STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD POINTE SENIOR LIVING	6235 STERLING CREEK RD, PORTAGE, , 46368

(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: October 22 and 23, 2025 Facility number: 012396 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/29/25.	R 0000	**The following is the Plan of Correction for Windward Pointe Senior Living in regards to the Statement of Deficiencies dated October 23rd, 2025. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.**	
R 0042	Residents' Rights - Noncompliance	R 0042	**1. What corrective actions will be accomplished**	11/17/2025

	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 observation and interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 72 residents residing in the facility. Finding includes: A general tour of the facility was conducted on 10/22/25 at 10:07 a.m. The annual survey results were not available in the lobby area and there was no sign to indicate where they were located. During an interview on 10/22/25 at 10:08 a.m., Concierge 1 indicated the survey results binder was usually kept in the lobby area. After a brief search, she located the survey binder behind the reception desk with the other facility binders. She indicated she was unsure why it was placed there. Based on observation and interview, the facility failed to ensure the most recent annual		**for those residents found to have been affected by the deficient practice?The most recent annual survey results binder was immediately located and placed in the designated, clearly visible location in the main lobby area on 10/22/25. A sign was posted in lobby indicating, *“Most Recent State Survey Results and Plan of Correction – Available for Resident and Visitor Review.”*** **2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Because the survey results were not readily visible to residents and visitors, all residents had the potential to be affected.To correct this and prevent recurrence, the Administrator verified that the binder and signage are properly displayed and easily accessible to all residents, family members, and visitors. Staff were reminded that this binder should not be stored behind the desk or out of public view. A sign is**	

	survey results were readily available for review. This had the potential to affect all 72 residents residing in the facility. Finding includes: A general tour of the facility was conducted on 10/22/25 at 10:07 a.m. The annual survey results were not available in the lobby area and there was no sign to indicate where they were located. During an interview on 10/22/25 at 10:08 a.m., Concierge 1 indicated the survey results binder was usually kept in the lobby area. After a brief search, she located the survey binder behind the reception desk with the other facility binders. She indicated she was unsure why it was placed there.		**also displayed letting people know Binder is available.** 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?will be reeducated by 11/17/25 by Executive Director? regarding regulatory requirements for the binder being readily available and the survey results binder will be in the lobby, and a sign will remain posted at all times. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?The Executive director or designee will conduct a weekly audit for 6 weeks to ensure the survey binder in present and clearly visible in the lobby and then will be reviewed monthly at QA meeting.	
R 0045	Residents' Rights - Deficiency	R 0045	**1. What Corrective actions accomplished for those**	11/17/2025

	410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the		**residents found to have been affected by the deficient practiceStaff will be re-educated by DON or designee by 11/17/25 on the proper use and completion of the State-approved transfer/discharge form whenever a resident is transferred or discharged, including hospital transfers.** **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents who experience a hospital transfer or discharge have the potential to be affected. A review of all resident transfers and discharges from the previous 90 days will be conducted by the DON or designee by 11/17/25 to ensure that each include a completed and properly filed State-approved Transfer and Discharge Notice.** **3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?Staff will be**	

	resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged.		**reeducated by DON or designee by 11/17/25 on transfer and discharge forms including when and how to complete the form and DON will ensure forms are easily accessible at each nurses station.** **4. How the corrective action will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)The DON or designee will audit all resident transfers and discharges weekly for 6 weeks ensuring that each includes properly completed State approved transfer and discharge form. If compliance is maintained, audits will the occur monthly for 3 months and findings will be reported during QA meeting.**	

(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .

(E) The name of the director and the address, telephone number, and hours of operation of the division.

(F) A hearing request form prescribed by the department.

(G) The name, address, and telephone number of the state and local long term care ombudsman.

(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

	Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 1 of 7 records reviewed. (Resident 7) Finding includes: The closed record for Resident 7 was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease. A Progress Note, dated 8/25/25 at 11:00 a.m., indicated the resident was observed attempting to self-transfer from the wheelchair to the sofa. The wheelchair was not locked and rolled backwards. The resident slipped off the edge of the seat landing on buttock on the floor. She did not hit her head and a full assessment was completed. The resident stated her "butt hurts a little." Range of motion was within normal limits on all four extremities and no shortening/rotation was observed to the bilateral lower extremities. The Power of Attorney (POA) and Nurse Practitioner were notified. A Progress Note, dated 8/25/25 at 2:00 p.m., indicated the resident was transported to the emergency room from the dialysis center for complaints of			

pain. The Nurse Practitioner and the Administrator were aware.

A Progress Note, dated 9/1/25 at 11:00 a.m., indicated the resident was complaining of severe pain to entire body and stated she wanted to go to the hospital. Her POA was visiting and aware.

A Progress Note, dated 9/1/25 at 8:50 p.m., indicated the resident was being admitted to the hospital with diagnosis of inferior pubic rami fracture.

There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization.

During an interview on 10/23/25 at 1:56 p.m., the Director of Nursing indicated she was unable to find any transfer/discharge paperwork related to the hospitalization.

Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 1 of 7 records reviewed. (Resident 7)

Finding includes:

The closed record for Resident 7 was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end

	stage renal disease and chronic obstructive pulmonary disease. A Progress Note, dated 8/25/25 at 11:00 a.m., indicated the resident was observed attempting to self-transfer from the wheelchair to the sofa. The wheelchair was not locked and rolled backwards. The resident slipped off the edge of the seat landing on buttock on the floor. She did not hit her head and a full assessment was completed. The resident stated her "butt hurts a little." Range of motion was within normal limits on all four extremities and no shortening/rotation was observed to the bilateral lower extremities. The Power of Attorney (POA) and Nurse Practitioner were notified. A Progress Note, dated 8/25/25 at 2:00 p.m., indicated the resident was transported to the emergency room from the dialysis center for complaints of pain. The Nurse Practitioner and the Administrator were aware. A Progress Note, dated 9/1/25 at 11:00 a.m., indicated the resident was complaining of severe pain to entire body and stated she wanted to go to the hospital. Her POA was visiting and aware. A Progress Note, dated 9/1/25 at 8:50 p.m., indicated the resident was being admitted to			

	the hospital with diagnosis of inferior pubic rami fracture. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization. During an interview on 10/23/25 at 1:56 p.m., the Director of Nursing indicated she was unable to find any transfer/discharge paperwork related to the hospitalization.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings;	R 0090	**1. What Corrective actions were accomplished for those residents found to have been affected by the deficient practice?Resident 7 is no longer residing in the facility. The incident was retrospectively reported to the Indiana Department of Health on 10/23/25, once identified during survey.The Administrator reviewed the event with the Director of Nursing (DON) and staff involved to ensure full understanding of the requirement to report any major accident, including all fractures, to IDOH within 24 hours of awareness.All licensed nurses and department heads were re-educated on the IDOH Long Term Care Incident and Accident**	11/17/2025

	(C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the		**Reporting Policy on 10/23/25.** **2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected if incidents are not reported in a timely manner.To identify any similar occurrences, the Administrator and DON completed a review of all incident and accident reports on 10/24/25 for the previous 90 days to ensure all reportable events were submitted to IDOH as required.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?Staff will be reeducated by 11/17/25 by DON or designee of accident and incident policy which included reporting guidelines. All incidents will be reviewed at morning**	

	public upon request Based on record review and interview, the facility failed to ensure a fall resulting in a fracture was reported to the Indiana Department of Health (IDOH) for 1 of 7 residents reviewed. (Resident 7) Finding includes: The closed record for Resident 7 was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease. A Progress Note, dated 8/25/25 at 11:00 a.m., indicated the resident was observed attempting to self-transfer from the wheelchair to the sofa. The wheelchair was not locked and rolled backwards. The resident slipped off the edge of the seat landing on buttock on the floor. She did not hit her head and a full assessment was completed. The resident stated her "butt hurts a little." Range of motion was within normal limits on all four extremities and no shortening/rotation was observed to the bilateral lower extremities. The Power of Attorney (POA) and Nurse Practitioner were notified. A Progress Note, dated 8/25/25 at 2:00 p.m., indicated the resident was transported to the		**meeting to confirm if they meet reporting criteria.** **4. How the corrective action will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)The ED or DON will audit all incidents and accident reports weekly for 6 weeks to ensure all reportable incidents get properly submitted to ISDH within 24 hours. Ongoing compliance monitoring will continue as part of the facility QA program.**	

emergency room from the dialysis center for complaints of pain. The Nurse Practitioner and the Administrator were aware.

A Progress Note, dated 9/1/25 at 11:00 a.m., indicated the resident was complaining of severe pain to entire body and stated she wanted to go to the hospital. Her POA was visiting and aware.

A Progress Note, dated 9/1/25 at 8:50 p.m., indicated the resident was being admitted to the hospital with diagnosis of inferior pubic rami fracture.

During an interview on 10/23/25 at 3:15 p.m., the Administrator indicated the staff had not informed her that the resident had been admitted to the hospital with a fracture so it was never reported.

The Indiana Department of Health Long Term Care Abuse and Incident Reporting Policy, updated 12/6/22, indicated "...Licensed Residential Care Facilities...C. Types of incidents reportable under state rules. Any occurrence that directly threatens the welfare, safety, or health of a resident, such as:...10. Major accidents: Required to report examples include but are not limited to: a. All fractures..."

Based on record review and interview, the facility failed to

ensure a fall resulting in a fracture was reported to the Indiana Department of Health (IDOH) for 1 of 7 residents reviewed. (Resident 7)

Finding includes:

The closed record for Resident 7 was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease.

A Progress Note, dated 8/25/25 at 11:00 a.m., indicated the resident was observed attempting to self-transfer from the wheelchair to the sofa. The wheelchair was not locked and rolled backwards. The resident slipped off the edge of the seat landing on buttock on the floor. She did not hit her head and a full assessment was completed. The resident stated her "butt hurts a little." Range of motion was within normal limits on all four extremities and no shortening/rotation was observed to the bilateral lower extremities. The Power of Attorney (POA) and Nurse Practitioner were notified.

A Progress Note, dated 8/25/25 at 2:00 p.m., indicated the resident was transported to the emergency room from the dialysis center for complaints of pain. The Nurse Practitioner and the Administrator were aware.

	A Progress Note, dated 9/1/25 at 11:00 a.m., indicated the resident was complaining of severe pain to entire body and stated she wanted to go to the hospital. Her POA was visiting and aware. A Progress Note, dated 9/1/25 at 8:50 p.m., indicated the resident was being admitted to the hospital with diagnosis of inferior pubic rami fracture. During an interview on 10/23/25 at 3:15 p.m., the Administrator indicated the staff had not informed her that the resident had been admitted to the hospital with a fracture so it was never reported. The Indiana Department of Health Long Term Care Abuse and Incident Reporting Policy, updated 12/6/22, indicated "...Licensed Residential Care Facilities...C. Types of incidents reportable under state rules. Any occurrence that directly threatens the welfare, safety, or health of a resident, such as:...10. Major accidents: Required to report examples include but are not limited to: a. All fractures..."			

R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.	R 0092	**1. Corrective actions accomplished for those residents found to have been affected by the deficient practice** **Although no residents were directly affected by this deficient practice, all residents had the potential to be affected. By 11/17/25 the ED or Maintenance Director will contact the local fire department to re-establish collaboration for semiannually meeting for the fire and disaster drills and copies of documentation will be placed in fire/disaster binder and sent via email** **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **All residents residing in the facility have the potential to be affected. To ensure compliance, the maintenance director reviewed all fire drill logs for the previous 12 months to verify participation records and identify gaps. Moving forward, all future fire**	10/31/2025

	Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 72 residents residing in the facility. Finding includes: The fire drill log for the past twelve months was reviewed on 10/22/25 at 10:25 a.m. The logs included the date, time, and participants. There was no documentation the fire department had attended or been invited to any of the drills. During an interview on 10/22/25 at 10:40 a.m., the Maintenance Director indicated he had invited the fire department once. He provided an email dated 9/25/25 that invited the fire department to attend a fire drill at the facility. The Executive Director (ED) was present and indicated she had invited the fire department at another time and would provide a copy of the email. During an interview on 10/23/25 at 10:05 a.m., the ED indicated she was unable to locate any other emails and had no additional information to provide. Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the		**drill logs will include a specific section to document:** **The date the fire department was invited,** **Response received, and** **Attendance status (attended, declined, or unavailable).** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** **By 11/17/25 our online work order system/app has been updated to ensure we invite the fire department semiannually and document it.** **compliance semiannually.** **The Executive Director will review and sign off on each monthly drill record to confirm that invitations have been sent and documented as required.** **4. How the corrective action**	

	potential to affect all 72 residents residing in the facility. Finding includes: The fire drill log for the past twelve months was reviewed on 10/22/25 at 10:25 a.m. The logs included the date, time, and participants. There was no documentation the fire department had attended or been invited to any of the drills. During an interview on 10/22/25 at 10:40 a.m., the Maintenance Director indicated he had invited the fire department once. He provided an email dated 9/25/25 that invited the fire department to attend a fire drill at the facility. The Executive Director (ED) was present and indicated she had invited the fire department at another time and would provide a copy of the email. During an interview on 10/23/25 at 10:05 a.m., the ED indicated she was unable to locate any other emails and had no additional information to provide.		**will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)The Executive Director or designee will audit the fire drill logs and fire department invitation documentation quarterly for one year to ensure compliance.** **Results of fire drill and invitation to local fire department will be reviewed during the facility's QA meetings.**	
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	R 0216	**1. Corrective actions accomplished for those residents found to have been affected by the deficient practice** **Resident 2 and Resident 5**	10/31/2025

	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 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. 2. Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident admitted to the facility on 1/25/25. There was no admission weight available for review. During an interview on 10/23/25 at 8:40 a.m., the Director of Nursing indicated she was not able to find any weights recorded at the time of admission in the resident's record.		**were both weighed within 30 days and DON reviewed both residents' records to ensure all other required evaluation components were complete and up to date.** **By 11/17/25 all licensed nursing staff responsible for admissions and monthly vitals will be re-educated by DON or designee on the requirement to obtain and document admission and semiannual weights for every resident.** **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **All residents residing in the facility have the potential to be affected by this deficient practice.** **By 11/17/25 The DON and designee will complete an audit of all resident records to verify that each record includes: An admission weight and semi annual weight** **3. What measures will be put into place or what**	

	Based on record review and interview, the facility failed to ensure resident weights were obtained on admission and/ or semi-annually for 2 of 7 records reviewed. (Residents 2 and 5) Findings include: 1. Resident 2's record was reviewed on 10/22/25 at 11:00 a.m. The resident was admitted on 1/24/25. There was no admission weight recorded on admission. The monthly vital signs and weight log had vital signs recorded for January 2025, but no weight was recorded. There was no weight recorded until March 2025. During an interview on 10/22/25 at 2:57 p.m., the Director of Nursing indicated there was no admission weight available. 2. Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident admitted to the facility on 1/25/25. There was no admission weight available for review. During an interview on 10/23/25 at 8:40 a.m., the Director of Nursing indicated she was not able to find any weights recorded at the time of		**systemic changes will the facility make to ensure that the deficient practice does not recur** **All staff will be reeducated by 11/17/25 on the procedures for obtaining weights, recording, and documenting weights.** **4. How will the corrective action be monitored to ensure the deficient practice will not recur (Quality Assurance Program)** **The DON or designee will audit all move in documentation within 48 hours of the move in x 2 months, and will audit 10% resident files each month x 3 months, for semi-annual weights. The results of the file audits will be reported to the monthly QA committee meeting.**	

admission in the resident's record.

Based on record review and interview, the facility failed to ensure resident weights were obtained on admission and/ or semi-annually for 2 of 7 records reviewed. (Residents 2 and 5)

Findings include:

1. Resident 2's record was reviewed on 10/22/25 at 11:00 a.m. The resident was admitted on 1/24/25. There was no admission weight recorded on admission.

The monthly vital signs and weight log had vital signs recorded for January 2025, but no weight was recorded. There was no weight recorded until March 2025.

During an interview on 10/22/25 at 2:57 p.m., the Director of Nursing indicated there was no admission weight available.

2. Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident admitted to the facility on 1/25/25.

There was no admission weight available for review.

During an interview on 10/23/25 at 8:40 a.m., the Director of

	Nursing indicated she was not able to find any weights recorded at the time of admission in the resident's record. Based on record review and interview, the facility failed to ensure resident weights were obtained on admission and/ or semi-annually for 2 of 7 records reviewed. (Residents 2 and 5) Findings include: 1. Resident 2's record was reviewed on 10/22/25 at 11:00 a.m. The resident was admitted on 1/24/25. There was no admission weight recorded on admission. The monthly vital signs and weight log had vital signs recorded for January 2025, but no weight was recorded. There was no weight recorded until March 2025. During an interview on 10/22/25 at 2:57 p.m., the Director of Nursing indicated there was no admission weight available. 2. Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident admitted to the facility on 1/25/25.			

	There was no admission weight available for review. During an interview on 10/23/25 at 8:40 a.m., the Director of Nursing indicated she was not able to find any weights recorded at the time of admission in the resident's record. Based on record review and interview, the facility failed to ensure resident weights were obtained on admission and/ or semi-annually for 2 of 7 records reviewed. (Residents 2 and 5) Findings include: 1. Resident 2's record was reviewed on 10/22/25 at 11:00 a.m. The resident was admitted on 1/24/25. There was no admission weight recorded on admission. The monthly vital signs and weight log had vital signs recorded for January 2025, but no weight was recorded. There was no weight recorded until March 2025. During an interview on 10/22/25 at 2:57 p.m., the Director of Nursing indicated there was no admission weight available.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	**1. Corrective actions accomplished for those residents**	10/31/2025

	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (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		**found to have been affected by the deficient practice** **Resident 5's service plan was immediately reviewed and updated on 10/23/25 to reflect continuous oxygen therapy at 5 liters per minute and staff assistance as needed. Resident 7's service plan was reviewed and updated by DON on 10/23/25 to include participation in physical and occupational therapy services, with documentation of therapy coordination and progress monitoring.** **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **All residents receiving oxygen therapy, third-party therapy (PT/OT/ST), or other outside clinical services have the potential to be affected by this deficient practice.** **To identify any similar issues:** **The DON or designee will conduct an audit of all**	

	be provided. Based on observation, record review, and interview, the facility failed to ensure a resident's service plan was up to date related to oxygen use and therapy services for 2 of 7 residents reviewed. (Resident 5 and 7) Findings include: 1. During an observation of Resident 5 on 10/22/25 at 1:20 p.m., the resident was observed in his room with oxygen via nasal cannula running at 5 liters per minute. Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus. A resident list provided by the Director of Nursing on 10/22/25 at 9:45 a.m., indicated the resident used oxygen therapy. The Service Plan, dated 6/11/25, indicated the resident had occasional confusion and some difficulty recalling details and needed occasional prompting or orientation. Oxygen therapy use and employee assistance with oxygen use both were marked "no." During an interview on 10/22/25		**residents receiving oxygen or therapy services by 11/17/25, reviewing each service plan to ensure the services provided are documented.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** **By 11/17/25 staff will be reeducated by DON on process for reviewing and revising resident service plans when changes occur. The DON or ED will review each new or revised service plan for completeness and accuracy before filing.** **4. How the corrective action will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)** **The DON or designee will audit: 10 resident service plans weekly for 6 weeks, verifying that each reflects**	

	at 3:29 p.m., the Director of Nursing indicated the resident had oxygen therapy continuously, however it was not marked on the Service Plan. 2. Resident 7's closed record was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease. A Progress Note, dated 7/16/25 at 8:00 a.m., indicated the resident had requested physical/occupational therapy (PT/OT) due to recent falls and weakness post hospital stay, information was faxed to the Nurse Practitioner. A Progress Note, dated 7/22/25 at 10:00 a.m., indicated orders for PT and OT were received and the therapy company was sent the information. The Service Plan, dated 7/7/25, indicated the resident was alert and oriented. There were no third party services listed on the service plan. There were no updated service plans in the resident record. During an interview on 10/23/25 at 3:19 p.m., the Director of Nursing indicated she had no further information to provide. Based on observation, record review, and interview, the facility failed to ensure a resident's		**current treatments, oxygen therapy, and outside service involvement. Ongoing compliance will be monitored through the facility's QA Program.**	

service plan was up to date related to oxygen use and therapy services for 2 of 7 residents reviewed. (Resident 5 and 7)

Findings include:

1. During an observation of Resident 5 on 10/22/25 at 1:20 p.m., the resident was observed in his room with oxygen via nasal cannula running at 5 liters per minute.

Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but were not limited to, dementia and diabetes mellitus.

A resident list provided by the Director of Nursing on 10/22/25 at 9:45 a.m., indicated the resident used oxygen therapy.

The Service Plan, dated 6/11/25, indicated the resident had occasional confusion and some difficulty recalling details and needed occasional prompting or orientation. Oxygen therapy use and employee assistance with oxygen use both were marked "no."

During an interview on 10/22/25 at 3:29 p.m., the Director of Nursing indicated the resident had oxygen therapy continuously, however it was not marked on the Service Plan.

	2. Resident 7's closed record was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease. A Progress Note, dated 7/16/25 at 8:00 a.m., indicated the resident had requested physical/occupational therapy (PT/OT) due to recent falls and weakness post hospital stay, information was faxed to the Nurse Practitioner. A Progress Note, dated 7/22/25 at 10:00 a.m., indicated orders for PT and OT were received and the therapy company was sent the information. The Service Plan, dated 7/7/25, indicated the resident was alert and oriented. There were no third party services listed on the service plan. There were no updated service plans in the resident record. During an interview on 10/23/25 at 3:19 p.m., the Director of Nursing indicated she had no further information to provide.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in	R 0273	**1. Corrective actions accomplished for those residents found to have been affected by the deficient practice? Although no residents were identified as being**	10/31/2025

	accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dishes stored upright on a kitchen shelf, not sanitizing a blender blade in between uses, and touching food and non-food items with the same gloved hands. This had the potential to affect all 72 residents who received food from the kitchen. (Main Kitchen) Findings include: 1. The initial Kitchen Tour was completed on 10/22/25 at 9:21 a.m. with the Culinary Director (CD). The following was observed: Plates were stored upright on a shelf near the ovens and steam table. 2. On 10/22/25 at 11:02 a.m., with Cook 1 and the CD, the following was observed: a. Cook 1 was observed finishing up pureed spinach and indicated she was going to puree roast beef. She then took the blender blade to the sink and rinsed it with hot water. The cook did not wash or sanitize the blender blade. She then started the preparation to puree the roast beef. During an interview at that time, Cook 1		**directly affected, all residents receiving food prepared in the facility's kitchen had the potential to be affected.On 10/22/25, the culinary service director immediately removed dishes from the shelf, washed, sanitized, and re-stored in an inverted position to prevent contamination. The blender and blade used for pureed foods were washed, rinsed, and sanitized. By 11/17/25 The Culinary Director and all culinary staff will be reeducated by ED on proper hand hygiene, glove changes between tasks, and sanitization procedures for all food-contact equipment between uses. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents receiving meals from the main kitchen have the potential to be affected. The Culinary Director conducted a comprehensive**	

	indicated she did not wash or sanitize the blender blade and only rinsed it under hot water. During an interview at that time, the CD indicated the cook was to wash and sanitize the blender blade in between uses. She then informed the cook to use a different blender. b. The CD was observed with gloves on. She proceeded to touch and open the oven door and take out a bun. She broke the bun up with the same gloved hands and put the bun into the puree blender. She then touched the puree blender and opened the oven door again and took out another bun with the same gloved hands, broke it up, and placed it into the puree blender. During an interview on 10/22/25 at 11:35 a.m., the CD indicated the dishes should have been stored inverted. She also should not have touched the food and non-food items with the same gloved hands. The facility did not provide any policies related to the above concerns. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dishes stored upright on a kitchen shelf, not sanitizing a blender blade in between uses,		**inspection of the kitchen and food preparation areas on 10/23/25, including all utensils, blenders, and dish storage areas, to ensure compliance with sanitation standards.** **Any items not stored or maintained according to state and local sanitation codes were rewashed, sanitized, and properly stored.** **A review of staff practices was conducted by observation of meal prep and service on all shifts to ensure adherence to proper glove use, food handling, and sanitization procedures.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** **By 11/17/25 All culinary staff will be reeducated by Culinary Director or Administrator regarding sanitation policies and proper food handling techniques. The Culinary Director or designee will complete**	

	and touching food and non-food items with the same gloved hands. This had the potential to affect all 72 residents who received food from the kitchen. (Main Kitchen) Findings include: 1. The initial Kitchen Tour was completed on 10/22/25 at 9:21 a.m. with the Culinary Director (CD). The following was observed: Plates were stored upright on a shelf near the ovens and steam table. 2. On 10/22/25 at 11:02 a.m., with Cook 1 and the CD, the following was observed: a. Cook 1 was observed finishing up pureed spinach and indicated she was going to puree roast beef. She then took the blender blade to the sink and rinsed it with hot water. The cook did not wash or sanitize the blender blade. She then started the preparation to puree the roast beef. During an interview at that time, Cook 1 indicated she did not wash or sanitize the blender blade and only rinsed it under hot water. During an interview at that time, the CD indicated the cook was to wash and sanitize the blender blade in between uses. She then informed the cook to use a different blender. b. The CD was observed with		**checks of dish storage, sanitization logs, and food prep areas to ensure ongoing compliance at least 3 times per week for 1 month and then if compliance is met weekly for 1 month.** **4. How the corrective action will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)** **The Culinary Director or designee will conduct weekly sanitation audits for 6 weeks, then monthly for 3 months, verifying compliance with: proper dish storage, equipment sanitation between uses, and glove use/food handling procedures.** **Ongoing compliance will be maintained through inclusion of food safety audits in the facility's continuous QA monitoring program.**	

	gloves on. She proceeded to touch and open the oven door and take out a bun. She broke the bun up with the same gloved hands and put the bun into the puree blender. She then touched the puree blender and opened the oven door again and took out another bun with the same gloved hands, broke it up, and placed it into the puree blender. During an interview on 10/22/25 at 11:35 a.m., the CD indicated the dishes should have been stored inverted. She also should not have touched the food and non-food items with the same gloved hands. The facility did not provide any policies related to the above concerns.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.	R 0349	**1. Corrective actions accomplished for those residents found to have been affected by the deficient practice** **The DON reviewed the medication orders with licensed nursing staff to ensure future clarity and accuracy in documentation. No current residents were identified as having medication order discrepancies or**	10/31/2025

	Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medications for 2 of 7 records reviewed. (Residents 8 and 7) Findings include: 1. Closed record review for Resident 8 was completed on 10/23/25 at 11:17 a.m. Diagnoses included, but were not limited to, hypertension, dementia, and anxiety. A Service Plan, dated 7/18/25, indicated the resident was cognitively impaired. The August 2025 Physician's Order Summary (POS) indicated the following orders. - Check blood pressure (BP) once daily in the morning. If the BP was greater than 140/90, give 20 mg (milligrams) PRN (when necessary) furosemide (reduces excess fluid in the body). - furosemide 20 mg once daily PRN for BP 140/90 The July 2025 Medication Administration Record (MAR) indicated the following: - 7/25/25 at 8:00 a.m., BP was 141/92, the PRN furosemide		**incomplete MARs during an immediate audit conducted on 10/23/25.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** **By 11/17/25 All residents receiving PRN and parameter-based medications (e.g., those requiring blood pressure parameters for administration or holding) will have MAR audited for accuracy of documentation and PRN administration compliance. The audit will be completed by DON weekly for 6 weeks.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** **Staff will be reeducated by DON or designee by 11/17/25 in regards to accurate and complete documentation of medication**	

	was not administered - 7/31/25 at 8:00 a.m., BP was 143/94, the PRN furosemide was not administered The August 2025 MAR indicated the following: - 8/5/25 at 8:00 a.m., BP was 147/92, the PRN furosemide was not administered During an interview on 10/23/25 at 3:20 p.m., the Director of Nursing (DON) indicated she could not provide any further information related to the PRN furosemide. The PRN furosemide should have been administered on the above dates and times. 2. Resident 7's closed record was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, high blood pressure, end stage renal disease, and dependence on renal dialysis. A Physician's Order, dated 7/22/25, indicated midodrine (medication to treat low blood pressure) 10 milligram tablet, 1 tablet by mouth three times daily with meals. Hold for systolic blood pressure (top number) greater than 140. The July and August 2025 Medication Administration Record indicated the midodrine was not held as ordered on		**administration on the MAR, Correct use of PRN medications in accordance with physician parameters, Documentation of reasons when medications are held or not administered, Proper documentation of blood pressure readings tied to medication decisions. Emphasis will be placed on ensuring that documentation matches physician orders exactly and that clinical rationale is noted when medications are held or administered outside parameters.** **4. How the corrective action will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)** **The DON or designee will perform weekly audits for 6 weeks of 5 randomly selected resident MARs (focusing on PRN and parameter-based medications) to ensure all documentation is accurate and complete.** **Ongoing compliance will be monitored through the facility's routine medication pass observations and quarterly documentation**	

	7/28/25 at 12:00 p.m. with a blood pressure (BP) of 142/65. The July and August 2025 Medication Administration Record indicated the midodrine was held outside of parameters on the following dates and times: - 8:00 a.m.: 8/3/25 BP 102/74 and 8/11/25 BP 121/78 - 12:00 p.m.: 8/3/25 BP 119/81 - 5:00 p.m.: 8/2/25 BP 112/62 and 8/3/25 BP 113/90 During an interview on 10/23/25 at 3:19 p.m., the Director of Nursing indicated she had no further information related to the midodrine medication administration and holding outside of the parameters. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medications for 2 of 7 records reviewed. (Residents 8 and 7) Findings include: 1. Closed record review for Resident 8 was completed on 10/23/25 at 11:17 a.m. Diagnoses included, but were not limited to, hypertension, dementia, and anxiety. A Service Plan, dated 7/18/25,		**audits conducted by the DON or consultant pharmacist.**	

indicated the resident was cognitively impaired.

The August 2025 Physician's Order Summary (POS) indicated the following orders.

- Check blood pressure (BP) once daily in the morning. If the BP was greater than 140/90, give 20 mg (milligrams) PRN (when necessary) furosemide (reduces excess fluid in the body).

- furosemide 20 mg once daily PRN for BP 140/90

The July 2025 Medication Administration Record (MAR) indicated the following:

- 7/25/25 at 8:00 a.m., BP was 141/92, the PRN furosemide was not administered

- 7/31/25 at 8:00 a.m., BP was 143/94, the PRN furosemide was not administered

The August 2025 MAR indicated the following:

- 8/5/25 at 8:00 a.m., BP was 147/92, the PRN furosemide was not administered

During an interview on 10/23/25 at 3:20 p.m., the Director of Nursing (DON) indicated she could not provide any further information related to the PRN furosemide. The PRN furosemide should have been

administered on the above dates and times.

2. Resident 7's closed record was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, high blood pressure, end stage renal disease, and dependence on renal dialysis.

A Physician's Order, dated 7/22/25, indicated midodrine (medication to treat low blood pressure) 10 milligram tablet, 1 tablet by mouth three times daily with meals. Hold for systolic blood pressure (top number) greater than 140.

The July and August 2025 Medication Administration Record indicated the midodrine was not held as ordered on 7/28/25 at 12:00 p.m. with a blood pressure (BP) of 142/65.

The July and August 2025 Medication Administration Record indicated the midodrine was held outside of parameters on the following dates and times:

- 8:00 a.m.: 8/3/25 BP 102/74 and 8/11/25 BP 121/78

- 12:00 p.m.: 8/3/25 BP 119/81

- 5:00 p.m.: 8/2/25 BP 112/62 and 8/3/25 BP 113/90

During an interview on 10/23/25 at 3:19 p.m., the Director of

Nursing indicated she had no further information related to the midodrine medication administration and holding outside of the parameters.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medications for 2 of 7 records reviewed. (Residents 8 and 7)

Findings include:

1. Closed record review for Resident 8 was completed on 10/23/25 at 11:17 a.m. Diagnoses included, but were not limited to, hypertension, dementia, and anxiety.

A Service Plan, dated 7/18/25, indicated the resident was cognitively impaired.

The August 2025 Physician's Order Summary (POS) indicated the following orders.

- Check blood pressure (BP) once daily in the morning. If the BP was greater than 140/90, give 20 mg (milligrams) PRN (when necessary) furosemide (reduces excess fluid in the body).

- furosemide 20 mg once daily PRN for BP 140/90

The July 2025 Medication Administration Record (MAR)

indicated the following:

- 7/25/25 at 8:00 a.m., BP was 141/92, the PRN furosemide was not administered

- 7/31/25 at 8:00 a.m., BP was 143/94, the PRN furosemide was not administered

The August 2025 MAR indicated the following:

- 8/5/25 at 8:00 a.m., BP was 147/92, the PRN furosemide was not administered

During an interview on 10/23/25 at 3:20 p.m., the Director of Nursing (DON) indicated she could not provide any further information related to the PRN furosemide. The PRN furosemide should have been administered on the above dates and times.

2. Resident 7's closed record was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, high blood pressure, end stage renal disease, and dependence on renal dialysis.

A Physician's Order, dated 7/22/25, indicated midodrine (medication to treat low blood pressure) 10 milligram tablet, 1 tablet by mouth three times daily with meals. Hold for systolic blood pressure (top number) greater than 140.

The July and August 2025 Medication Administration Record indicated the midodrine was not held as ordered on 7/28/25 at 12:00 p.m. with a blood pressure (BP) of 142/65.

The July and August 2025 Medication Administration Record indicated the midodrine was held outside of parameters on the following dates and times:

- 8:00 a.m.: 8/3/25 BP 102/74 and 8/11/25 BP 121/78

- 12:00 p.m.: 8/3/25 BP 119/81

- 5:00 p.m.: 8/2/25 BP 112/62 and 8/3/25 BP 113/90

During an interview on 10/23/25 at 3:19 p.m., the Director of Nursing indicated she had no further information related to the midodrine medication administration and holding outside of the parameters.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medications for 2 of 7 records reviewed. (Residents 8 and 7)

Findings include:

1. Closed record review for Resident 8 was completed on 10/23/25 at 11:17 a.m. Diagnoses included, but were

not limited to, hypertension, dementia, and anxiety.

A Service Plan, dated 7/18/25, indicated the resident was cognitively impaired.

The August 2025 Physician's Order Summary (POS) indicated the following orders.

- Check blood pressure (BP) once daily in the morning. If the BP was greater than 140/90, give 20 mg (milligrams) PRN (when necessary) furosemide (reduces excess fluid in the body).

- furosemide 20 mg once daily PRN for BP 140/90

The July 2025 Medication Administration Record (MAR) indicated the following:

- 7/25/25 at 8:00 a.m., BP was 141/92, the PRN furosemide was not administered

- 7/31/25 at 8:00 a.m., BP was 143/94, the PRN furosemide was not administered

The August 2025 MAR indicated the following:

- 8/5/25 at 8:00 a.m., BP was 147/92, the PRN furosemide was not administered

During an interview on 10/23/25 at 3:20 p.m., the Director of Nursing (DON) indicated she

	could not provide any further information related to the PRN furosemide. The PRN furosemide should have been administered on the above dates and times. 2. Resident 7's closed record was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, high blood pressure, end stage renal disease, and dependence on renal dialysis. A Physician's Order, dated 7/22/25, indicated midodrine (medication to treat low blood pressure) 10 milligram tablet, 1 tablet by mouth three times daily with meals. Hold for systolic blood pressure (top number) greater than 140. The July and August 2025 Medication Administration Record indicated the midodrine was not held as ordered on 7/28/25 at 12:00 p.m. with a blood pressure (BP) of 142/65. The July and August 2025 Medication Administration Record indicated the midodrine was held outside of parameters on the following dates and times: - 8:00 a.m.: 8/3/25 BP 102/74 and 8/11/25 BP 121/78 - 12:00 p.m.: 8/3/25 BP 119/81 - 5:00 p.m.: 8/2/25 BP 112/62			

	and 8/3/25 BP 113/90 During an interview on 10/23/25 at 3:19 p.m., the Director of Nursing indicated she had no further information related to the midodrine medication administration and holding outside of the parameters.			
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis.	R 0354	**1. Corrective actions accomplished for those residents found to have been affected by the deficient practice** **Staff involved in Resident 7's transfer were re-educated on the facility's requirement to complete and send a State-approved Transfer Form with all necessary medical information whenever a resident is transferred to a hospital or another healthcare setting.** **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** **All residents who experience a hospital transfer or healthcare facility transfer**	10/31/2025

	(7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a resident who discharged to the hospital received a transfer form with information for continuity of care, for 1 of 2 closed records reviewed. (Resident 7) Finding includes: The closed record for Resident 7 was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease. A Progress Note, dated 8/25/25 at 11:00 a.m., indicated the resident was observed attempting to self-transfer from the wheelchair to the sofa. The wheelchair was not locked and rolled backwards. The resident slipped off the edge of the seat landing on buttock on the floor. She did not hit her head and a full assessment was completed. The resident stated her "butt hurts a little." Range of motion was within normal limits on all four extremities and no shortening/rotation was observed to the bilateral lower extremities. The Power of Attorney (POA) and Nurse Practitioner were notified. A Progress Note, dated 8/25/25		**have the potential to be affected. A review of all resident transfers from the previous 90 days will be conducted by the DON or designee by 11/17/25 to ensure that each include a completed and properly filed State-approved Transfer Form** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** **Staff will be reeducated by 11/17/25 on transfer forms including when and how to complete the form and DON will ensure forms are easily accessible at each nurses station.** **4. How the corrective action will be monitored to ensure the deficient practice will not recur (Quality Assurance Program)**	

	at 2:00 p.m., indicated the resident was transported to the emergency room from the dialysis center for complaints of pain. The Nurse Practitioner and the Administrator were aware. A Progress Note, dated 9/1/25 at 11:00 a.m., indicated the resident was complaining of severe pain to entire body and stated she wanted to go to the hospital. Her POA was visiting and aware. A Progress Note, dated 9/1/25 at 8:50 p.m., indicated the resident was being admitted to the hospital with diagnosis of inferior pubic rami fracture. There was a lack of documentation a transfer form was provided to the receiving facility which included, but was not limited to, functional abilities, physical limitations, nursing care, diagnoses, diet, and other information for continuity of care. During an interview on 10/23/25 at 1:56 p.m., the Director of Nursing indicated she was unable to find any transfer paperwork related to the hospital transfers. Based on record review and interview, the facility failed to ensure a resident who discharged to the hospital received a transfer form with information for continuity of		**The DON or designee will audit all resident transfers weekly for 6 weeks ensuring all have properly completed transfer forms. If compliance is maintained, audits will the occur monthly for 3 months and findings will be reported during QA meeting.**	

care, for 1 of 2 closed records reviewed. (Resident 7)

Finding includes:

The closed record for Resident 7 was reviewed on 10/23/25 at 10:26 a.m. Diagnoses included, but were not limited to, end stage renal disease and chronic obstructive pulmonary disease.

A Progress Note, dated 8/25/25 at 11:00 a.m., indicated the resident was observed attempting to self-transfer from the wheelchair to the sofa. The wheelchair was not locked and rolled backwards. The resident slipped off the edge of the seat landing on buttock on the floor. She did not hit her head and a full assessment was completed. The resident stated her "butt hurts a little." Range of motion was within normal limits on all four extremities and no shortening/rotation was observed to the bilateral lower extremities. The Power of Attorney (POA) and Nurse Practitioner were notified.

A Progress Note, dated 8/25/25 at 2:00 p.m., indicated the resident was transported to the emergency room from the dialysis center for complaints of pain. The Nurse Practitioner and the Administrator were aware.

A Progress Note, dated 9/1/25 at 11:00 a.m., indicated the resident was complaining of

	severe pain to entire body and stated she wanted to go to the hospital. Her POA was visiting and aware. A Progress Note, dated 9/1/25 at 8:50 p.m., indicated the resident was being admitted to the hospital with diagnosis of inferior pubic rami fracture. There was a lack of documentation a transfer form was provided to the receiving facility which included, but was not limited to, functional abilities, physical limitations, nursing care, diagnoses, diet, and other information for continuity of care. During an interview on 10/23/25 at 1:56 p.m., the Director of Nursing indicated she was unable to find any transfer paperwork related to the hospital transfers.			
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	R 0410	**1. What Corrective actions were accomplished for those residents affected by the deficient practice? On 10/24/25Resident #5 received immediate corrective action. A review of their medical record was completed and the second-step Mantoux TB test was administered and documented as required. Additionally, the DON/designee re-educated**	10/31/2025

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 record review and interview, the facility failed to ensure infection control measures were in place related to not completing tuberculosis (TB) testing upon admission for 1 of 7 residents reviewed. (Resident 5)

Finding includes:

Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but was not limited to, dementia and diabetes mellitus.

The initial TB test was administered on 1/24/25 and read on 1/26/25. The section for the 2nd step was blank. There was a lack of documentation to indicate the two-step Mantoux test (TB test) had been completed upon admission.

During an interview on 10/22/25

the nursing staff directly involved on proper TB testing procedures and documentation requirements.

2. How the facility will identify other residents who have the potential to be affected and what corrective actions will be taken? A facility-wide audit was initiated on all current residents admitted within the past 12 months to ensure compliance with required two-step baseline TB testing. Any missing documentation or incomplete testing will be immediately corrected through completion of testing and/or physician notification. All findings will be documented and reviewed by the DON/designee.

3. What measures will be put into place or systemic changes made to ensure the deficient practice does not recur?All licensed nurses will receive mandatory re-education on TB testing procedures, including proper two-step Mantoux requirements and full documentation elements.

4. How the corrective action will be monitored to ensure the deficient practice does not recur?DON/designee will audit all new admissions for accurate and complete TB testing documentation weekly for 6 weeks, then monthly for

	at 3:29 p.m., the Director of Nursing indicated she was unable to find any other TB test documentation. Based on record review and interview, the facility failed to ensure infection control measures were in place related to not completing tuberculosis (TB) testing upon admission for 1 of 7 residents reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 10/22/25 at 11:41 a.m. Diagnoses included, but was not limited to, dementia and diabetes mellitus. The initial TB test was administered on 1/24/25 and read on 1/26/25. The section for the 2nd step was blank. There was a lack of documentation to indicate the two-step Mantoux test (TB test) had been completed upon admission. During an interview on 10/22/25 at 3:29 p.m., the Director of Nursing indicated she was unable to find any other TB test documentation.		**3 months, and quarterly thereafter.Findings will be reviewed during monthly QAPI meetings.**	

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 SIGNATUREKristin Pawlak	TITLEExecutive Director	(X6) DATE11/17/2025