STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/07/2024

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: August 6 and 7, 2024 Facility number: 011970 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 9, 2024.	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 of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective September 7, 2024.	
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:	R 0217	R217 It is the practice of 1019 Senior Living Vermillion Place to ensure that service plans are signed by residents or their respective resident representatives. What corrective action will be	09/07/2024

	(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. (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 interview and record review, the facility failed to ensure service plans were signed by residents or their representative for 7 of 7 residents reviewed for services plans. (Residents 4, 27, 29,		accomplished for those residents found to have been affected by the deficient practice? Residents 4, 27, 29, 31 and 37 all have current service plans that have been reviewed and signed. Residents 100 and 101 no longer reside at this facility. 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. The Director of Nursing has completed resident file audits. All residents now have current signed service plans in place. Moving forward, the Administrator and/or designee will audit all new admission service plans to ensure that all documentation is obtained 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?	

	100, 101, 31, and 37) Findings include: 1. Resident 29's clinical record was reviewed on 8/6/24- at 1:55 p.m. Current diagnoses included hypertension and bipolar disorder. The resident's current 4/22/24 service plan was not signed by the resident or a representative. 2. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m.. Diagnoses at the time of discharge included hypertension, anxiety and depression. The resident's most current 2/13/24 service plan was not signed by the resident or a representative. 3. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. Current diagnoses included major depressive disorder and hypertension. The resident's current 5/20/24 service plan was not signed by the resident or a representative. 4. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. Diagnoses included left hemiparesis and end stage renal disease. A current service plan, dated 7/2/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature.		All staff responsible for completion of service plans have been educated on facility policy for service plans. Moving forward, the Administrator and/or designee will audit all new admission service plans to ensure that all documentation is obtained as required. The administrator and/ or designee will sign off on all new admission service plans to ensure that the service plan is complete. This will allow for any corrections to be made 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 DON will audit the service plans monthly for three months, then quarterly thereafter. Date of Compliance: Sep 7, 2024	

	5. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. Diagnoses included right hemiparesis and diabetes mellitus type 2. A current service plan, dated 7/5/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 6. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary emphysema. A current service plan, dated 3/29/24, indicated the resident was alert, required use of a walker for ambulation, and required oxygen. The service plan lacked a resident or resident representative signature. 7. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. Diagnoses included hypertension and peripheral neuropathy. A service plan, dated 1/27/24, indicated the resident was alert and oriented, was independent with transfers, and required use of a walker for ambulation. The service plan lacked a resident or resident representative signature. During an interview, on 8/8/24 at 1:55 p.m., the Administrator indicated she could not locate			

	the signed service plans for the residents in question. A current facility policy, dated 12/23, titled "Resident Service Plan", and provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "... 5. Upon initial review and subsequent changes, members of the community care team that contributed to the Resident Service Plan, including the Executive Director, Wellness Director, or designee, and the resident/legally responsible party should sign the Resident Service Plan...." Based on interview and record review, the facility failed to ensure service plans were signed by residents or their representative for 7 of 7 residents reviewed for services plans. (Residents 4, 27, 29, 100, 101, 31, and 37) Findings include: 1. Resident 29's clinical record was reviewed on 8/6/24- at 1:55 p.m. Current diagnoses included hypertension and bipolar disorder. The resident's current 4/22/24 service plan was not signed by the resident or a representative. 2. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m.. Diagnoses at the time of discharge included hypertension, anxiety and			

	depression. The resident's most current 2/13/24 service plan was not signed by the resident or a representative. 3. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. Current diagnoses included major depressive disorder and hypertension. The resident's current 5/20/24 service plan was not signed by the resident or a representative. 4. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. Diagnoses included left hemiparesis and end stage renal disease. A current service plan, dated 7/2/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 5. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. Diagnoses included right hemiparesis and diabetes mellitus type 2. A current service plan, dated 7/5/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 6. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. Diagnoses included chronic obstructive pulmonary			

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Service Plan...."

Based on interview and record review, the facility failed to ensure service plans were signed by residents or their representative for 7 of 7 residents reviewed for services plans. (Residents 4, 27, 29, 100, 101, 31, and 37)

Findings include:

1. Resident 29's clinical record was reviewed on 8/6/24- at 1:55 p.m. Current diagnoses included hypertension and bipolar disorder. The resident's current 4/22/24 service plan was not signed by the resident or a representative.

2. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m.. Diagnoses at the time of discharge included hypertension, anxiety and depression. The resident's most current 2/13/24 service plan was not signed by the resident or a representative.

3. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. Current diagnoses included major depressive disorder and hypertension. The resident's current 5/20/24 service plan was not signed by the resident or a representative.

4. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. Diagnoses included left

	hemiparesis and end stage renal disease. A current service plan, dated 7/2/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 5. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. Diagnoses included right hemiparesis and diabetes mellitus type 2. A current service plan, dated 7/5/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 6. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary emphysema. A current service plan, dated 3/29/24, indicated the resident was alert, required use of a walker for ambulation, and required oxygen. The service plan lacked a resident or resident representative signature. 7. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. Diagnoses included hypertension and peripheral neuropathy. A service plan, dated 1/27/24, indicated the resident was alert and oriented,			

was independent with transfers, and required use of a walker for ambulation. The service plan lacked a resident or resident representative signature.

During an interview, on 8/8/24 at 1:55 p.m., the Administrator indicated she could not locate the signed service plans for the residents in question.

A current facility policy, dated 12/23, titled "Resident Service Plan", and provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "... 5. Upon initial review and subsequent changes, members of the community care team that contributed to the Resident Service Plan, including the Executive Director, Wellness Director, or designee, and the resident/legally responsible party should sign the Resident Service Plan...."

Based on interview and record review, the facility failed to ensure service plans were signed by residents or their representative for 7 of 7 residents reviewed for services plans. (Residents 4, 27, 29, 100, 101, 31, and 37)

Findings include:

1. Resident 29's clinical record was reviewed on 8/6/24- at 1:55 p.m. Current diagnoses included hypertension and bipolar disorder. The resident's current

	4/22/24 service plan was not signed by the resident or a representative. 2. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m.. Diagnoses at the time of discharge included hypertension, anxiety and depression. The resident's most current 2/13/24 service plan was not signed by the resident or a representative. 3. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. Current diagnoses included major depressive disorder and hypertension. The resident's current 5/20/24 service plan was not signed by the resident or a representative. 4. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. Diagnoses included left hemiparesis and end stage renal disease. A current service plan, dated 7/2/24, indicated the resident was alert and oriented and was independent with transfers. The service plan lacked a resident or resident representative signature. 5. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. Diagnoses included right hemiparesis and diabetes mellitus type 2. A current service plan, dated 7/5/24, indicated the resident was alert and oriented and was			

	independent with transfers. The service plan lacked a resident or resident representative signature. 6. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary emphysema. A current service plan, dated 3/29/24, indicated the resident was alert, required use of a walker for ambulation, and required oxygen. The service plan lacked a resident or resident representative signature. 7. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. Diagnoses included hypertension and peripheral neuropathy. A service plan, dated 1/27/24, indicated the resident was alert and oriented, was independent with transfers, and required use of a walker for ambulation. The service plan lacked a resident or resident representative signature. During an interview, on 8/8/24 at 1:55 p.m., the Administrator indicated she could not locate the signed service plans for the residents in question. A current facility policy, dated 12/23, titled "Resident Service Plan", and provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...			

	5. Upon initial review and subsequent changes, members of the community care team that contributed to the Resident Service Plan, including the Executive Director, Wellness Director, or designee, and the resident/legally responsible party should sign the Resident Service Plan...."			

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. 2. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. The residents admission date was 7/2/24. The record lacked documentation of a 2-step TB test. 3. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. The residents admission date was 7/5/24. The record lacked documentation of a	R 0410	R 410 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? Residents 4 and 27 have received a new 1st TB Test. Resident 4 and 27 are both scheduled to receive the 2nd Step TB Test. 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. The Director of Nursing has completed resident file audits. All new admissions now have received a new 1st Step TB and are scheduled to receive the 2nd Step TB Test. Moving forward,	09/07/2024

	2-step TB test. 4. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. The residents admission date was 1/15/24. The record lacked documentation of a 2-step TB test. During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional documentation to provide showing TB testing results or TB testing for new admissions. A current facility policy, revised 5/24 and titled "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...The required tuberculosis test shall include the two-step Mantoux test for tuberculosis using purified protein derivative (PPD); or, if the individual has a documented history of a significant Mantoux test, PPD reactor; a chest x-ray...." Based on interview and record review, the facility failed to ensure residents had either a tuberculin 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 3 of 3 residents reviewed for TB		the Administrator and/or designee will audit all new admission upon admission and on day 21 to ensure that all documentation is obtained 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 2 Step TB Tests have been educated on facility policy for 2 Step TB Testing. Moving forward, the Administrator and/or designee will audit all new admitted resident records to ensure 2nd Step TB Tests are obtained as required. The Administrator and/or designee will audit all new admits at 21 days after admittance to ensure the 2nd Step TB has been administered. This will allow for any corrections to be made 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 DON will audit the resident	

	screening upon admission. (Residents 101, 4, 27, and 100) Findings include: 1. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m. The resident was admitted to the facility on 2/11/24. The clinical record lacked proof of a tuberculin skin test completed within 3 months prior to admission, a two- step skin test upon admission, or a history of a TB skin test within 12 months prior to admission. 2. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. The residents admission date was 7/2/24. The record lacked documentation of a 2-step TB test. 3. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. The residents admission date was 7/5/24. The record lacked documentation of a 2-step TB test. 4. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. The residents admission date was 1/15/24. The record lacked documentation of a 2-step TB test.		records in accordance to 2 Step TB Tests weekly for four weeks, monthly for three months, then quarterly thereafter. Date of Compliance: Sep 7, 2024	

	During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional documentation to provide showing TB testing results or TB testing for new admissions. A current facility policy, revised 5/24 and titled "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...The required tuberculosis test shall include the two-step Mantoux test for tuberculosis using purified protein derivative (PPD); or, if the individual has a documented history of a significant Mantoux test, PPD reactor; a chest x-ray...." Based on interview and record review, the facility failed to ensure residents had either a tuberculin 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 3 of 3 residents reviewed for TB screening upon admission. (Residents 101, 4, 27, and 100) Findings include: 1. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m. The resident was admitted to the facility on			

	2/11/24. The clinical record lacked proof of a tuberculin skin test completed within 3 months prior to admission, a two- step skin test upon admission, or a history of a TB skin test within 12 months prior to admission. 2. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. The residents admission date was 7/2/24. The record lacked documentation of a 2-step TB test. 3. Resident 27's clinical record was reviewed on 8/6/24 at 2:23 p.m. The residents admission date was 7/5/24. The record lacked documentation of a 2-step TB test. 4. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. The residents admission date was 1/15/24. The record lacked documentation of a 2-step TB test. During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional documentation to provide showing TB testing results or TB testing for new admissions. A current facility policy, revised 5/24 and titled "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...The required tuberculosis test shall include the two-step Mantoux test for tuberculosis			

using purified protein derivative (PPD); or, if the individual has a documented history of a significant Mantoux test, PPD reactor; a chest x-ray...."

Based on interview and record review, the facility failed to ensure residents had either a tuberculin 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 3 of 3 residents reviewed for TB screening upon admission. (Residents 101, 4, 27, and 100)

Findings include:

1. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m. The resident was admitted to the facility on 2/11/24. The clinical record lacked proof of a tuberculin skin test completed within 3 months prior to admission, a two- step skin test upon admission, or a history of a TB skin test within 12 months prior to admission.

2. Resident 4's clinical record was reviewed on 8/6/24 at 2:00 p.m. The residents admission date was 7/2/24. The record lacked documentation of a 2-step TB test.

3. Resident 27's clinical record

	was reviewed on 8/6/24 at 2:23 p.m. The residents admission date was 7/5/24. The record lacked documentation of a 2-step TB test. 4. Resident 100's clinical record was reviewed on 8/7/24 at 1:22 p.m. The residents admission date was 1/15/24. The record lacked documentation of a 2-step TB test. During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional documentation to provide showing TB testing results or TB testing for new admissions. A current facility policy, revised 5/24 and titled "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...The required tuberculosis test shall include the two-step Mantoux test for tuberculosis using purified protein derivative (PPD); or, if the individual has a documented history of a significant Mantoux test, PPD reactor; a chest x-ray...." Based on interview and record review, the facility failed to ensure residents had either a tuberculin 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 3 of 3 residents reviewed for TB screening upon admission. (Residents 101, 4, 27, and 100) Findings include: 1. Resident 101's closed clinical record was reviewed on 8/7/24 at 10:45 a.m. The resident was admitted to the facility on 2/11/24. The clinical record lacked proof of a tuberculin skin test completed within 3 months prior to admission, a two- step skin test upon admission, or a history of a TB skin test within 12 months prior to admission.			
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i) (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record	R 0412	R 412 It is the practice of 1019 Senior Living Vermillion Place to ensure that all residents who have resided within the facility for longer than 1 year have received a TB Skin Test or Annual TB Risk Assessment if TB Skin Test is contraindicated. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	09/07/2024

	review, the facility failed to ensure residents who had resided in the facility for longer than one year had either annual TB (tuberculosis) risk assessments or annual TB skin tests completed for 3 of 4 residents reviewed for annual TB screening. (Residents 29, 37, and 31) Findings include: 1. Resident 29's clinical record was reviewed on 8/6/24 at 1:55 p.m. The resident was admitted to the facility on 4/4/19. The clinical record lack an annual TB test and/or annual risk assessment. 2. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. The resident was admitted to the facility on 6/13/22. The clinical record lack an annual TB test and/or annual risk assessment. 3. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. The resident admitted to the facility on 12/26/22. The clinical record lacked an annual TB risk assessment or testing. During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional information to provide for annual TB screenings or testing. A current facility policy, revised		Residents 29, 37, and 31 have received a TB Skin Test or Annual TB Risk Assessment if TB Skin Test is contraindicated. 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. The Director of Nursing has completed resident file audits. All residents have received an Annual TB Skin Test or Annual TB Risk Assessment if TB Skin Test is contraindicated. Moving forward, the Administrator and/or designee will audit resident records to ensure that all documentation is obtained 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 Annual TB Skin Tests or Annual TB Risk	

	5/24, titled, "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...Policy: Residents will be asked to provide proof of a negative TB test prior to move-in. Thereafter, the test will be performed at least once every 12 months or per State regulations...." Based on interview and record review, the facility failed to ensure residents who had resided in the facility for longer than one year had either annual TB (tuberculosis) risk assessments or annual TB skin tests completed for 3 of 4 residents reviewed for annual TB screening. (Residents 29, 37, and 31) Findings include: 1. Resident 29's clinical record was reviewed on 8/6/24 at 1:55 p.m. The resident was admitted to the facility on 4/4/19. The clinical record lack an annual TB test and/or annual risk assessment. 2. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. The resident was admitted to the facility on 6/13/22. The clinical record lack an annual TB test and/or annual risk assessment. 3. Resident 31's clinical record was reviewed on 8/7/24 at		Assessments if contraindicated have been educated on the facility policy for Annual TB Testing. Moving forward, the Administrator and/or designee will audit all resident records to ensure all required TB Tests or Annual Risk Assessments are obtained and 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? The DON will audit the resident records in accordance monthly for three months, then quarterly thereafter. Any discrepancies will be documented and reported to the Administrator. Date of Compliance: Sep 7, 2024	

11:15 a.m. The resident admitted to the facility on 12/26/22. The clinical record lacked an annual TB risk assessment or testing.

During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional information to provide for annual TB screenings or testing.

A current facility policy, revised 5/24, titled, "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...Policy: Residents will be asked to provide proof of a negative TB test prior to move-in. Thereafter, the test will be performed at least once every 12 months or per State regulations...."

Based on interview and record review, the facility failed to ensure residents who had resided in the facility for longer than one year had either annual TB (tuberculosis) risk assessments or annual TB skin tests completed for 3 of 4 residents reviewed for annual TB screening. (Residents 29, 37, and 31)

Findings include:

1. Resident 29's clinical record was reviewed on 8/6/24 at 1:55 p.m. The resident was admitted to the facility on 4/4/19. The clinical record lack an annual TB

test and/or annual risk assessment.

2. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. The resident was admitted to the facility on 6/13/22. The clinical record lack an annual TB test and/or annual risk assessment.

3. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. The resident admitted to the facility on 12/26/22. The clinical record lacked an annual TB risk assessment or testing.

During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional information to provide for annual TB screenings or testing.

A current facility policy, revised 5/24, titled, "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...Policy: Residents will be asked to provide proof of a negative TB test prior to move-in. Thereafter, the test will be performed at least once every 12 months or per State regulations...."

Based on interview and record review, the facility failed to ensure residents who had resided in the facility for longer than one year had either annual TB (tuberculosis) risk

assessments or annual TB skin tests completed for 3 of 4 residents reviewed for annual TB screening. (Residents 29, 37, and 31)

Findings include:

1. Resident 29's clinical record was reviewed on 8/6/24 at 1:55 p.m. The resident was admitted to the facility on 4/4/19. The clinical record lack an annual TB test and/or annual risk assessment.

2. Resident 37's clinical record was reviewed on 8/7/24 at 11:22 a.m. The resident was admitted to the facility on 6/13/22. The clinical record lack an annual TB test and/or annual risk assessment.

3. Resident 31's clinical record was reviewed on 8/7/24 at 11:15 a.m. The resident admitted to the facility on 12/26/22. The clinical record lacked an annual TB risk assessment or testing.

During an interview, on 8/8/24 at 1:55 p.m., the DON indicated she had no additional information to provide for annual TB screenings or testing.

A current facility policy, revised 5/24, titled, "TB testing - Resident", provided by the Administrator on 8/7/24 at 2:05 p.m., indicated the following: "...Policy: Residents will be

	asked to provide proof of a negative TB test prior to move-in. Thereafter, the test will be performed at least once every 12 months or per State regulations...."			

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