6/11/26 at 3:00 p.m., the DON indicated TB tests were to be read 48-72 hours after administration and the second step TB test was to be administered two weeks after the first step was given. She confirmed the documentation errors on LPN 4, CNA 5, and LPN 6's "Mantoux Tubercullin Skin Test Record" forms. During an interview, on 6/12/26 at 9:42 a.m., the DON indicated the facility did not have a TB policy specific for employees. They used the resident TB policy and employee handbook as guidance for employee TB testing. A current policy, dated 9/08, titled "Resident Screening for Tuberculosis", provided by the Administrator on 6/12/26 at 9:51 a.m., indicated the following: "Policy" ...(e) ... a tuberculin skin test shall be... 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) ...who have not had a documented negative tuberculin test result during the preceding twelve (12) months, the baseline tuberculin test should employ the two-step method. If the first step is negative, a second step should be performed within one (1) to three (3) weeks after the first test ...."			
R 0150	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(g) (g) Each facility shall have a policy concerning pets. Based on interview and record review, the facility failed to ensure 4 of 7 pets living with residents in the facility had received their required immunizations. Finding includes: Pet immunizations records for the facility were reviewed on 6/12/26 at 11:50 a.m. The records indicated the following:	R 0150	R150- Sanitation and Safety Standards • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The 4 pets that did not have updated vet records on file have since had their proper immunization and documentation was added to their file. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to have been affected by the alleged deficient practice.	06/23/2026

	Resident 75 had two cats and signed a separate pet agreement for each. The first agreement was signed on 4/28/23 and indicated the type of pet, breed, and pet's name. The pet's age, color, and license number was blank. Vaccination dates listed was 8/8/24. Another pet agreement was signed on 4/20/24. The type, breed, pet's name, and color was listed on the agreement. The pet's age, license number, and vaccination dates were blank. A "Rabies Vaccination Certificate" for a male cat indicated the pet was vaccinated on 9/5/24 and the next vaccination was due by 9/5/25. A "Feline Health Record" indicated the other pet received a combination vaccination for rhinotracheitis, calicivirus, and distemper on 4/20/24. No health records were received for the first pet reviewed. Resident 67 signed a pet agreement on 2/3/25. The agreement indicated the pet was a two-year-old cat. The agreement lacked the pet's license number and vaccination dates. A "Vaccination Certificate" indicated the pet received a rabies vaccination on 2/7/25 and the vaccine expired on 2/7/26. Resident 25 signed a pet agreement on 7/29/25. The agreement indicated the		• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Facility immediately educated all administrative staff on required pet documentation. Facility will ensure all further admission who sign pet agreement will have all pet documentation prior pet being admitted to facility. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Facility audited all pet agreements to ensure that vaccinations are in compliance state and federal regulations. A Pet Audit tool will be held in the business office and updated with new pet additions as well as current. The Audit tool will be monitored monthly ongoing to ensure compliance by the ED or designee. • By what date the systemic changes will be completed. 7/15/26	

	following: type, breed, and pet's name. The pet's age, color, license number, and vaccination dates were blank. A medical visit note, dated 10/30/24, indicated the pet received a rabies vaccination on 10/29/24 and the next rabies vaccination was due on 10/30/25. During an interview, on 6/12/26 at 1:24 p.m., the Administrator indicated four of the seven pets residing in the facility were not up to date on their vaccinations. She personally checked with Residents 25, 67, and 75 regarding updated vaccination records and the three residents indicated they did not have updated information. A current policy, revised 1/2017, titled "Pet Policy", provided by the Administrator on 6/12/26 at 12:47 p.m., indicated the following: "Policy:..In conjunction with 410 I AC 16.2-5-1.5(g) this community will have a policy regarding pets. Any pet within the community will have periodic veterinary examinations and required immunizations in conjunction with 410 IC 16.2 -5-1.5(h). Procedure:..2. Upon signing a residency agreement or upon obtaining the pet the resident or legal representative will sign the Pet Agreement, which indicates acknowledgement that the resident will be accountable for			

	the care and actions of the pet within the community ...3. The following criteria must be met in order for pets to be accepted and retained within the community. Pets must have current vaccinations. Required vaccinations will be rabies, Bordetella, distemper, and parvovirus.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.	R 0217	**217** • Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The services plan for the two residents noted were immediately reviewed and signed or sent for signature. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	06/23/2026

	(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 reviewed with the resident and/or their representative and acknowledged by signature for 2 of 7 residents reviewed for service plans. (Residents 41 and 81) Findings include: Resident 41's clinical record was reviewed on 6/11/26 at 11:45 a.m. Diagnoses included hypertension, diabetes, and insomnia. Resident 41's record indicated she was admitted to the facility on 4/28/26. A service plan was completed on 4/29/26. The service plan lacked a resident or		Any residents have the potential to be affected by the alleged deficient practice. All resident service plans were reviewed by the Director of Nursing to ensure signatures are/were obtained. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Director of Nursing will do regular audits on service plans which will include review of falls, frequency of needs, preferences of needs and all-over general person-centered care for residents' service plans. The DON will then ensure upon update that service plans are signed by the resident or authorized representative. A Service Plan Audit Tool has been created to ensure timely completion and ensure service plans are reviewed with the residents and/or their representative and acknowledged by signature. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and A Service Plan Audit Tool has been created to ensure timely	

	resident representative signature. Resident 81's clinical record was reviewed on 6/12/26 at 10:05 a.m. Diagnoses included dementia, need for assistance with personal care, and congestive heart failure. A service plan was completed for Resident 81 on 1/29/26. The service plan indicated Resident 81 had a decline in her functional status and required more assistance. The service plan lacked a resident or resident representative signature. During an interview, on 6/12/26 at 12:16 p.m., the DON indicated Resident 41 did not have a signed service plan. During an interview, on 6/12/26 at 12:20 p.m., the Administrator indicated service plans were to be completed upon a resident's admission to the facility and with a change of condition.		completion and ensure service plans are reviewed with the resident and/or their representative and acknowledged by signature. The audit tool will be monitored monthly and ongoing to ensure compliance. • By what date the systemic changes will be completed. 7/1/26	

	During an interview, on 6/12/26 at 1:40 p.m., the DON indicated Resident 81 had a level of care assessment completed on 1/29/26 which indicated Resident 81 needed more assistance. An updated service plan was not signed by the resident or her representative in regard to the changes that were made. A facility policy, dated 4/2015, titled "Service Plan Process Policy - CS-70-3", provided by the Administrator on 6/15/26 at 3:46 p.m., indicated the following: "Policy Overview: Individual resident service plans are developed through the evaluation process or other identified systems and provide information about the residents needs to the care associates. Service plans are implemented and maintained for each resident to address these needs. Policy Detail: 1) An initial Service plan should be developed by an appropriately trained Brookdale associate on move in/admission. The resident and/or their responsible party may participate in the development of the resident's service plan...3) The Service plan should be completed and reviewed by the community care team and the resident/legally responsible party within 14 to 30 days after move-in of the resident or as required by state			

	regulations ...."			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation and interview, the facility failed to ensure accurate medication administration for 1 of 5 residents reviewed (Resident 52). Findings include: During a medication administration observation, on 6/11/26 at 11:19 a.m., accompanied by LPN 6, the following was observed: LPN 3 placed a needle onto an insulin pen without cleaning the needle attachment area. After administering the insulin, LPN 6 removed her gloves before leaving the room and, once in the hallway, removed the used needle from the pen bare handed and disposed of the needle in the sharps container. During an interview at the time of observation, LPN 6 indicated	R 0296	**R296** • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The associate who administered the insulin was immediately re-educated on insulin preparation and administration. •How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No additional residents were found to have been affected by the alleged deficient practice. •What measures will be put into place or what systemic changes the facility made to ensure that the deficient practice does not recur. All staff licensed to give insulin pen injections have been reeducated on "Insulin preparation and Administration" to ensure compliance. The 3rd shift nurse/QMA is completing a nightly medication cart audit to ensure all	06/23/2026

	she should have cleaned the syringe before attaching the needle and should have kept her gloves on while removing the used needle. During an interview, on 6/11/26 at 1:25 p.m., the DON indicated LPN 6 should have cleaned the pen before attaching the needle and should have worn gloves when removing the needle after administration. A current facility policy, dated 2/22/22, titled "Insulin preparation and Administration," provided by the DON, on 6/11/26 at 2:00 p.m., indicated the following: "...8. Insulin Pen Procedure. Remove cap from the insulin pen and wipe needle attachment area briskly with alcohol swab ...."		equipment needed is available and all insulins/meds are dated and communicating any concerns to the DON or designee. •How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and An Insulin Administration audit tool has been created, and the Director of Nursing or designee will compete random medication administration checks with staff to ensure proper administration of insulin. The audit will be completed 2x weekly X 1 week, weekly x 2 weeks then monthly thereafter until the deficient practice does not recur. •By what date the systemic changes will be completed. 7/1/26	
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	R 0298	**R 298 Pharmaceutical Services** • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	06/23/2026

	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. A. Based on record review and interview, the facility failed to ensure shift to shift narcotic count and reconciliation was completed for 3 of 3 carts reviewed for medication reconciliation. (B Hall, C Hall and D Hall). B. Based on observation and staff interview, the facility failed to ensure medications were stored in a manner to prevent loose pills in the medication cart drawers for 1 of 1 medication carts reviewed for medication storage. Findings include: A1. During a medication storage observation of B Hall medication cart, on 6/11/26 at 11:32 a.m., accompanied by LPN 6, the "Controlled Substance Change		All residents had the potential to be affected by the alleged deficient practice. The loose pills in the cart were immediately removed from the cart and destroyed. Staff was immediately reeducated on the requirement of counting their carts at shift change. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to be affected by the alleged deficient practice. The loose pills in the cart were immediately removed from the cart and destroyed. Staff were immediately reeducated on the requirement of counting their carts at shift change. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. DON immediately checked the carts for additional loose pills and none were found.	

	of Shift Audit sheets" were reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: May 2026- lacked shift to shift narcotic reconciliation signatures: May 6th: second shift May 9th: second shift May 13th: second shift May 25th: second shift June 2026- lacked shift to shift narcotic reconciliation signatures: June 1st: second shift June 3rd: second shift June 5th: third shift June 9th: second shift During an interview, on 6/11/26 at 11:34 a.m., LPN 6 indicated that oncoming and offgoing signature sheets were missing signatures. The sheets were to be signed every shift by both oncoming and offgoing staff members. A2. During a medication storage observation of C Hall medication cart, on 6/11/26 at 11:54 a.m., accompanied by LPN 3, the "Controlled Substance Change		Staff education immediately initiated and ongoing over expectation of counting the carts. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A med cart audit tool will be completed weekly x 1 month then monthly X 3 months to ensure no loose pills are in the cart and that staff are always counting their narcotic drawer and signing off at each shift. • By what date the systemic changes will be completed. 7/1/26	

	of Shift Audit sheets" were reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: May 2026- lacked shift to shift narcotic reconciliation signatures: May 10th: third shift May 11th: first shift May 12th: first shift May 13th: first shift May 14th: first shift May 24th: first shift May 26th: second shift April 2026- lacked shift to shift narcotic reconciliation signatures: April 7th: first and second shift April 10th: third shift April 11th: first shift During an interview, on 6/11/26 at 11:56 a.m., LPN 3 indicated it was expected for staff to sign the narcotic shift-to-shift signature sheets at the start and end of each shift. During an interview, on 6/11/26 at 11:57 a.m., QMA 7 indicated staff were required to sign in at			

	the beginning and end of their shift and signatures confirmed narcotic punch pack numbers matched the sign-out sheets for the resident medications. A3. During a medication storage observation of D Hall medication cart, on 6/11/26 at 12:00 p.m., the "Controlled Substance Change of Shift Audit sheets" were reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: May 2026- lacked shift to shift narcotic reconciliation signatures: May 23rd: third shift May 24th: first shift May 25th: first and second shift May 26th: second shift May 31st: third shift June 2026- lacked shift to shift narcotic reconciliation signatures: June 1st: first, second and third shift June 2nd: first and third shift June 3rd: first and second shift June 4th: first and second shift			

	June 5th: first and third shift June 6th: first and second shift June 8th: first shift June 9th: first and second shift June 10th: first shift During an interview, on 6/11/26 at 1:18 p.m., the Administrator indicated that shift-to-shift oncoming and offgoing narcotic count sheets were missing staff signatures. During an interview, on 6/11/26 at 1:25 p.m., the DON indicated staff were required to sign oncoming and offgoing shift-to-shift counts at the beginning and end of their shifts, and the narcotic count sheets were missing staff signatures. A current facility policy, dated 3/1/14, titled "Medication Treatment-Storage," provided by the Administrator, on 6/12/26 at 2:24 p.m., indicated the following: "...1. Medications and treatments stored by the community are to be stored in designated locations that must be locked when not in use or when unattended. The designated area should be clean and orderly ...." B. During a medication storage observation of the B Hall			

	medication cart, on 6/11/28 at 11:32 a.m., accompanied by LPN 6, the following was observed: The left third drawer contained one loose blue oblong pill and one loose white round pill with the marking "50". The left fourth drawer contained one loose light yellow oblong pill with the marking "I51", a peach-red pill with illegible markings, and a small loose white round pill at the back of the drawer. The right third drawer contained a loose red-and-blue capsule marked "L5" and a loose long white oblong pill with the marking "L484". LPN 6 indicated that medication carts were cleaned during third shift and any loose pills were placed into a drug buster solution (liquid solution that destroys pills). During an interview, on 6/11/26 at 1:25 p.m., the ADON indicated third was responsible for nightly medication cart cleaning and that any loose medications were to be destroyed using the drug buster solution. A current facility policy, dated 3/1/14, titled "Medication Treatment-Storage," provided			

	by the DON, on 6/11/26 at 2:00 p.m., indicated the following: "...1. Medications and treatments stored by the community are to be stored in designated locations that must be locked when not in use or when unattended. The designated area should be clean and orderly ...."			
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 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.	R 0410	**R0410- Infection Control** • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The 2 residents found to not have TB documentation on file had their 1st and 2nd step TB test was administered and TB symptom questionnaire was completed and added to the file. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No other residents were found to have been affected by the deficient practice. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does	06/23/2026

	Based on record review and interview, the facility failed to ensure a tuberculin (TB) skin test was completed with documented times on or prior to admission for 2 of 7 residents reviewed for TB administration. (Resident's 41 and 82) Findings include: Resident 41's clinical record was reviewed on 6/11/26 at 1:45 p.m. The record indicated Resident 41 was admitted to the facility on 4/28/26. The record lacked documentation of TB administration upon her admission to the facility. Resident 82's clinical record was reviewed on 6/12/26 at 10:40 a.m. The record indicated Resident 82 was admitted to the facility on 3/20/26. The record lacked documentation of TB administration upon her admission to the facility. During an interview, on 6/12/26 at 11:22 a.m., the DON indicated Resident 41 did not receive a first or second step TB test at the time of her admission to the facility. The TB testing was to have been completed. During an interview, on 6/12/26 at 11:34 a.m., the DON indicated Resident 82 did not receive a first or second step TB		not recur. ED and DON reeducated staff on proper TB policies and procedures for new residents upon admissions. Facility will ensure that all new admissions are incompliance with the TB policy and procedures. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A Tuberculosis audit tool has been created to ensure all residents receive their TB tests upon admission. The Audit tool will be monitored monthly ongoing. • By what date the systemic changes will be completed. 7/1/26	

	test at the time of her admission to the facility. The TB testing was to have been completed. A current policy, dated 9/08, titled "Resident Screening for Tuberculosis", provided by the Administrator on 6/12/26 at 9:51 a.m., indicated the following: "Policy" ...(e) In addition, a tuberculin skin test should 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) ...who have not had a documented negative tuberculin test result during the preceding twelve (12) months, the baseline tuberculin test should employ the two-step method. If the first step is negative, a second step should be performed within one (1) to three (3) weeks after the first test ...."				

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
Cassandra L. Dixon	executive director	07/08/2026