STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MARQUIS, THE	300 E WASHINGTON BLVD, FORT WAYNE, , 46802

(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. This visit included the Investigation of Intake IN00465491. Intake IN00465491- No deficiencies related to the allegations are cited. Survey dates: October 22, 23, and 24 2025 Facility number: 012288 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 27, 2025	R 0000		
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently,	R 0119	1. -CNA's 2 & 3, both received and were trained on the facility's	11/21/2025

	each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each		Job Specific Training for CNAs as of 11/7/25. 2. -An Audit of CNA employee files was completed by the HR Director of CNAs to identify any additional CNAs who required Job Specific Training. Any CNAs identified through the audit to not have Job Specific Training were addressed as part of the plan of correction. 3. -The facility’s policy on Personnel Training; specific to Job Specific Training, was reviewed and revised by the Administrator on 11/7/25. -The IDT was in-serviced by the Administrator on 11/7/25 on the facility’s Personnel Training Policy; specific to, Job Specific Training and orientation to the facility of the department in which the direct care employee will work.	

	resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to provide job-specific orientation for 2 of 5 employee files reviewed (Certified Nursing Assistant (CNA) 2 and CNA 3). On 10/22/2025, the Administrator provided a completed state form for Residential Care Employee Records, indicating the facility ' s employees, their job titles, and start dates. The completed form showed CNA 2 had a start date of 7/2024, and CNA 3 had a start date of 4/2023. On 10/23/2025, a review of CNA 2's employee file was completed, and a job-specific orientation was not available in the record. On 10/23/2025, a review of CNA 3's employee file was completed, and a job-specific orientation was not available in the record.		-Newly hired CNA employee files will be audited on a monthly basis by the HR Director, or designee, to ensure newly hired CNAs have received and were trained on Job Specific Training upon hire. 4. -The HR Director, with oversight from the Administrator, will conduct monthly audits to ensure newly hired CNAs have Job Specific Training upon hire. The findings from the audits will be reviewed during the facility’s quarterly QAPI meeting until there is 100% compliance.	

	In an interview, on 10/23/2025 at 2:40 PM, the Business Office Manager (BOM) indicated the facility did not have a job-specific orientation for CNA 2 and CNA 3. On 10/24/2025 at 9:45 AM, a request was made to be able to review the policy and procedure for job-specific orientation. In an interview, on 10/24/2025 at 10:30 AM, the DON indicated the BOM had informed her there was no job-specific training for CNAs. The DON indicated the facility's policies were located in the Administrator's office and she did not have access to them. The DON indicated the Administrator was not available. In an interview, on 10/24/2025 at 11:25 AM, the DON indicated she had reviewed the policies and was unable to find one for job-specific orientation training. The DON indicated the Administrator was not available. At the time of exit, the facility had not provided a policy and procedure for job-specific orientation. Based on interview and record review, the facility failed to provide job-specific orientation for 2 of 5 employee files reviewed (Certified Nursing Assistant (CNA) 2 and CNA 3). On 10/22/2025, the			

	Administrator provided a completed state form for Residential Care Employee Records, indicating the facility ' s employees, their job titles, and start dates. The completed form showed CNA 2 had a start date of 7/2024, and CNA 3 had a start date of 4/2023. On 10/23/2025, a review of CNA 2's employee file was completed, and a job-specific orientation was not available in the record. On 10/23/2025, a review of CNA 3's employee file was completed, and a job-specific orientation was not available in the record. In an interview, on 10/23/2025 at 2:40 PM, the Business Office Manager (BOM) indicated the facility did not have a job-specific orientation for CNA 2 and CNA 3. On 10/24/2025 at 9:45 AM, a request was made to be able to review the policy and procedure for job-specific orientation.			

	In an interview, on 10/24/2025 at 10:30 AM, the DON indicated the BOM had informed her there was no job-specific training for CNAs. The DON indicated the facility's policies were located in the Administrator's office and she did not have access to them. The DON indicated the Administrator was not available. In an interview, on 10/24/2025 at 11:25 AM, the DON indicated she had reviewed the policies and was unable to find one for job-specific orientation training. The DON indicated the Administrator was not available. At the time of exit, the facility had not provided a policy and procedure for job-specific orientation.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training	R 0120	1. -CNA’s 2 & 3, and LPN 6, all received 6 hours of required Dementia Training as of 11/8/25 as part of the facility’s in-service requirements. CNA 5 is no longer employed by facility. 2. -An Audit was completed by	11/21/2025

	programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to provide dementia training for 4 of 5 employee files reviewed (Certified Nursing Assistant (CNA) 2, CNA 3, CNA 5, and		the HR Director of all employee files to identify any additional employees who required Dementia Training as part of the in-service requirements. Any employees identified through the audit to not have the required Dementia Training as part of the in-service requirements will receive the required dementia training as part of the plan of correction. 3. -The facility's policy on Personnel Training; specific to, the required Dementia Training upon hire and annually, was reviewed and revised by the Administrator on 11/7/25. -The HR Director was in-serviced by the Administrator on 11/7/25 on the facility's Personnel Training Policy; specific to, the required Dementia Training upon hire and annually, as part of the facility's in-service training requirements. -Newly hired employee files will be audited on a monthly basis by the HR Director, or designee, to ensure newly	

	Licensed Practical Nurse (LPN) 6). On 10/22/2025, the Administrator provided a completed state form for Residential Care Employee Records, indicating the facility's employees, their job titles, and start dates. The completed form showed CNA 2 had a start date of 7/2024, CNA 3 had a start date of 4/2023, CNA 5 had a start date of 1/2020, and LPN 6 had a start date of 2/2024. On 10/23/2025, a review of CNA 2's employee file was completed, and a dementia training certificate was not available in the file. On 10/23/2025, a review of CNA 3's employee file was completed, and a dementia training certificate was not available in the file. On 10/23/2025, a review of CNA 5's employee file was completed, and a dementia training certificate was not available in the file. On 10/23/2025, a review of LPN 6's employee file was completed, and a dementia training certificate was not available in the file. In an interview, on 10/23/2025 at 2:35 PM, the BOM indicated the facility did not provide dementia training, as they		hired employees have received and been trained on the required Dementia Training upon hire and annually, thereafter. 4. -The HR Director, with oversight from the Administrator, will conduct monthly audits to ensure newly hired employees have the required Dementia Training upon hire and annually thereafter. The findings from the audits will be reviewed during the facility’s quarterly QAPI meeting until there is 100% compliance.	

	primarily served residents with mental health needs and did not have any residents with dementia or offer dementia care. On 10/23/2025 at 2:50 PM, a review of the facility's resident records was completed. Residents 16, 17, 18, 19, and 20 were found to have a diagnosis of dementia. On 10/24/2025 at 9:45 AM, a request was made to the DON to provide a policy and procedure for dementia training. In an interview, on 10/24/2025 at 10:30 AM, the DON indicated the facility's policies were located in the Administrator's office and she did not have access to them. The DON indicated the Administrator was not available. In an interview, on 10/24/2025 at 11:25 AM, the DON indicated she had reviewed the policies and was unable to find one for dementia training. The DON indicated the Administrator was not available. At the time of exit, the facility had not provided a policy and procedure for dementia training. Based on interview and record review, the facility failed to provide dementia training for 4 of 5 employee files reviewed (Certified Nursing Assistant			

	(CNA) 2, CNA 3, CNA 5, and Licensed Practical Nurse (LPN) 6). On 10/22/2025, the Administrator provided a completed state form for Residential Care Employee Records, indicating the facility's employees, their job titles, and start dates. The completed form showed CNA 2 had a start date of 7/2024, CNA 3 had a start date of 4/2023, CNA 5 had a start date of 1/2020, and LPN 6 had a start date of 2/2024. On 10/23/2025, a review of CNA 2's employee file was completed, and a dementia training certificate was not available in the file. On 10/23/2025, a review of CNA 3's employee file was completed, and a dementia training certificate was not available in the file. On 10/23/2025, a review of CNA 5's employee file was completed, and a dementia training certificate was not available in the file. On 10/23/2025, a review of LPN 6's employee file was completed, and a dementia training certificate was not available in the file. In an interview, on 10/23/2025 at 2:35 PM, the BOM indicated the facility did not provide			

	dementia training, as they primarily served residents with mental health needs and did not have any residents with dementia or offer dementia care. On 10/23/2025 at 2:50 PM, a review of the facility's resident records was completed. Residents 16, 17, 18, 19, and 20 were found to have a diagnosis of dementia. On 10/24/2025 at 9:45 AM, a request was made to the DON to provide a policy and procedure for dementia training. In an interview, on 10/24/2025 at 10:30 AM, the DON indicated the facility's policies were located in the Administrator's office and she did not have access to them. The DON indicated the Administrator was not available. In an interview, on 10/24/2025 at 11:25 AM, the DON indicated she had reviewed the policies and was unable to find one for dementia training. The DON indicated the Administrator was not available. At the time of exit, the facility had not provided a policy and procedure for dementia training.			
R 0151	Sanitation & Safety Standards -Noncompliance	R 0151	1.	11/21/2025

	410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure pet vaccinations were current and up to date for 4 of 19 residents who owned pets requiring them. (Resident 4, Resident 10, Resident 14, and Resident 15) Finding included: A record review on 10/22/25 at 10:35 AM, of the facility pet vaccination book, indicated the following resident's pets did not have current up to date vaccines. 1. Review of Resident 4's pet (cat) vaccination form, dated 3/29/24, indicated the vaccination for rabies was given on 3/29/24. This vaccine was only current for one year. The expiration date was 3/29/25. 2. Review of Resident 10's pet (dog) vaccination form, dated 3/30/22, indicated. the vaccination for rabies was given on 3/20/22. This vaccine was only current for one year. The expiration dated was 3/20/23. 3. Review of Resident 14's pet (cat) vaccination form, dated 3/28/24, indicated the		Residents 4, 10, 14, and 15 are scheduled to have their pets vaccinated on 11/12/25 by a licensed veterinarian. 2. -An Audit was completed by the Administrator on 11/3/25 of residents' pet vaccination records. Any pet records identified through the audit to not have complete documentation or up to date vaccinations were addressed as part of the plan of correction. 3. -The Case Manager was in-serviced by the Administrator on 11/7/25 on the facility's Pet Policy; specific to, ensuring residents' pet records are complete and vaccinations are up to date. -Residents' pet records will be reviewed on a monthly basis by the Case Manager, or designee, to ensure resident pet records are	

	vaccination for rabies was given on 3/28/24. This vaccine was only current for one year. The expiration date was 3/28/25. 4. Review of Resident 15's Pet A and Pet B (cats) vaccination forms, dated 2/24/23 indicated Pet A's rabies vaccine was given on 2/24/23. This vaccine was only current for one year. The expiration date was 2/24/24. Pet B's rabies vaccine was given on 2/24/23. This vaccine was only current for one year. The expiation date was 2/24/24. A record review, on 10/22/25 at 11:05 AM, a form listed all pets that reside in facility, dated 10/2/25, indicated Resident 4, Resident 10, Resident 14, and Resident 15 pets did not have current, up to date vaccination. In an interview, on 10/22/25 at 2:14 PM, the Administrator indicated the facility planned on having a clinic in November to catch up on the vaccinations not up to date. No other forms were provided by administration before or during exit. A current facility policy, titled, Pet Policy, no date, was provided by the Administrator on 10/22/25 at 2:14 PM. The policy indicated..." A certificate signed by a licensed veterinarian or a state or local authority		complete and vaccination records are up to date. 4.The Case Manager, with oversight from the Administrator, will conduct monthly audits to ensure residents' pet records are complete and vaccinations are up to date. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	

empowered to inoculate animals (or designated agent of such authority) stating that the pet has received all inoculations required by applicable state and local law...."

Based on record review and interview, the facility failed to ensure pet vaccinations were current and up to date for 4 of 19 residents who owned pets requiring them. (Resident 4, Resident 10, Resident 14, and Resident 15)

Finding included:

A record review on 10/22/25 at 10:35 AM, of the facility pet vaccination book, indicated the following resident's pets did not have current up to date vaccines.

1. Review of Resident 4's pet (cat) vaccination form, dated 3/29/24, indicated the vaccination for rabies was given on 3/29/24. This vaccine was only current for one year. The expiration date was 3/29/25.

2. Review of Resident 10's pet (dog) vaccination form, dated 3/30/22, indicated. the vaccination for rabies was given on 3/20/22. This vaccine was only current for one year. The expiration dated was 3/20/23.

3. Review of Resident 14's pet (cat) vaccination form, dated 3/28/24, indicated the

vaccination for rabies was given on 3/28/24. This vaccine was only current for one year. The expiration date was 3/28/25.

4. Review of Resident 15's Pet A and Pet B (cats) vaccination forms, dated 2/24/23 indicated Pet A's rabies vaccine was given on 2/24/23. This vaccine was only current for one year. The expiration date was 2/24/24. Pet B's rabies vaccine was given on 2/24/23. This vaccine was only current for one year. The expiation date was 2/24/24.

A record review, on 10/22/25 at 11:05 AM, a form listed all pets that reside in facility, dated 10/2/25, indicated Resident 4, Resident 10, Resident 14, and Resident 15 pets did not have current, up to date vaccination.

In an interview, on 10/22/25 at 2:14 PM, the Administrator indicated the facility planned on having a clinic in November to catch up on the vaccinations not up to date.

No other forms were provided by administration before or during exit.

A current facility policy, titled, Pet Policy, no date, was provided by the Administrator on 10/22/25 at 2:14 PM. The policy indicated..." A certificate signed by a licensed veterinarian or a state or local authority

	empowered to inoculate animals (or designated agent of such authority) stating that the pet has received all inoculations required by applicable state and local law...."			
R 0353	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(f) (f) The facility shall have a policy that ensures the staff has sufficient information to meet the residents ' needs. Based on interview and record review, the facility failed to maintain current information in the emergency file book related to hospital preference for 6 of 6 residents reviewed (Resident 3, Resident 4, Resident 7, Resident 11, Resident 12, and Resident 13). Findings include: During a review of the emergency file book on 10/22/25 at 2:10 PM., 6 residents lacked hospital preference on their emergency file. 1. Review of Resident 3's emergency file, dated 11/21/223, indicated there was not a hospital preference available in the file. 2. Review of Resident 4's emergency file, dated 11/21/23,	R 0353	1. The residents' clinical record was updated as of 11/3/25 with the hospital preference for Resident's 3, 4, 7, 11, 12, and 13 and updated in the emergency binder. 2. An Audit was completed by the administrator of resident's clinical records to ensure a hospital preference was listed on each resident's clinical record in the event of an emergency. Any resident's clinical record identified through the audit that were found to not have complete documentation or a hospital preference listed were addressed at the time of the finding.	11/21/2025

	indicated was not a hospital preference available in the file. 3. Review of Resident 7's emergency file, dated 6/25/25, indicated there was not a hospital preference available in the file. 4. Review of Resident 11's emergency file, dated 11/21/23, there was not a hospital preference available in the file. 5. A review of Resident 12's emergency file, dated 11/20/23, indicated there was not a hospital preference available in the file. 6. Review of Resident 13's emergency file, dated 7/9/25, indicated there was not a hospital preference available in the file. In an interview, on 10/22/25 at 2:13 PM, the Administrator indicated the hospital preference should have printed in the emergency file. The Administrator indicated she would be figuring out what needed to be printed so all pertinent information would be available in case of an emergency. A current facility policy, titled, Emergency Evacuation-Resident's Information, dated 6/1/23, was provided by the Director of Nursing on 10/24/25 at 1:22		3. -The IDT was in-serviced by the Administrator on 11/7/25 on the facility's Emergency Evacuation - Resident's Information Policy; specific to, ensuring resident records include the hospital preference on the resident's emergency file. -Resident records will be reviewed upon admission by the DON, or designee, to ensure resident records include a hospital preference on the resident's emergency file. 4.The DON, with oversight from the Administrator, will conduct monthly audits to ensure resident records are complete and accurate to include; the resident record having a hospital preference listed on the resident's emergency file. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	

	PM. The policy indicated..." An emergency evacuation binder will be kept available and up to date with each residents emergency contact information and specific needs. This emergency evacuation binder will be kept at the central command station in the event of a facility emergency and/or evacuation proceedings...Each residents personal emergency information will be collected for each upon admission, and updated as needed throughout the resident's admission, and no less than annually during the resident's care plan...Emergency information will include: Resident name and pertinent identifying information, resident representative and contact information, evacuation type, hospital preference, and medical diagnosis...." Based on interview and record review, the facility failed to maintain current information in the emergency file book related to hospital preference for 6 of 6 residents reviewed (Resident 3, Resident 4, Resident 7, Resident 11, Resident 12, and Resident 13). Findings include: During a review of the emergency file book on 10/22/25 at 2:10 PM., 6 residents lacked hospital preference on their emergency			

file.

1. Review of Resident 3's emergency file, dated 11/21/223, indicated there was not a hospital preference available in the file.

2. Review of Resident 4's emergency file, dated 11/21/23, indicated was not a hospital preference available in the file.

3. Review of Resident 7's emergency file, dated 6/25/25, indicated there was not a hospital preference available in the file.

4. Review of Resident 11's emergency file, dated 11/21/23, there was not a hospital preference available in the file.

5. A review of Resident 12's emergency file, dated 11/20/23, indicated there was not a hospital preference available in the file.

6. Review of Resident 13's emergency file, dated 7/9/25, indicated there was not a hospital preference available in the file.

In an interview, on 10/22/25 at 2:13 PM, the Administrator indicated the hospital preference should have printed in the emergency file. The Administrator indicated she would be figuring out what needed to be printed so all

	pertinent information would be available in case of an emergency. A current facility policy, titled, Emergency Evacuation-Resident's Information, dated 6/1/23, was provided by the Director of Nursing on 10/24/25 at 1:22 PM. The policy indicated..." An emergency evacuation binder will be kept available and up to date with each residents emergency contact information and specific needs. This emergency evacuation binder will be kept at the central command station in the event of a facility emergency and/or evacuation proceedings...Each residents personal emergency information will be collected for each upon admission, and updated as needed throughout the resident's admission, and no less than annually during the resident's care plan...Emergency information will include: Resident name and pertinent identifying information, resident representative and contact information, evacuation type, hospital preference, and medical diagnosis...."			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including	R 0409	1. -The resident’s clinical record was updated as of 11/2/25 with a current annual health statement for Resident’s	11/21/2025

history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.

Based on interview and record review the facility failed to ensure 3 of 6 residents reviewed had a current annual health statement. (Resident 3, Resident 7, and Resident 10)

Findings include:

1) Resident 3's record review began on 10/22/25 at 9:33 AM. The record indicated his diagnosis included major depressive disorder, Parkinson's, and anxiety. Resident 3 did not have a current annual health statement available in the record. His health statement was dated 3/5/2020.

2) Resident 7's record review began on 10/22/25 10:24AM. The record indicated her diagnosis included bipolar disorder, borderline personality, and schizoaffective disorder. Resident 7 did not have an annual physician statement documented in the record to indicate she was free from communicable diseases.

3) Resident 10's record review began on 10/22/25 at 11:16AM. The record indicated his diagnosis included alcoholic and

3, 7, and 10.

2.

-An Audit was completed by the DON of residents' clinical records to ensure residents had a current annual health assessment/statement. Any resident clinical records identified through the audit to not have a current health statement on record were addressed at the time of the finding.

3.

-The facility's policy on Infection Control, specific to, ensuring residents' clinical record includes a current annual health assessment/statement that the resident is free from past or present infectious diseases upon admission, and annually thereafter, was reviewed and revised by the Administrator on 11/5/25.

-The DON was in-serviced by the Administrator on 11/7/25 on the facility's Infection Control

	polyneuropathy. Resident 10's physician orders indicated his annual health statement was dated 5/21/21. In an interview, on 10/22/25 at 2:13PM, the Administrator indicated everyone should have a current annual health statement done annually and no more than 12 months apart. In an interview, on 10/24/25 at 10:03AM, the Director of Nursing (DON) indicated she was not aware residents were to have annual health statements. She indicated she did not know the health statement needed to be renewed annually. A policy was requested on 10/22/25 at 2:16 PM, 2 policies were provided, neither were specific to the annual health statement. In an interview, on 10/24/25 at 10:34AM, the DON indicated she did not have access to the policy. She indicated The policies were locked up in the Administrators office. The administrator was not available at the time. In an interview, on 10/24/25 at 11:25AM, the DON indicated she was unable to find a policy regarding annual health statements. Upon exit on 10/24/25 at 11:30AM no policy regarding		policy, specific to, ensuring residents' clinical record includes a current annual health assessment/statement that the resident is free from past or present infectious diseases upon admission, and annually thereafter. -Residents' physicians orders will be reviewed upon admission by the DON, or designee, to ensure residents have a current health assessment/statement as part of the resident's clinical record. 4. The DON, with oversight from the Administrator, will conduct monthly audits to ensure residents' clinical records have a current annual health statement as part of the resident's clinical record. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	

	health statements had been provided. Based on interview and record review the facility failed to ensure 3 of 6 residents reviewed had a current annual health statement. (Resident 3, Resident 7, and Resident 10) Findings include: 1) Resident 3's record review began on 10/22/25 at 9:33 AM. The record indicated his diagnosis included major depressive disorder, Parkinson's, and anxiety. Resident 3 did not have a current annual health statement available in the record. His health statement was dated 3/5/2020. 2) Resident 7's record review began on 10/22/25 10:24AM. The record indicated her diagnosis included bipolar disorder, borderline personality, and schizoaffective disorder. Resident 7 did not have an annual physician statement documented in the record to indicate she was free from communicable diseases.			

3) Resident 10's record review began on 10/22/25 at 11:16AM. The record indicated his diagnosis included alcoholic and polyneuropathy. Resident 10's physician orders indicated his annual health statement was dated 5/21/21.

In an interview, on 10/22/25 at 2:13PM, the Administrator indicated everyone should have a current annual health statement done annually and no more than 12 months apart.

In an interview, on 10/24/25 at 10:03AM, the Director of Nursing (DON) indicated she was not aware residents were to have annual health statements. She indicated she did not know the health statement needed to be renewed annually.

A policy was requested on 10/22/25 at 2:16 PM, 2 policies were provided, neither were specific to the annual health statement.

In an interview, on 10/24/25 at 10:34AM, the DON indicated she did not have access to the policy. She indicated The policies were locked up in the Administrators office. The administrator was not available at the time.

In an interview, on 10/24/25 at 11:25AM, the DON indicated she was unable to find a policy regarding annual health

	statements. Upon exit on 10/24/25 at 11:30AM no policy regarding health statements had been provided.			

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 SIGNATUREJina Babani	TITLEAdministrator	(X6) DATE11/11/2025