STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY DEVELOPMENT CORPORATION OF MISHAWAKA, IN	500 LINCOLNWAY EAST, MISHAWAKA, , 46544

(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 Complaint IN00458166. Complaint IN00458166 - State deficiencies related to the allegations are cited at R0047. Survey dates: June 18 & 19, 2025 Facility number: 012688 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 6/26/2025	R 0000	Response Listed for R0047 below.	
R 0047	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(14-17) (14) An intrafacility transfer can be made only if the transfer is	R 0047	1. Corrective Action for Resident Affected •	07/19/2025

	necessary for: (A) medical reasons as judged by the attending physician; or (B) the welfare of the resident or other persons. (15) If an intrafacility transfer is required, the resident must be given notice at least two (2) days before relocation, except 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 (D) an immediate transfer is required by the resident ' s urgent medical needs. (16) The written notice of an intrafacility transfer must include the following: (A) Reasons for transfer. (B) Effective date of transfer. (C) Location to which the resident is to be transferred. (D) Name, address, and telephone number of the local and state long term care ombudsman. (E) 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.		Resident B was not discharged from the facility and successfully appealed the involuntary discharge decision. • The facility acknowledges the lack of sufficient documentation in the medical record to support the discharge decision, including the absence of physician documentation, clinical justification, and regulatory components of the required written notice. Corrective Action Taken: • Resident B's rights were restored, and she remained at the facility following the successful appeal. • A retrospective review of Resident B’s record has been completed, and the missing documentation has been flagged. 2. Identification of Other Residents at Risk	

	(17) The resident has the right to relocate prior to the expiration of the two (2) days ' notice. Based on record review and interview, the facility failed to ensure sufficient documentation regarding an involuntary discharge was present in the resident's electronic medical record for 1 of 2 residents reviewed for closed records (Resident B). Finding includes: A record review was completed for Resident B on 6/18/2025 at 1:29 P.M. The record indicated the resident was admitted to the facility on 9/15/2022 and discharged from the facility on 6/9/2025. A review of Nursing Progress Notes indicated Resident B had a care plan meeting on 4/15/2025 with the Executive Director (ED) and Director of Nursing (DON) regarding the resident's multiple medication incidents she had had. The resident was notifiied by the facility that they were sending out referrals to find her alternate placement. The resident was verbally notified of her residents rights and her right to appeal the discharge. The reisdent verbalized understanding and signed the discharge/transfer notice. The discharge notice		• A facility-wide audit of all resident intrafacility transfers (past 90 days) was completed by the Director of Nursing by July 18th, 2025. 3. Systemic Changes To prevent recurrence, the facility will review the current policy to see that it is following systemic changes, to be completed by July 11th, 2025: a. Policy Revision for Acceptance, Retention, and Discharge Criteria • The policy shall include: • Criteria for when an involuntary discharge or transfer is permissible. • Required documentation elements include: •	

	was then sent to the Ombudsman via email. A Notice of Transfer or Discharge, dated 4/15/2025, indicated the resident was being discharged to another nursing facility effective 5/15/2025. The notice indicated the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. The notice lacked documentation of what needs were unable to be met by the facility. During an interview, on 6/19/2025 at 10:00 A.M., the Area 2 Ombudsman indicated the facility had given the resident a 30 day notice for several reasons,which included the resident's daughter stealing her medications and the facility stated they could no longer take care of the resident's needs and she required a higher level of care. She indicated there was no information in the residents chart indicating she required a higher level of care. The Omsbudsman indicated the resident had submitted an appeal regarding the involuntary discharge and had won her appeal. Resident B's record lacked documentation from a Physician that she required a higher level of care and any documentation supporting the involuntary		• Physician documentation stating medical necessity or inability of facility to meet resident's needs. • Written notice with all regulatory components (reason, effective date, destination, ombudsman contact, etc.). • Conditions under which notice may be less than two (2) days. • Procedures for notifying the resident, resident representative, Ombudsman, and Indiana State Department of Health. b. Education and Training • All Licensed Nursing Staff and Administrative staff (including ED and DON) were in-serviced on:	

	discharge attempt by the facility. A review of Resident B's appeal indicated the resident's clinical record lacked documentation by the Physician concerning the reasons for the resident's discharge. During an interview, on 6/19/2025 at 10:22 A.M., the DON confirmed the Physician had not documented in the resident's medical record indicating the reasons why the resident needed to be involuntarily discharged. On 6/19/2025 at 10:28 A.M. a policy regarding involuntary discharges was requested but one was not provided prior to the survey exit. This citation relates to complaint IN00458166. Based on record review and interview, the facility failed to ensure sufficient documentation regarding an involuntary discharge was present in the resident's electronic medical record for 1 of 2 residents reviewed for closed records (Resident B). Finding includes: A record review was completed for Resident B on 6/18/2025 at 1:29 P.M. The record indicated the resident was admitted to the facility on 9/15/2022 and		• Resident rights regarding discharges and transfers. • Documentation requirements and physician involvement. • Appeal rights and timelines. • In-service conducted on July 11th, 2025 by Thomas C. Klempay Sr. c. Physician Engagement • A process has been implemented requiring physician review and written documentation prior to initiating any involuntary discharge or transfer. • Discharges without physician support will not proceed. d. Oversight and Interdisciplinary Review	

	discharged from the facility on 6/9/2025. A review of Nursing Progress Notes indicated Resident B had a care plan meeting on 4/15/2025 with the Executive Director (ED) and Director of Nursing (DON) regarding the resident's multiple medication incidents she had had. The resident was notifiied by the facility that they were sending out referrals to find her alternate placement. The resident was verbally notified of her residents rights and her right to appeal the discharge. The reisdent verbalized understanding and signed the discharge/transfer notice. The discharge notice was then sent to the Ombudsman via email. A Notice of Transfer or Discharge, dated 4/15/2025, indicated the resident was being discharged to another nursing facility effective 5/15/2025. The notice indicated the transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. The notice lacked documentation of what needs were unable to be met by the facility. During an interview, on 6/19/2025 at 10:00 A.M., the Area 2 Ombudsman indicated the facility had given the resident a 30 day notice for		• A Discharge Review Committee has been established to review all proposed involuntary discharges. • Committee includes ED, DON, and the Attending Physician (or designee). • No discharge is finalized until documentation and process are verified as complete and compliant. 4. Monitoring and Quality Assurance • Monthly audits of all proposed discharges and transfers will be conducted by the DON or designee for 6 months to ensure: • Physician documentation is present. • Written notice includes all required elements. •	

	several reasons,which included the resident's daughter stealing her medications and the facility stated they could no longer take care of the resident's needs and she required a higher level of care. She indicated there was no information in the residents chart indicating she required a higher level of care. The Omsbudsman indicated the resident had submitted an appeal regarding the involuntary discharge and had won her appeal. Resident B's record lacked documentation from a Physician that she required a higher level of care and any documentation supporting the involuntary discharge attempt by the facility. A review of Resident B's appeal indicated the resident's clinical record lacked documentation by the Physician concerning the reasons for the resident's discharge. During an interview, on 6/19/2025 at 10:22 A.M., the DON confirmed the Physician had not documented in the resident's medical record indicating the reasons why the resident needed to be involuntarily discharged. On 6/19/2025 at 10:28 A.M. a policy regarding involuntary discharges was requested but one was not provided prior to		Notice is timely and appropriately distributed. • Continued noncompliance will result in retraining and corrective action for responsible staff. 5. Completion Date for Plan of Correction All corrective actions will be completed by: July 19th, 2025	

	the survey exit. This citation relates to complaint IN00458166.			
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; (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	R 0090	1. Corrective Action for Affected Resident: The stove/oven in Resident C's apartment was repaired to prevent further risk. Resident C's service plan was reviewed and updated to reflect additional supervision and meal support. Resident C's nutritional needs were met safely following the incident because resident used the dining facility to eat her meals. 2. Identification of Others Potentially Affected: No additional fire or burn hazards were identified. A review of the past 60 days of maintenance logs and nursing notes was conducted to ensure no other unreported incidents had occurred. 3. Systemic Changes:	07/19/2025

	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 public upon request Based on observation, interview and record review, the facility failed to report to the Indiana Department of Health (IDOH) an apartment fire for 1 of 7 residents reviewed for environment. (Resident C)		The “Unusual Occurrence Reporting” policy has been reviewed and updated to clearly define fire-related incidents, including those that may initially appear minor (e.g., smoke, melted equipment). Mandatory in-service training will be conducted for DON, and ED on July 11th, 2025, covering: Identifying reportable incidents. Reporting procedures and timelines to IDOH. Documentation requirements. 4. Monitoring and Quality Assurance: Using our policy we will set up in-service with Nursing department to log all unusual occurrences in our EMAR, by July 19th, 2025. The Executive Director or designee will review all incident reports daily to determine if they meet the criteria for state	

	Finding includes: A record review for Resident C was completed on 6/18/2025 at 10:46 A.M. Diagnoses included, but were not limited to: anxiety disorder, post traumatic stress disorder, schizoaffective disorder and sleep tremors. A Service Plan, dated 4/24/2025, indicated Resident C needed assistance with food preparation. The plan indicated Resident C mostly preferred to cook in her kitchen instead of going to the dining room to eat. The goal of the plan for Resident C was to maintain proper food preparation standards with assistance. A Nursing Observation Note, on 6/17/2025 at 11:45 A.M., indicated Resident C reported her stove had caught on fire. Resident C's first statement indicated oil was spilt and her second statement indicated the lasagna had burnt. Resident C indicated she had called the maintenance department and the maintenance department was on their way to fix the problem. The note indicated there were visible burn marks on the top of the stove and in the bottom of the oven. During an interview, on 6/19/2025 at 10:21 A.M., Resident C indicated the incident was not a fire. She		reporting for the next 6 months. 5. Completion Date: All corrective actions will be completed by July 19th, 2025.	

	indicated the maintenance management knew what happened and she had been cooking a roast in the oven, had fallen asleep, the stove door had not shut completely and the stove knobs had melted away. During an observation, on 6/19/2025 at 10:46 A.M., Resident C's stove/oven was observed. The knobs for the stovetop and oven were not present and the electrical stovetop burners were not present. During an interview, on 6/19/2025 at 11:34 A.M., the Executive Director indicated the situation had been brought to his attention. He indicated he had not been sure if it (the incident) was truly a fire or just smoke. He indicated the incident had not been reported to IDOH. A policy was provided by the Director of Nursing, on 6/19/2025 at 12:16 P.M. The policy titled, "State Reportable Unusual Occurrences", indicated, "...The administrator is responsible for immediately informing the Indiana Department of Health, Long Term Care by telephone, followed by written notice within twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or			

residents, including, but not limited to any epidemic outbreaks, poisonings, fires, or major accidents...."

Based on observation, interview and record review, the facility failed to report to the Indiana Department of Health (IDOH) an apartment fire for 1 of 7 residents reviewed for environment. (Resident C)

Finding includes:

A record review for Resident C was completed on 6/18/2025 at 10:46 A.M. Diagnoses included, but were not limited to: anxiety disorder, post traumatic stress disorder, schizoaffective disorder and sleep tremors.

A Service Plan, dated 4/24/2025, indicated Resident C needed assistance with food preparation. The plan indicated Resident C mostly preferred to cook in her kitchen instead of going to the dining room to eat. The goal of the plan for Resident C was to maintain proper food preparation standards with assistance.

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	maintenance department and the maintenance department was on their way to fix the problem. The note indicated there were visible burn marks on the top of the stove and in the bottom of the oven. During an interview, on 6/19/2025 at 10:21 A.M., Resident C indicated the incident was not a fire. She indicated the maintenance management knew what happened and she had been cooking a roast in the oven, had fallen asleep, the stove door had not shut completely and the stove knobs had melted away. During an observation, on 6/19/2025 at 10:46 A.M., Resident C's stove/oven was observed. The knobs for the stovetop and oven were not present and the electrical stovetop burners were not present. During an interview, on 6/19/2025 at 11:34 A.M., the Executive Director indicated the situation had been brought to his attention. He indicated he had not been sure if it (the incident) was truly a fire or just smoke. He indicated the incident had not been reported to IDOH. A policy was provided by the Director of Nursing, on 6/19/2025 at 12:16 P.M. The			

	policy titled, "State Reportable Unusual Occurrences", indicated, "...The administrator is responsible for immediately informing the Indiana Department of Health, Long Term Care by telephone, followed by written notice within twenty-four hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to any epidemic outbreaks, poisonings, fires, or major accidents...."			
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	R 0092	1. Corrective Action Taken for Residents Found to Have Been Affected: No residents were physically harmed due to the missed fire drills. However, the facility recognizes the potential risk and has taken immediate steps to ensure drills are properly conducted and documented moving forward. 2. How the Facility Will Identify Other Residents Potentially Affected: All 37 residents currently residing in the facility were	07/19/2025

	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. Based on record review and interview, the facility failed to ensure fire drills were completed monthly during the past 12 months. This had the potential to affect 37 of 37 residents. Finding includes: During the entrance conference, on 6/18/2025 at 9:42 A.M., documentation of monthly fire drills for the past 12 months was requested. During an interview, on 6/18/2025 at 11:05 A.M., the Executive Director indicated he could not provide monthly fire drill documentation before January 2025. However, documentation from January 2025 through May 2025 was provided. Review of the documentation provided for the monthly fire drills included the following: -1/8/2025 at 9:00 A.M. fire drill activated.		identified as potentially affected due to the lack of complete fire drill documentation and inconsistent implementation across all shifts. 3. Measures/Systems Implemented to Prevent Recurrence: A Fire Drill Log has been in place but will be maintained to include accurate records for each shift, including: Date and time of drill Type of drill (simulated, alarm activated, etc.) Shift covered The Executive Director (ED) or their designee will audit drill records monthly to ensure compliance. Fire drills will be conducted monthly and rotated to ensure	

	-2/4/2025 at 9:00 P.M. alarmed. -2/25/2025 at 10:45 A.M. fire detector room 404. -3/25/2025 at 11:00 A.M. fire drill announced 5th floor. -4/16/2025 at 3:00 A.M. Simulation. -5/14/2025 at 2:00 P.M. burnt food apartment 510. A policy was provided, on 6/19/2025 at 12:16 P.M., by the Director of Nursing. The current policy titled, "Emergency and Disaster Plan", indicated, "...Fire drills are conducted monthly and are rotated to cover all shifts and include all staff..." Based on record review and interview, the facility failed to ensure fire drills were completed monthly during the past 12 months. This had the potential to affect 37 of 37 residents. Finding includes: During the entrance conference, on 6/18/2025 at 9:42 A.M., documentation of monthly fire drills for the past 12 months was requested. During an interview, on 6/18/2025 at 11:05 A.M., the Executive Director indicated he could not provide monthly fire drill documentation before January 2025. However,		coverage across all three shifts (day, evening, night). 4. How the Facility Will Monitor Corrective Actions: The Safety Committee will review fire drill logs quarterly to ensure all drills are completed and documented correctly. The Administrator will review a fire drill log each month for the next six months. A monthly compliance checklist will be completed by the Administrator to confirm drills occurred on each shift. Any identified gaps will be addressed immediately with retraining and follow-up. 5. Completion Date: All corrective actions will be fully implemented by July 19th,	

	documentation from January 2025 through May 2025 was provided. Review of the documentation provided for the monthly fire drills included the following: -1/8/2025 at 9:00 A.M. fire drill activated. -2/4/2025 at 9:00 P.M. alarmed. -2/25/2025 at 10:45 A.M. fire detector room 404. -3/25/2025 at 11:00 A.M. fire drill announced 5th floor. -4/16/2025 at 3:00 A.M. Simulation. -5/14/2025 at 2:00 P.M. burnt food apartment 510. A policy was provided, on 6/19/2025 at 12:16 P.M., by the Director of Nursing. The current policy titled, "Emergency and Disaster Plan", indicated, "...Fire drills are conducted monthly and are rotated to cover all shifts and include all staff..."		2025.	
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 accordance with state and local sanitation and safe food handling	R 0273	1 How the deficiency will be corrected:	07/19/2025

	standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to foods not sealed tightly for 1 of 1 kitchen observed. This issue had the potential to affect 37 of 37 residents who received food from this kitchen. Findings include: On 6/18/2025 at 9:40 A.M., a kitchen tour was conducted with the Dietary Manager. The following was observed in the walk-in freezer: - An opened bag of corn dogs not sealed tightly. The following was observed in the dry storage: - An opened bag of granola not sealed tightly. - An opened bag of brownie mix not sealed tightly. During an interview, on 6/18/2025 at 9:48 A.M., the Dietary Manager indicated the foods should have been sealed properly.		The improperly stored food items (corn dogs, granola, and brownie mix) were immediately discarded. All remaining opened food items were checked and properly sealed or discarded as needed. Staff will be re-trained on proper food storage and sealing procedures by July 11th, 2025. 2 How residents were protected: No resident became ill as a result of this issue. All food currently served has been verified to be safe and stored properly. 3 Systemic changes implemented:	

	During an interview, on 6/18/2025 at 12:26 P.M., the Administrator indicated the facility did not have a policy and followed food safe serve guidelines. Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to foods not sealed tightly for 1 of 1 kitchen observed. This issue had the potential to affect 37 of 37 residents who received food from this kitchen. Findings include: On 6/18/2025 at 9:40 A.M., a kitchen tour was conducted with the Dietary Manager. The following was observed in the walk-in freezer: - An opened bag of corn dogs not sealed tightly. The following was observed in the dry storage: - An opened bag of granola not sealed tightly. - An opened bag of brownie mix not sealed tightly. During an interview, on 6/18/2025 at 9:48 A.M., the Dietary Manager indicated the foods should have been sealed properly. During an interview, on		A written policy for food storage and sealing of opened items will be created and implemented by July 19th, 2025. All dietary staff received in-service training on 410 IAC 7-24 food safety and proper food sealing practices. 4 Monitoring to ensure ongoing compliance: The Dietary Manager or designee will complete weekly audits of food storage areas for the next 6 months. Any issues found will be corrected immediately. 5 Date of completion: July 19th, 2025	

	6/18/2025 at 12:26 P.M., the Administrator indicated the facility did not have a policy and followed food safe serve guidelines.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to establish an infection control program that included, but was not limited to, a system that enabled the facility to analyze patterns of known infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect 37 of 37 residents who reside in the	R 0407	1. Corrective Action Taken for Affected Residents • No residents showed harm from this deficiency, but all 37 residents were at potential risk. • An infection control audit was completed on 6/20/2025 to ensure no current infections were missed. 2. Measures to Prevent Recurrence • Infection Control Log Created: As of 6/23/2025, a standardized infection surveillance log has been implemented. This log will be used daily to track infection symptoms, diagnoses, and follow-up	07/19/2025

facility.

Finding includes:

During an interview, on 6/19/2025 at 10:20 A.M., LPN 1 and QMA 2 indicated an erasable white board was used in the nursing office to communicate the residents with active infections or who were on quarantine between healthcare staff.

During an interview, on 6/19/2025 at 10:35 A.M., the Director of Nursing was unable to provide an infection control log book showing surveillance of infections throughout the facility. The DON indicated the facility did not have a staff member assigned to monitor and carry out an infection control program.

On 6/19/2025 at 10:35 A.M., a policy was requested but the Director of Nursing indicated the facility did not have an infection control surveillance and follow-up policy program or policy.

16.2-5-12(b)(1)

Based on record review and interview, the facility failed to establish an infection control program that included, but was not limited to, a system that enabled the facility to analyze patterns of known infection symptoms and ongoing analysis of surveillance data and review

actions.

- Assigned Infection Control Coordinator (ICC):

  The Director of Nursing (DON) has assigned an LPN as the Infection Control Coordinator effective 6/23/2025. This staff member is responsible for maintaining records and leading surveillance efforts.
- Written Policy Implemented:

  A formal Infection Control Surveillance and Follow-Up Policy was created and approved on 6/23/2025. This policy outlines:

  - How to track infection trends
  - Required follow-up
  - Required documentation
  - Communication procedures among staff
-

of data and documentation of follow-up activity. This had the potential to affect 37 of 37 residents who reside in the facility.

Finding includes:

During an interview, on 6/19/2025 at 10:20 A.M., LPN 1 and QMA 2 indicated an erasable white board was used in the nursing office to communicate the residents with active infections or who were on quarantine between healthcare staff.

During an interview, on 6/19/2025 at 10:35 A.M., the Director of Nursing was unable to provide an infection control log book showing surveillance of infections throughout the facility. The DON indicated the facility did not have a staff member assigned to monitor and carry out an infection control program.

On 6/19/2025 at 10:35 A.M., a policy was requested but the Director of Nursing indicated the facility did not have an infection control surveillance and follow-up policy program or policy.

16.2-5-12(b)(1)

Removed Use of White Board for Infections:

The erasable whiteboard was discontinued on 6/23/2025 to protect resident confidentiality and reduce potential communication errors.

- Staff Education Provided:

  On 6/27/2025, all nursing staff received in-service training on the new infection control procedures, universal precautions, and documentation practices. New hires will receive infection control training during orientation.

- Reporting Procedures Updated:

  The ICC and DON will ensure all reportable diseases are promptly reported to public health authorities per state guidelines.

3. Monitoring for Compliance

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			The Infection Control Coordinator will: • Review the infection log weekly • The Administrator will audit infection control documentation monthly for 3 months, then quarterly, to ensure compliance. 4. Completion Date • Full compliance will be achieved by: July 19th, 2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE