STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1019 SENIOR LIVING VERMILLION PLACE	449 MAIN ST, ANDERSON, , 46016

(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: July 14 & 15, 2025 Facility number: 011970 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 18, 2025.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement deficiencies, or any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective August 15th, 2025.	
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on record review and	R 0042	It is the practice of 1019 Senior Living Vermillion Place to ensure that all residents and resident representatives have access to the most recent annual survey, any plan of corrections and any subsequent survey thereafter. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?**	08/15/2025

	interview, the facility failed to ensure the most recent survey results were available and readily accessible to residents and resident representatives. Finding includes: A review of the facility survey binder on 7/14/25 at 10:28 a.m., located on the wall behind the receptionist desk, included the previous annual survey which was dated 8/7/24. The additional survey included in the survey binder was dated 10/15/24. The survey binder lacked a plan of correction for the annual survey dated 8/7/24. Review of survey activities conducted by the Indiana Department of Health indicated complaint surveys were completed on 11/15/24 and 3/7/25. During an interview, on 7/15/25 at 3:32 p.m., the Administrator indicated she was responsible for keeping the facility survey binder up to date, but was not aware the binder needed to reference surveys where a citation was not written. She had not included the complaint surveys completed since last year's annual survey. The Administrator had not placed a copy of the plan of correction for the last annual survey into the survey binder. She indicated there was not a facility policy		The survey binder is now up to date with all surveys and plans of correction. **How other resident having the potential to be affected by the same deficient can be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice, although no residents were affected. The Administrator has completed an audit of the survey binder. All surveys and plans of corrections are available and readily accessible to residents and their representatives. Moving Forward, the Administrator and/or designee will audit the survey binder to ensure that all documentation is posted as required. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff responsible for the completion of the survey binder have been educated on the facility policy regarding the survey binder being up to date. Moving forward, the Administrator will audit the survey binder to ensure all documentation is posted as requires. **How the corrective action will be monitored to ensure the**	

	regarding the posting of survey results. Based on record review and interview, the facility failed to ensure the most recent survey results were available and readily accessible to residents and resident representatives. Finding includes: A review of the facility survey binder on 7/14/25 at 10:28 a.m., located on the wall behind the receptionist desk, included the previous annual survey which was dated 8/7/24. The additional survey included in the survey binder was dated 10/15/24. The survey binder lacked a plan of correction for the annual survey dated 8/7/24. Review of survey activities conducted by the Indiana Department of Health indicated complaint surveys were completed on 11/15/24 and 3/7/25. During an interview, on 7/15/25 at 3:32 p.m., the Administrator indicated she was responsible for keeping the facility survey binder up to date, but was not aware the binder needed to reference surveys where a citation was not written. She had not included the complaint surveys completed since last year's annual survey. The Administrator had not placed a copy of the plan of correction for		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator and/or designee will audit the survey binder in accordance monthly for three months, then quarterly thereafter. Any discrepancies will be documented and reported to the Administrator.	

	the last annual survey into the survey binder. She indicated there was not a facility policy regarding the posting of survey results.			
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: (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 interview and record review, the facility failed to submit the application for certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver prior to completing laboratory testing for 6 residents who received blood glucose testing from the facility.	R 0086	It is the practice of 1019 Senior Living Vermillion Place to ensure that the CLIA waiver is up to date and posted. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The CLIA waiver was paid on 7/14/25 and is now up to date and posted in the common area. **How other resident having the potential to be affected by the same deficient practicewill be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice, although none were affected. The Administrator has completed the updating process for the CLIA waiver. The CLIA waiver is now up to date and posted in the common area. Moving forward, The Administrator and/or designee will audit the application process of the CLIA waiver to ensure that all parts of the process are completed as needed. **What measures will be put into**	08/15/2025

	Finding includes: Review of a CLIA waiver document posted by the main entrance and receptionist desk indicated the certification was expired. Review of a facility document provided following entrance conference indicated six residents received blood glucose testing from the facility. During an interview, on 7/14/25 at 3:30 p.m., the Administrator indicated the payment was submitted today for the renewal of the facility CLIA waiver. She had located the information in her electronic mail (e-mail) and completed the payment process today. The CLIA waiver expired on 2/27/25. Review of the CLIA Application for Certification, on 7/15/25 at 10:45 a.m., indicated the application payment due date was 2/21/25. The date the payment transaction was completed was listed as 7/14/25. During a follow-up interview, on 7/15/25 at 3:32 p.m., the Administrator indicated it was her responsibility to ensure the CLIA waiver was current and active. She completed the application back in January but forgot to send in the payment. She indicated the facility lacked a policy regarding CLIA waivers.		**place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff responsible for the updating of the CLIA waiver have been educated on the Indiana Department of Health guidelines related to laboratory testing and CLIA waiver requirements. Moving forward, the Administrator and/or designee will audit the application process of the CLIA waiver to ensure that all parts of the process are completed as needed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator and/or designee will audit the CLIA waiver application process in accordance to monthly for three months, quarterly for four quarters than annually thereafter. Any discrepancies will be documented and reported to the Administrator.	

	The facility followed the Indiana Department of Health guidelines related to laboratory testing and CLIA waiver requirements. Based on interview and record review, the facility failed to submit the application for certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver prior to completing laboratory testing for 6 residents who received blood glucose testing from the facility. Finding includes: Review of a CLIA waiver document posted by the main entrance and receptionist desk indicated the certification was expired. Review of a facility document provided following entrance conference indicated six residents received blood glucose testing from the facility. During an interview, on 7/14/25 at 3:30 p.m., the Administrator indicated the payment was submitted today for the renewal of the facility CLIA waiver. She had located the information in her electronic mail (e-mail) and completed the payment process today. The CLIA waiver expired on 2/27/25. Review of the CLIA Application			

	for Certification, on 7/15/25 at 10:45 a.m., indicated the application payment due date was 2/21/25. The date the payment transaction was completed was listed as 7/14/25. During a follow-up interview, on 7/15/25 at 3:32 p.m., the Administrator indicated it was her responsibility to ensure the CLIA waiver was current and active. She completed the application back in January but forgot to send in the payment. She indicated the facility lacked a policy regarding CLIA waivers. The facility followed the Indiana Department of Health guidelines related to laboratory testing and CLIA waiver requirements.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually	R 0216	It is the practice of 1019 Senior Living Vermillion Place to ensure all residents have a Self Administration Medication Assessment completed at least semi-annually. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 3 now has an up to date Self Administration Medication	08/15/2025

	thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure a current medication self-administration evaluation was completed for 1 of 2 residents reviewed for self-administration of medications. (Resident 3) Finding includes: On 7/14/25 at 11:00 a.m., Resident 3 was seated in her recliner. On the side table next to her, was a bi-color weekly pill planner with medications inside and a blood glucose monitoring device with supplies. Resident 3 indicated she gave herself medications in the evening and at night. She had no medications to take in the mornings. The night shift staff refilled the pill planner every Saturday night.		Assessment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice, although none were affected. The Director of Nursing has completed resident file audits. All appropriate residents have a completed Self Administration Medication Assessment. Moving forward, the DON and/or designee will audit resident records to ensure that all documentation is obtained as required. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff responsible for the completion of Self Administration Medication Assessments have been educated on the facility policy for Self Administration Medication Assessments. Moving forward, the DON and/or designee will audit all resident records to ensure that all required Self Administration Medication Assessments are complete. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

	Resident 3's clinical record was reviewed on 7/14/25 at 3:00 p.m. Diagnoses included type 2 diabetes mellitus and other pulmonary embolism without cor pulmonale (a blood clot in the pulmonary artery not causing the heart's right ventricle to fail). A 8/23/24, "Self Administration of Medication Assessment", indicated the resident was deemed able to safely self-administer medications. The comments indicated the resident needs assist of pill planner set up. A, 7/9/25, "Service Plan", indicated the resident needs reminders. Caregiver administration and/or observations of medications requiring judgement for necessity, dosage, and/or effect. Round the clock need. A, 7/9/25, " Resident assessment", indicated the residents needs level as max, needs reminders. Caregiver administration and/or observations of medications requiring judgement for necessity, dosage, and/or effect. Round the clock need. The clinical record lacked a current Self Administration of Medication Assessment. During an interview, on 7/15/25 at 12:15 p.m., the DON indicated Resident 3 utilized a		The DON will audit the resident records in accordance monthly for 3 months, then quarterly thereafter. Any discrepancies will be documented and reported to the Administrator.	

	pill planner and self administered her medications. The staff refilled the pill planners for the resident. During an interview, on 7/15/25 at 3:18 p.m., the Administrator indicated there was not a current Self Administration of Medication Assessment for Resident 3. This assessment was missed as the facility was transferring from paper to electronic charts. The Self Administration of Medication Assessment should be completed semi-annually. A facility policy, revised 11/1/24, titled, " Medication Management- Administration & Setup", provided by the Administrator on 7/15/25 at 1:09 p.m., indicated the following: " The nursing staff trained to provided medication administration at 1019 Senior Living will document any medication administration provided accurately in each resident record. A licensed nurse and or QMA will correctly and accurately document any medication setup provided. All set up will be based on residents individual assessment..." Based on interview and record review, the facility failed to ensure a current medication self-administration evaluation was completed for 1 of 2			

residents reviewed for self-administration of medications. (Resident 3)

Finding includes:

On 7/14/25 at 11:00 a.m., Resident 3 was seated in her recliner. On the side table next to her, was a bi-color weekly pill planner with medications inside and a blood glucose monitoring device with supplies. Resident 3 indicated she gave herself medications in the evening and at night. She had no medications to take in the mornings. The night shift staff refilled the pill planner every Saturday night.

Resident 3's clinical record was reviewed on 7/14/25 at 3:00 p.m. Diagnoses included type 2 diabetes mellitus and other pulmonary embolism without cor pulmonale (a blood clot in the pulmonary artery not causing the heart's right ventricle to fail).

A 8/23/24, "Self Administration of Medication Assessment", indicated the resident was deemed able to safely self-administer medications. The comments indicated the resident needs assist of pill planner set up.

A, 7/9/25, "Service Plan", indicated the resident needs reminders. Caregiver administration and/or observations of medications

	requiring judgement for necessity, dosage, and/or effect. Round the clock need. A, 7/9/25, " Resident assessment", indicated the residents needs level as max, needs reminders. Caregiver administration and/or observations of medications requiring judgement for necessity, dosage, and/or effect. Round the clock need. The clinical record lacked a current Self Administration of Medication Assessment. During an interview, on 7/15/25 at 12:15 p.m., the DON indicated Resident 3 utilized a pill planner and self administered her medications. The staff refilled the pill planners for the resident. During an interview, on 7/15/25 at 3:18 p.m., the Administrator indicated there was not a current Self Administration of Medication Assessment for Resident 3. This assessment was missed as the facility was transferring from paper to electronic charts. The Self Administration of Medication Assessment should be completed semi-annually. A facility policy, revised 11/1/24, titled, " Medication Management- Administration & Setup", provided by the Administrator on 7/15/25 at 1:09			

	p.m., indicated the following: " The nursing staff trained to provided medication administration at 1019 Senior Living will document any medication administration provided accurately in each resident record. A licensed nurse and or QMA will correctly and accurately document any medication setup provided. All set up will be based on residents individual assessment..."			
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. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements.	R 0383	It is the practice of 1019 Senior Living Vermillion Place to ensure that service plans are developed with the input/coordination of the residents' Mental Health Provider. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents 20 and 37 all have current service plans that have been reviewed and signed with input/coordination from their Mental Health Providers. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**	08/15/2025

	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 2 of 2 residents reviewed for mental health services (Residents 20 and 37). Findings include: 1. Resident 20's clinical record was reviewed on 7/15/25 at 9:42 a.m. Current diagnoses included chronic obstructive lung disease, anxiety, and schizoaffective disorder bipolar type. The resident was admitted to the facility on 5/21/25. The resident received Medicaid benefits. The resident received psychiatric services from a mental health service provider who provided services through in facility visits. The resident had a most current signed, 6/24/25, "Service Plan." 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:		All residents have the potential to be affected by the alleged deficient practice, although none were affected. The Director of Nursing has completed resident file audits. All residents who have Mental Health Diagnosis or Providers now have set coordination between 1019 Senior Living Vermillion Place and their provider of choice. Moving Forward, the Administrator and/or designee will audit all new admission and quarterly service plans to ensure that all input/ coordination from Mental Health Providers is documented as required. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff responsible for completion of service plans have been educated on the facility policy for service plans. Moving forward the Administrator and/or designee will audit all new admission and quarterly service plans to ensure that all coordination is documented as required. The Administrator and/or designee will sign off on all new admission and quarterly service plans to ensure that the service plan is complete with input or coordination from Mental Health Providers. This will allow for any corrections to be made in a timely manner. **How the corrective action will be**	

	(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 service plan did not identify it had been developed with the input/cooperation of the resident's mental health provider. 2. Resident 37's clinical record was reviewed on 7/14/25 at 2:12 p.m. Current diagnoses included bipolar disorder, attention deficit hyperactive disorder, depression, and fibromyalgia . The resident was admitted to the facility on 6/14/23. The current diagnoses were present at the time of admission. The resident received psychoactive medication management services from her general practitioner. The resident had a most current signed, 4/29/25, "Service Plan." The resident's service plan lacked a plan of care developed in cooperation with their mental health services provider which included: (1) Psychosocial rehabilitation		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON and/or designee will audit the service plans of those who have Mental Health Providers monthly for three months, then quarterly thereafter. Any discrepancies will be documented and reported to the Administrator.	

	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 service plan did not identify it had been developed with the input/cooperation of the resident's general practitioner who managed the resident's mental health. During an interview on 7/15/25 at 2:37 p.m., the Administrator indicated Residents 20 and 37 did not have mental health service plans that had been completed with the resident's mental health service provider. A current, 11/1/23, policy titled, "Service/Care Plan", which was provided by the Administrator in 7/15/24 at 3:09 p.m., indicated: "Service/care plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the			

	resident's needs and preferences..." 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 2 of 2 residents reviewed for mental health services (Residents 20 and 37). Findings include: 1. Resident 20's clinical record was reviewed on 7/15/25 at 9:42 a.m. Current diagnoses included chronic obstructive lung disease, anxiety, and schizoaffective disorder bipolar type. The resident was admitted to the facility on 5/21/25. The resident received Medicaid benefits. The resident received psychiatric services from a mental health service provider who provided services through in facility visits. The resident had a most current signed, 6/24/25, "Service Plan." 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 service plan did not identify it had been developed with the input/cooperation of the resident's mental health provider. 2. Resident 37's clinical record was reviewed on 7/14/25 at 2:12 p.m. Current diagnoses included bipolar disorder, attention deficit hyperactive disorder, depression, and fibromyalgia . The resident was admitted to the facility on 6/14/23. The current diagnoses were present at the time of admission. The resident received psychoactive medication management services from her general practitioner. The resident had a most current signed, 4/29/25, "Service Plan." 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 service plan did not identify it had been developed with the input/cooperation of the resident's general practitioner who managed the resident's mental health. During an interview on 7/15/25 at 2:37 p.m., the Administrator indicated Residents 20 and 37 did not have mental health service plans that had been completed with the resident's mental health service provider. A current, 11/1/23, policy titled, "Service/Care Plan", which was provided by the Administrator in 7/15/24 at 3:09 p.m., indicated: "Service/care plans are based			

	on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences..."			
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. Based on interview and record review, the facility failed to ensure a resident had either a	R 0410	It is the practice of 1019 Senior Living Vermillion Place to ensure that all newly admitted residents have the 2 Step TB Test completed. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident 20 has received a 1 Step TB Test and is scheduled for a 2 Step TB Test to be administered and read before 8/15/25. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice, although none were affected. The Director of Nursing has completed resident filed audits. All new admissions now have received a 1 Step TB Test and are scheduled to receive the 2 Step TB Test. An audit of all residents has been performed to ensure	08/15/2025

	tuberculin (TB) skin test completed within three months prior to admission or upon admission or for residents who did not have a documented negative tuberculin skin test result during the preceding twelve (12) months, a baseline tuberculin skin testing using the two-step method for 1 of 2 residents reviewed for TB screening upon admission. (Resident 20) Findings include: Resident 20's clinical record was reviewed on 7/15/25 at 9:42 a.m. Current diagnoses included chronic obstructive lung disease, anxiety, and schizoaffective disorder bipolar type. The resident was admitted to the facility on 5/21/25. The clinical record lacked documentation of a tuberculin skin test completed within 3 months prior to admission and/or a 2 step skin test upon admission, or a history of a TB skin test within 12 steps prior to admission followed by a single test at admission. During an interview on 7/15/25 at 2:37 p.m., the Administrator indicated Resident 20 had not had a 2 step TB test upon admission and had been identified in the facilities audit. Review of an undated facility document titled, "CQI PPD",		residents have their 2 Step TB Tests. Moving forward, the Administrator and/or designee will audit all new admissions upon admission day and day 21 to ensure all documentation is obtained as required. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff responsible for the compeletion of 2 Step TB Testing have been educated on facility policy for 2 Step TB Testing. Moving forward the Administrator and/or designee will audit all newly admitted resident records to ensure the 2 Step TB Tests are administered as required. The Administrator and/or designee will audit all new admits upon admission day and at day 21 to ensure the 2 Step TB Tests have been administered. This will allow for any corrections to be mad in a timely manner. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator and/or designee will audit all new admissions resident records/ in accordance with 2 Step TB Tests weekly for four weeks, monthly for three	

	which was provided by the Administrator on 7/15/25 at 3:09 p.m., indicated Resident 20 had been identified on 7/14/25 (the first day of the survey) as needing a 2 step PPD. The goal for the completion of the 2 step PPD was 8/15/25 (3 months after the resident's admission to the facility). A current, 11/1/24, facility policy titled, "7.13 Tuberculosis Screening", which was provided by the Administrator on 7/15/25 at 3:09 p.m., indicated: "... establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Center for Disease Control and Prevention." Based on interview and record review, the facility failed to ensure a resident had either a tuberculin (TB) skin test completed within three months prior to admission or upon admission or for residents who did not have a documented negative tuberculin skin test result during the preceding twelve (12) months, a baseline tuberculin skin testing using the two-step method for 1 of 2 residents reviewed for TB screening upon admission. (Resident 20)		months then quarterly thereafter.	

Findings include:

Resident 20's clinical record was reviewed on 7/15/25 at 9:42 a.m. Current diagnoses included chronic obstructive lung disease, anxiety, and schizoaffective disorder bipolar type. The resident was admitted to the facility on 5/21/25.

The clinical record lacked documentation of a tuberculin skin test completed within 3 months prior to admission and/or a 2 step skin test upon admission, or a history of a TB skin test within 12 steps prior to admission followed by a single test at admission.

During an interview on 7/15/25 at 2:37 p.m., the Administrator indicated Resident 20 had not had a 2 step TB test upon admission and had been identified in the facilities audit.

Review of an undated facility document titled, "CQI PPD", which was provided by the Administrator on 7/15/25 at 3:09 p.m., indicated Resident 20 had been identified on 7/14/25 (the first day of the survey) as needing a 2 step PPD. The goal for the completion of the 2 step PPD was 8/15/25 (3 months after the resident's admission to the facility).

A current, 11/1/24, facility policy titled, "7.13 Tuberculosis Screening", which was provided

	by the Administrator on 7/15/25 at 3:09 p.m., indicated: "... establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Center for Disease Control and Prevention."			

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