| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 10/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROSE SENIOR LIVING CARMEL | 1285 FAIRFAX MANOR DRIVE, CARMEL, , 46032 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Intakes IN00465277 and IN00465262.<br><br>Intake IN00465277-State deficiencies related to the allegations are cited at R0052.<br><br>Intake IN00465262-No deficiencies related to the allegations are cited.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: October 16 and 17, 2025.<br><br>Facility number: 013719<br><br>Residential Census: 77<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on October 27, 2025. | R 0000 | The following is the Plan of Correction for Rose Senior Living Carmel regarding the Statement of Deficiencies dated 10/17/2025. Please accept this Plan of Correction as confirmation of our ongoing efforts to comply with regulatory requirements. | |

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| R 0052 | Residents' Rights - Offense<br><br>410 IAC 16.2-5-1.2(v)(1-6)<br><br>(v) Residents have the right to be free from:<br><br>(1) sexual abuse;<br><br>(2) physical abuse;<br><br>(3) mental abuse;<br><br>(4) corporal punishment;<br><br>(5) neglect; and<br><br>(6) involuntary seclusion.<br><br>Based on observation, interview and record review, the facility failed to ensure residents with a diagnosis of dementia were free from physical abuse from a staff member for 2 of 2 residents reviewed for abuse. (Resident C and B) This deficient practice resulted in Resident C receiving a skin tear and bruising to her wrist and Resident B being slapped in the face.<br><br>Findings include:<br><br>During an interview, on 10/16/25 at 2:40 p.m., CNA 2 indicated Resident B and C were best friends and often walked around the unit together. On 10/1/25, both Resident B and C tried to enter another resident's room. CNA 2 witnessed QMA 5 running after the residents, grabbing Resident C's left wrist and pulling her away. Resident | R 0052 | Tag R052 – Resident Abuse<br><br>What we did for the affected residents:<br><br>The staff member involved (QMA 5) was immediately suspended and then terminated. Residents B and C were assessed, and skin assessments were completed. families and primary care providers were notified.<br><br>How we addressed others who might be affected:<br><br>The incident was determined to be isolated.<br><br>What changes we made to prevent this from happening again:<br><br>All staff members involved were immediately in- by the ED on proper and timely reporting. abuse and neglect in-service and reporting guidelines will be reviewed and documented at the All Staff Meeting in November.Abuse prevention materials will be posted in staff areas.The zero-tolerance policy was reinforced in team huddle meetings.We will continue to complete Resident Abuse Training upon hire and at least annually thereafter.<br><br>How we'll monitor this going forward:Daily review of incident reports by the Director of Health | 11/30/2025 |

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| | B tried to defend Resident C and hit QMA 5 on the left arm. QMA 5 then slapped Resident B in the face. CNA 2 indicated QMA 5 was aggressive with both residents, held Resident C's wrist very tightly, and dug her fingernails into Resident C's skin which caused it to bleed. CNA 2 redirected the residents' away but did not confront QMA 5 or report the abuse because QMA 5 was aggressive and intimidating. CNA 2 indicated she should have reported the abuse right away.<br><br>During an observation, on 10/16/25 at 10:21 a.m., Resident B and Resident C were walking down the hallway together in the memory care unit. Light purple bruising was observed on Resident C's left wrist. When Resident C was asked how she received the bruise, she pulled her left sleeve up and a Band-Aid was observed just above the bruise. Resident C was unable to answer any questions appropriately.<br><br>A facility investigation report, dated 10/8/25, indicated a nurse had received concerns from another staff member about mistreatment of Resident B and C by QMA 5. An investigation was started and QMA 5 admitted the allegations were true and she had failed to report the incident. Based on QMA 5's | | Services and Executive Director. Employee training will be documented and audited quarterly for compliance by the HR Director and Executive Director.<br><br>When it will be completed:All actions will be completed by November 30, 2025. | |

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| | statement and video surveillance footage, the facility determined the incident was substantiated.<br><br>1. The clinical record for Resident C was reviewed on 10/16/25 at 10:01 a.m. The diagnoses included, but were not limited to, dementia and anxiety disorder.<br><br>A current service plan, dated 6/6/25, indicated Resident C had behavioral issues with occasional disruptive, aggressive, and/or socially inappropriate behaviors either verbally or physically and could require special tolerance or staff training. She had severe impairment with her short-term memory, long-term memory, and was frequently disoriented which could require repeated verbal prompts and/or directions and reminders from others. Resident C was a very social person who loved interacting with people. She had poor judgement issues, would resist care at times, and would need protection and supervision due to making unsafe or inappropriate decisions.<br><br>A nursing progress note, dated 10/9/25 at 12:56 p.m., indicated a full-body assessment was completed for Resident C in which a small bruise was observed on the left arm, along with a dime-sized skin tear | | | |

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| | located on the bottom portion of the left arm, slightly above the wrist. Resident C reported minor pain upon touching around the bruise and the skin tear. The skin tear was cleansed and covered with a Band-Aid. Additional small areas of red and purple bruising were noted in the same region of the arm.<br><br>During an interview, on 10/16/25 at 1:44 p.m., Resident C's family member indicated they were contacted a few days ago by the facility and was informed QMA 5 had been suspended for inappropriately redirecting Resident C by grabbing her wrist which caused redness and bleeding.<br><br>2. The clinical record for Resident B was reviewed on 10/16/25 at 2:55 p.m. The diagnoses included, but were not limited to, dementia and depression.<br><br>A current service plan, dated 8/14/25, indicated Resident B did not have any current or a history of disruptive, aggressive, verbal or socially inappropriate behavior. She had occasional poor judgement issues, could resist care at times, and needed protection and supervision due to unsafe or inappropriate decisions. Resident B had a severe impairment with her short-term memory, long-term memory, and was frequently | | | |

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| | disoriented which could require repeated verbal prompts and/or directions.<br><br>A skin assessment, from 10/1/25 to 10/16/25, was not documented in the clinical record for Resident B.<br><br>During an interview, on 10/17/25 at 9:11 a.m., Resident B's husband indicated he was contacted by the Director of Nursing (DON) and was informed QMA 5 had slapped Resident B across the face. He indicated Resident B and C were friends prior to being moved into the memory care unit, had a very close friendship, and were very protective of each other.<br><br>During an interview, on 10/16/25 at 1:30 p.m., QMA 5 indicated, on 10/1/25, Resident B was walking down the hall with Resident C when she noticed them attempting to enter another resident's room. QMA 5 ran down the hall to the residents to attempt to stop them from entering the room while she yelled for assistance from CNA 2. QMA 5 grabbed Resident C's arm to direct the resident away from the room and indicated at that time, Resident B hit her in the face, knocking her glasses into her eye. QMA 5 indicated without realizing what she was doing, she hit Resident B back. QMA 5 | | | |

did not report the incident and indicated she should have.

During an interview, on 10/17/25 at 10:42 a.m., the DON indicated he was informed of an incident in which QMA 5 was hit by a resident during one of her shifts. The DON immediately contacted QMA 5 via telephone and discussed the incident with her. QMA 5 wrote a statement about the incident, which the facility later found out was not an accurate description of what had occurred. On 10/8/25, the unit manager was contacted by another staff member who reported QMA 5 had abused a resident. An investigation was immediately initiated.

During an interview, on 10/17/25 at 11:00 a.m., the Dementia Care Coordinator indicated she completed skin assessments on both Resident B and C within 2 hours of one another and documented the assessments in the electronic health record. She was not sure where the assessment for Resident B was and there could have been a possible issue/error with saving the assessment. She indicated only a couple of the nursing staff worked consistently in the memory care unit, most of the staff worked throughout the facility from one day to another. Education on abuse and neglect were completed by staff in January and additional

education on how to handle situations which may arise were laminated and kept on the unit.

A facility signed job description, by QMA 5, indicated to always maintain a calm atmosphere, report all unusual behavior of residents to the DON and/or LPN, assure resident safety, follow the residents' rights policy, and to control own emotions and behaviors as to protect residents' rights and respond professionally with respect and dignity.

A current facility policy, titled "RESIDENT ABUSE," dated as last revised 1/3/22 and received from the DON on 10/16/25 at 10:00 a.m., indicated "...All residents shall be free from verbal, sexual, and mental abuse. All allegations or incidents of abuse shall be reported...Physical abuse-includes hitting, slapping, pinching, and kicking...All allegations or incidents of abuse must be reported immediately to the Director of Health Services...Executive Director, and the Department Manager in person or by phone...."

A current facility policy, titled "Resident Rights," dated as last updated 2/10/17 and received from the DON on 10/16/25 at 10:00 a.m., indicated "...ensure that residents are aware not only of their rights as a resident

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| | but are able to freely enjoy those rights...."<br><br>This citation relates to Intake IN00465277.<br><br>Based on observation, interview and record review, the facility failed to ensure residents with a diagnosis of dementia were free from physical abuse from a staff member for 2 of 2 residents reviewed for abuse. (Resident C and B) This deficient practice resulted in Resident C receiving a skin tear and bruising to her wrist and Resident B being slapped in the face.<br><br>Findings include:<br><br>During an interview, on 10/16/25 at 2:40 p.m., CNA 2 indicated Resident B and C were best friends and often walked around the unit together. On 10/1/25, both Resident B and C tried to enter another resident's room. CNA 2 witnessed QMA 5 running after the residents, grabbing Resident C's left wrist and pulling her away. Resident B tried to defend Resident C and hit QMA 5 on the left arm. QMA 5 then slapped Resident B in the face. CNA 2 indicated QMA 5 was aggressive with both residents, held Resident C's wrist very tightly, and dug her fingernails into Resident C's skin which caused it to bleed. CNA 2 redirected the residents' away but did not confront QMA | | | |

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| | 5 or report the abuse because QMA 5 was aggressive and intimidating. CNA 2 indicated she should have reported the abuse right away.<br><br>During an observation, on 10/16/25 at 10:21 a.m., Resident B and Resident C were walking down the hallway together in the memory care unit. Light purple bruising was observed on Resident C's left wrist. When Resident C was asked how she received the bruise, she pulled her left sleeve up and a Band-Aid was observed just above the bruise. Resident C was unable to answer any questions appropriately.<br><br>A facility investigation report, dated 10/8/25, indicated a nurse had received concerns from another staff member about mistreatment of Resident B and C by QMA 5. An investigation was started and QMA 5 admitted the allegations were true and she had failed to report the incident. Based on QMA 5's statement and video surveillance footage, the facility determined the incident was substantiated. | | | |

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| | 1. The clinical record for Resident C was reviewed on 10/16/25 at 10:01 a.m. The diagnoses included, but were not limited to, dementia and anxiety disorder.<br><br>A current service plan, dated 6/6/25, indicated Resident C had behavioral issues with occasional disruptive, aggressive, and/or socially inappropriate behaviors either verbally or physically and could require special tolerance or staff training. She had severe impairment with her short-term memory, long-term memory, and was frequently disoriented which could require repeated verbal prompts and/or directions and reminders from others. Resident C was a very social person who loved interacting with people. She had poor judgement issues, would resist care at times, and would need protection and supervision due to making unsafe or inappropriate decisions.<br><br>A nursing progress note, dated 10/9/25 at 12:56 p.m., indicated a full-body assessment was completed for Resident C in which a small bruise was observed on the left arm, along with a dime-sized skin tear located on the bottom portion of the left arm, slightly above the wrist. Resident C reported minor pain upon touching around the bruise and the skin tear. The | | | |

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| | skin tear was cleansed and covered with a Band-Aid. Additional small areas of red and purple bruising were noted in the same region of the arm.<br><br>During an interview, on 10/16/25 at 1:44 p.m., Resident C's family member indicated they were contacted a few days ago by the facility and was informed QMA 5 had been suspended for inappropriately redirecting Resident C by grabbing her wrist which caused redness and bleeding.<br><br>2. The clinical record for Resident B was reviewed on 10/16/25 at 2:55 p.m. The diagnoses included, but were not limited to, dementia and depression.<br><br>A current service plan, dated 8/14/25, indicated Resident B did not have any current or a history of disruptive, aggressive, verbal or socially inappropriate behavior. She had occasional poor judgement issues, could resist care at times, and needed protection and supervision due to unsafe or inappropriate decisions. Resident B had a severe impairment with her short-term memory, long-term memory, and was frequently disoriented which could require repeated verbal prompts and/or directions.<br><br>A skin assessment, from | | | |

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| | 10/1/25 to 10/16/25, was not documented in the clinical record for Resident B.<br><br>During an interview, on 10/17/25 at 9:11 a.m., Resident B's husband indicated he was contacted by the Director of Nursing (DON) and was informed QMA 5 had slapped Resident B across the face. He indicated Resident B and C were friends prior to being moved into the memory care unit, had a very close friendship, and were very protective of each other.<br><br>During an interview, on 10/16/25 at 1:30 p.m., QMA 5 indicated, on 10/1/25, Resident B was walking down the hall with Resident C when she noticed them attempting to enter another resident's room. QMA 5 ran down the hall to the residents to attempt to stop them from entering the room while she yelled for assistance from CNA 2. QMA 5 grabbed Resident C's arm to direct the resident away from the room and indicated at that time, Resident B hit her in the face, knocking her glasses into her eye. QMA 5 indicated without realizing what she was doing, she hit Resident B back. QMA 5 did not report the incident and indicated she should have.<br><br>During an interview, on 10/17/25 at 10:42 a.m., the DON | | | |

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| | indicated he was informed of an incident in which QMA 5 was hit by a resident during one of her shifts. The DON immediately contacted QMA 5 via telephone and discussed the incident with her. QMA 5 wrote a statement about the incident, which the facility later found out was not an accurate description of what had occurred. On 10/8/25, the unit manager was contacted by another staff member who reported QMA 5 had abused a resident. An investigation was immediately initiated.<br><br>During an interview, on 10/17/25 at 11:00 a.m., the Dementia Care Coordinator indicated she completed skin assessments on both Resident B and C within 2 hours of one another and documented the assessments in the electronic health record. She was not sure where the assessment for Resident B was and there could have been a possible issue/error with saving the assessment. She indicated only a couple of the nursing staff worked consistently in the memory care unit, most of the staff worked throughout the facility from one day to another. Education on abuse and neglect were completed by staff in January and additional education on how to handle situations which may arise were laminated and kept on the unit.<br><br>A facility signed job description, | | | |

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| | by QMA 5, indicated to always maintain a calm atmosphere, report all unusual behavior of residents to the DON and/or LPN, assure resident safety, follow the residents' rights policy, and to control own emotions and behaviors as to protect residents' rights and respond professionally with respect and dignity.<br><br>A current facility policy, titled "RESIDENT ABUSE," dated as last revised 1/3/22 and received from the DON on 10/16/25 at 10:00 a.m., indicated "...All residents shall be free from verbal, sexual, and mental abuse. All allegations or incidents of abuse shall be reported...Physical abuse-includes hitting, slapping, pinching, and kicking...All allegations or incidents of abuse must be reported immediately to the Director of Health Services...Executive Director, and the Department Manager in person or by phone...."<br><br>A current facility policy, titled "Resident Rights," dated as last updated 2/10/17 and received from the DON on 10/16/25 at 10:00 a.m., indicated "...ensure that residents are aware not only of their rights as a resident but are able to freely enjoy those rights...." | | | |

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| | This citation relates to Intake IN00465277. | | | |
| R 0064 | Residents' Rights- Noncompliance<br><br>410 IAC 16.2-5-1.2(hh)<br><br>(hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident was protected from misappropriation of property by a staff member for 1 of 1 resident reviewed for misappropriation of property. (Resident 2)<br><br>Findings include:<br><br>During an observation and interview, on 10/16/25 at 10:27 a.m., Resident 2 was alert and oriented. During the interview, she appeared to be distressed and looked as if she was going to cry. She indicated she knew QMA 4 for two years and thought he was a nice person which she trusted. Resident 2 indicated she wrote QMA 4 a check (number 765) for $100.00 for grooming her dog. She wrote on the memo line of check number 765 her dog's name | R 0064 | Tag R064 – Misappropriation of Resident Property<br><br>What we did for the affected resident:QMA 4 was suspended and then terminated for accepting money from Resident 2.The resident and her family were supported and referred to law enforcement.The community reported the incident per reporting requirements and fully participated in the investigation completed by law enforcement.<br>How we addressed others who might be affected:The incident was investigated and determined to be isolated.<br><br>What changes we made to prevent this from happening again:<br><br>Staff were re-educated on the policy prohibiting accepting gifts or money from residents and misappropriation of resident property at the All-Staff Meeting following this incident, on 7/24/2025.This policy is reviewed upon hire and annually thereafter.<br><br>How we'll monitor this going forward:<br><br>Immediate action will be taken for any suspected violations.Training will be documented and audited quarterly for compliance by the HR Director and Executive Director<br>When it will be completed:All actions will be completed by | 11/30/2025 |

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| | and 2t (2 times) for grooming the dog twice. She did not write QMA 4 check number 761 for $10,000. She had pressed charges, and the police were involved. She kept her checkbook in her purse in her closet.<br><br>The clinical record for Resident 2 was reviewed on 10/17/25 at 9:02 a.m. The diagnoses included, but were not limited to, dementia, iron deficiency anemia, depression, and adjustment disorder with anxiety.<br><br>A facility e-mail communication from Human Resources 9 to the Executive Director of the facility, dated 7/26/25, indicated Resident 2's daughter claimed one of the facility staff tried to steal money from her mother and it was QMA 4. Resident 2's family indicated the bank had contacted her about a suspicious check for $10,000 someone had attempted to cash on 7/24/25. Copies of the checks were provided to Human Resources 9, the signatures were reviewed, and the signature for the check in the amount of $10,000 did not match. Due to the evidence presented and the severity of the incident, QMA 4 was suspended pending an investigation. The e-mail indicated QMA 4 had not received any permission to | | November 30, 2025 | |

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| | volunteer or work for any residents outside of his official duties and no written approval was found in his employee file. Human Resource 9 felt it was relevant to include QMA 4 had a wage garnishment against his wages.<br><br>A copy of check number 761 was reviewed. The check was made out to QMA 4 in the amount of $10,000.00 on 7/7/25. The back of the check was signed by QMA 4 and contained his account number.<br><br>A copy of check number 765 was reviewed. The check was made out to QMA 4 in the amount of $100.00 on 7/17/25. The back of the check was signed by QMA 4 and contained his account number. The account numbers, for QMA 4, were the same on the back of both checks.<br><br>An untitled facility document indicated QMA 4 was placed on suspension pending investigation on 7/26/25. The Executive Director and Human Resources 9 attempted to contact QMA 4 by telephone on July 28th, 29th, and 30th. Voicemails were left but contact was not made. The facility made a decision to terminate QMA 4 based upon substantiating he had accepted $100 for grooming the resident's dog. The document indicated working | | | |

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| | off the clock and accepting payments from residents was against company policy. The termination documents were mailed to QMA 4's address on file. The document was signed on 7/30/25, by the Executive Director.<br><br>A facility document, titled "Separation Notice", dated 7/30/25, indicated QMA 4 was officially notified of his separation of employment from the facility for a violation of policy as listed in the Employee Handbook. The document was signed by the Executive Director and Human Resource 9 on 7/30/25.<br><br>During an interview, on 10/16/25 at 11:45 a.m., the Executive Director indicated QMA 4 was terminated from his position for taking money from Resident 2 for grooming her dog. He was not terminated for the $10,000 check because the facility was not able to speak with him on the topic. The employee handbook addressed not taking money from residents. The termination paperwork was mailed to his home address because he would not answer his phone. The Executive Director indicated Resident 2 self-administered her medications therefore QMA 4 had no reason to be in Resident 2's apartment. | | | |

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| | During an interview, on 10/17/25 at 10:41 a.m., the Executive Director indicated the facility followed the state regulations and misappropriation was included as abuse in the abuse policy.<br><br>During a telephone interview, on 10/17/25 at 8:45 a.m., QMA 4 indicated a check was written to him for $10,000 which he did take to the bank to cash, and the bank would not cash the check.<br><br>A current facility document, titled "Acceptance of Gifts and Tipping", undated and received from the Executive Director on 10/16/25 at 1:16 p.m., indicated "...Employees are prohibited from accepting gifts, tips, or gratitude's from residents, their families, or individuals and firms with which we do business...The acceptance of such gifts tips or gratuities may result in behavioral change discussion up to and including termination...."<br><br>A current facility policy, titled "RESIDENT ABUSE", dated as last reviewed on 1/3/22, covered abuse but did not include misappropriation specifically as a form of abuse.<br><br>A current facility policy, titled "Resident Rights," dated as last updated 2/10/17 and received from the DON on 10/16/25 at | | | |

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| | 10:00 a.m., indicated "...ensure that residents are aware not only of their rights as a resident but are able to freely enjoy those rights...."<br><br>Based on observation, interview and record review, the facility failed to ensure a resident was protected from misappropriation of property by a staff member for 1 of 1 resident reviewed for misappropriation of property. (Resident 2)<br><br>Findings include:<br><br>During an observation and interview, on 10/16/25 at 10:27 a.m., Resident 2 was alert and oriented. During the interview, she appeared to be distressed and looked as if she was going to cry. She indicated she knew QMA 4 for two years and thought he was a nice person which she trusted. Resident 2 indicated she wrote QMA 4 a check (number 765) for $100.00 for grooming her dog. She wrote on the memo line of check number 765 her dog's name and 2t (2 times) for grooming the dog twice. She did not write QMA 4 check number 761 for $10,000. She had pressed charges, and the police were involved. She kept her checkbook in her purse in her closet.<br><br>The clinical record for Resident 2 was reviewed on 10/17/25 at | | | |

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| | 9:02 a.m. The diagnoses included, but were not limited to, dementia, iron deficiency anemia, depression, and adjustment disorder with anxiety.<br><br>A facility e-mail communication from Human Resources 9 to the Executive Director of the facility, dated 7/26/25, indicated Resident 2's daughter claimed one of the facility staff tried to steal money from her mother and it was QMA 4. Resident 2's family indicated the bank had contacted her about a suspicious check for $10,000 someone had attempted to cash on 7/24/25. Copies of the checks were provided to Human Resources 9, the signatures were reviewed, and the signature for the check in the amount of $10,000 did not match. Due to the evidence presented and the severity of the incident, QMA 4 was suspended pending an investigation. The e-mail indicated QMA 4 had not received any permission to volunteer or work for any residents outside of his official duties and no written approval was found in his employee file. Human Resource 9 felt it was relevant to include QMA 4 had a wage garnishment against his wages.<br><br>A copy of check number 761 was reviewed. The check was | | | |

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| | 7/30/25, indicated QMA 4 was officially notified of his separation of employment from the facility for a violation of policy as listed in the Employee Handbook. The document was signed by the Executive Director and Human Resource 9 on 7/30/25.<br><br>During an interview, on 10/16/25 at 11:45 a.m., the Executive Director indicated QMA 4 was terminated from his position for taking money from Resident 2 for grooming her dog. He was not terminated for the $10,000 check because the facility was not able to speak with him on the topic. The employee handbook addressed not taking money from residents. The termination paperwork was mailed to his home address because he would not answer his phone. The Executive Director indicated Resident 2 self-administered her medications therefore QMA 4 had no reason to be in Resident 2's apartment.<br><br>During an interview, on 10/17/25 at 10:41 a.m., the Executive Director indicated the facility followed the state regulations and misappropriation was included as abuse in the abuse policy.<br><br>During a telephone interview, on 10/17/25 at 8:45 a.m., QMA 4 indicated a check was written to | | | |

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| R 0121 | Personnel - Noncompliance<br><br>410 IAC 16.2-5-1.4(f)(1-4)<br><br>(f) A health screen shall be | R 0121 | Tag R121 – TB Screening NoncomplianceWhat we did for the affected employees:The TB screening documentation for | 11/30/2025 |

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| | required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:<br><br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br><br>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br><br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. | | affected employees will be completed and filed.<br><br>How we addressed others who might be affected:<br><br>A full audit of employee health records was completed.<br><br>What changes we made to prevent this from happening again:<br><br>TB blood tests will now be conducted in conjunction with physicals during the hiring process.<br><br>HR staff were retrained on TB documentation requirements by the Executive Director.<br><br>How we'll monitor this going forward:<br><br>Weekly audits of new hire files will be completed by HR Director. Quarterly compliance reviews will be conducted by the Executive Director.<br><br>When it will be completed:<br><br>All actions will be completed by November 30, 2025. | |

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on interview and record review, the facility failed to ensure new employees had received tuberculosis screening tests prior to the start of employment and before resident interaction for 2 of 5 employees reviewed for tuberculosis testing. (QMA 10 and 11)

Findings include:

The employee records were reviewed on 10/16/25. Two new employees were found to not have proper documentation of tuberculosis screening tests.

QMA 10 was hired on 9/10/25. The facility was unable to provide documentation of a first or second step tuberculosis screening test.

QMA 11 was hired on 9/17/25. The facility was unable to provide documentation of a first or second step tuberculosis screening test.

A tuberculosis screening document for QMA 11, dated 9/16/25, was missing the TB assessment and testing information.

During an interview, on 10/17/25 at 10:43 a.m., Human Resources 9 indicated he could not provide the tuberculosis testing for the two new employees.

During an interview, on 10/17/25 at 10:41 a.m., the Executive Director indicated the facility followed the state regulations.

A current facility policy, titled "PRE-EMPLOYMENT TB TESTING AND FREE FROM COMMUNICABLE DISEASE," dated as last reviewed August 2023 and received from Human Resources 9 on 10/17/25 at 10:48 a.m., indicated "...The first step is to be given and read prior to the first day of employment...the second step is to be given 7 to 21 days after the first step is completed and read...."

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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.)

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAngela Martinez | TITLEExecutive Director | (X6) DATE11/06/2025 |