STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE MEMORY CARE OF ANDERSON	2101 N MADISON AVENUE, ANDERSON, , 46011

(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: April 21 and 22, 2025 Facility number: 013811 Residential Census: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 28, 2025.	R 0000		
R 0042	Residents' Rights - Noncompliance 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 interview and record	R 0042	A copy of the last annual survey with corrections has been replaced in the survey binder and is available to the public. Community policy “Required Postings,” was reviewed without change. The DMC will place a copy of all survey paperwork in the survey binder after each survey. The	05/11/2025

	review, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 15 of 15 resident residing in the facility. Findings include: During review of the State Survey binder on 4/22/25 at 9:39 a.m., the binder lacked the previous annual State Survey report, completed 2/28/24. During an interview with the DON on 4/22/25 at 9:40 a.m., she indicated the State Survey binder did not contain the results of the last annual survey. During an interview with the Interim Administrator on 4/22/25 at 9:50 a.m., he indicated all survey reports should be kept up to date in the State Survey binder and readily available for resident and visitor access. A current facility policy, revised 5/30/23, provided by the Interim Administrator on 4/22/25 at 12:56 p.m., titled "Required Postings," indicated the Executive Director or designee is responsible for posting results of State Surveys and making them readily available to residents and visitors. Based on interview and record review, the facility failed to have the most recent State Survey results readily available to the		DMC will be responsible for making sure the binder is up to date according to State requirements. The DMC or her representative will audit the survey binder 1X monthly for 90 days to ensure it contains the proper postings. Results of audits will be reported to the QA committee for further monitoring.	

	public. This deficiency had the potential to affect 15 of 15 resident residing in the facility. Findings include: During review of the State Survey binder on 4/22/25 at 9:39 a.m., the binder lacked the previous annual State Survey report, completed 2/28/24. During an interview with the DON on 4/22/25 at 9:40 a.m., she indicated the State Survey binder did not contain the results of the last annual survey. During an interview with the Interim Administrator on 4/22/25 at 9:50 a.m., he indicated all survey reports should be kept up to date in the State Survey binder and readily available for resident and visitor access. A current facility policy, revised 5/30/23, provided by the Interim Administrator on 4/22/25 at 12:56 p.m., titled "Required Postings," indicated the Executive Director or designee is responsible for posting results of State Surveys and making them readily available to residents and visitors.			
R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required	R 0095	The DMC has completed the initial twelve (12) hours of training for new Memory Care Directors.	05/11/2025

	under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure the Dementia Care Director completed the required minimum 12 hours of dementia-specific training within three months of employment as the Dementia Care Director for		The onboarding training schedule for DMCs and the Director of Memory Care Job Description were reviewed without change. Upon hire, Primrose will assign the initial twelve (12) hours of dementia training to the DMC to be completed within ninety (90) days of employment. The Business Office Manager or her representative will audit training transcripts monthly X90 days, to ensure the DMC is current on her required training. Results of these audits will be reported to the QA committee for further monitoring.	

	1 of 6 employee training records reviewed for dementia-specific training. This deficiency had the potential to affect 15 of 15 residents residing in the secured dementia care facility. Finding includes: An employee training record, provided by the Interim Administrator on 4/22/25 at 1:00 p.m., indicated the Dementia Care Director completed 4.25 hours of dementia-specific training within three months of hire as the Dementia Care Director. During an interview, on 4/22/25 at 2:40 p.m., the DON indicated the Dementia Care Director had 4.25 hours of dementia-specific training within three months of assuming the role of Dementia Care Director. A current facility form, provided by the Interim Administrator on 4/22/25 at 3:06 p.m., titled "Annual Training Plan for ADSCU Director," indicated six hours of dementia-specific training was scheduled annually for the Dementia Care Director. During an interview, on 4/22/25 at 3:09 p.m., the Interim Administrator indicated the facility did not have a policy for the education requirements for the Dementia Care Director. The facility followed an annual training plan protocol for the			

	Dementia Care Director. During an interview, on 4/22/25 at 3:41 p.m., the Interim Administrator indicated he was not aware of the number of dementia-specific training hours the Dementia Care Director was required to complete upon hire to the position. The Dementia Care Director assumed her role as the Dementia Care Director on 9/22/24. He reviewed the Director of Memory Care job description and indicated it did not include a requirement of 12 hours of dementia-specific training within three months of hire into the position. Based on record review and interview, the facility failed to ensure the Dementia Care Director completed the required minimum 12 hours of dementia-specific training within three months of employment as the Dementia Care Director for 1 of 6 employee training records reviewed for dementia-specific training. This deficiency had the potential to affect 15 of 15 residents residing in the secured dementia care facility. Finding includes: An employee training record, provided by the Interim Administrator on 4/22/25 at 1:00 p.m., indicated the Dementia Care Director completed 4.25 hours of dementia-specific			

	training within three months of hire as the Dementia Care Director. During an interview, on 4/22/25 at 2:40 p.m., the DON indicated the Dementia Care Director had 4.25 hours of dementia-specific training within three months of assuming the role of Dementia Care Director. A current facility form, provided by the Interim Administrator on 4/22/25 at 3:06 p.m., titled "Annual Training Plan for ADSCU Director," indicated six hours of dementia-specific training was scheduled annually for the Dementia Care Director. During an interview, on 4/22/25 at 3:09 p.m., the Interim Administrator indicated the facility did not have a policy for the education requirements for the Dementia Care Director. The facility followed an annual training plan protocol for the Dementia Care Director. During an interview, on 4/22/25 at 3:41 p.m., the Interim Administrator indicated he was not aware of the number of dementia-specific training hours the Dementia Care Director was required to complete upon hire to the position. The Dementia Care Director assumed her role as the Dementia Care Director on 9/22/24. He reviewed the Director of Memory Care job			

	description and indicated it did not include a requirement of 12 hours of dementia-specific training within three months of hire into the position.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.	R 0117	The current schedule has been reviewed to ensure there is at least one employee that is certified in CPR with the hands-on-component on every shift. All clinical staff have been audited to identify those who have not been certified in CPR. These individuals will be certified in CPR with hands-on-component at the earliest opportunity. The community policy “Life Safety Training” was reviewed without change. All management level nursing staff will be re-educated on this policy. The scheduler will ensure that there is at least one clinical staff member with proper CPR certification on each shift. The DON will review the schedule to ensure the schedule is compliant before the schedule is posted.	05/11/2025

	Based on interview and record review, the facility failed to ensure a minimum of one awake staff member certified in CPR (cardiopulmonary resuscitation) with a hands-on component was onsite for 13 of 21 shifts, and a first aid trained staff member was onsite for 10 of 21 shifts reviewed for staffing sufficiency. This deficiency had the potential to affect 15 of 15 residents residing in the facility. Findings include: Review of the facility's worked employee schedule, provided by the DON on 4/22/25 at 1:03 p.m., indicated 13 of 21 shifts for the week of 4/14/25 through 4/20/25 lacked a staff member certified in CPR with a hands-on training component and lacked a first aid trained staff member for 10 of 21 shifts. During an interview, on 4/22/25 at 11:57 a.m., the DON indicated the American Health Care Academy did not have a hands-on training component. She did not believe the National CPR Foundation had one either. She was unaware that a hand-on training component was required. During an interview, on 4/22/25 at 3:05 p.m., the DON indicated she was unable to provide additional CPR and first aid certifications for the staff		The DON or her representative will audit the schedule weekly X30 days, then bi-weekly X30 days, then monthly X30 days to ensure the schedule has at least one clinical staff member with the proper CPR certification on each shift. Results of these audits will be reported to the QA committee for further monitoring.	

	members that worked in the facility during the week of 4/14/25 through 4/20/25. Guidance from the National CPR Foundation website, accessed on 4/17/25 at 2:49 p.m., at https://nationalcprfoundation.com/support/, indicated the following: " ...Do I need hands-on training? ... if your employer or licensing board requires a hands-on component or a skills check, please visit CPRNearMe.com [an online company that provides a range of life-saving skills training providers, including hands-on and skills-check training for assessments] ...." A facility policy, dated 1/1/15, provided by the Interim Administrator on 4/22/25 at 4:15 p.m., indicated the following: " ...Staff are required to maintain current certification/training for CPR and First Aid, in accordance with state regulations ... At least one staff member who has CPR and First Aid training/certification should be on duty at all times unless otherwise required by state regulation ...." Based on interview and record review, the facility failed to ensure a minimum of one awake staff member certified in CPR (cardiopulmonary resuscitation) with a hands-on			

component was onsite for 13 of 21 shifts, and a first aid trained staff member was onsite for 10 of 21 shifts reviewed for staffing sufficiency. This deficiency had the potential to affect 15 of 15 residents residing in the facility.

Findings include:

Review of the facility's worked employee schedule, provided by the DON on 4/22/25 at 1:03 p.m., indicated 13 of 21 shifts for the week of 4/14/25 through 4/20/25 lacked a staff member certified in CPR with a hands-on training component and lacked a first aid trained staff member for 10 of 21 shifts.

During an interview, on 4/22/25 at 11:57 a.m., the DON indicated the American Health Care Academy did not have a hands-on training component. She did not believe the National CPR Foundation had one either. She was unaware that a hand-on training component was required.

During an interview, on 4/22/25 at 3:05 p.m., the DON indicated she was unable to provide additional CPR and first aid certifications for the staff members that worked in the facility during the week of 4/14/25 through 4/20/25.

Guidance from the National CPR Foundation website, accessed on 4/17/25 at 2:49

	p.m., at https://nationalcprfoundation.com/support/, indicated the following: " ...Do I need hands-on training? ... if your employer or licensing board requires a hands-on component or a skills check, please visit CPRNearMe.com [an online company that provides a range of life-saving skills training providers, including hands-on and skills-check training for assessments] ...." A facility policy, dated 1/1/15, provided by the Interim Administrator on 4/22/25 at 4:15 p.m., indicated the following: " ...Staff are required to maintain current certification/training for CPR and First Aid, in accordance with state regulations ... At least one staff member who has CPR and First Aid training/certification should be on duty at all times unless otherwise required by state regulation ...."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the	R 0120	LPN 6 and QMA 7 have completed the required dementia specific training. All staff training has been audited and all staff have completed their dementia specific training.	05/11/2025

	needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		The onboarding training schedule for direct care staff was reviewed and updated. Primrose will assign all newly hired direct care staff six (6) hours of dementia-specific training to be completed within six (6) months. Any direct care employee who has not completed their initial six (6) hours of dementia-specific training or their annual three (3) hours of dementia-specific training will not be permitted to work until they complete the required training. The Business Office Manager will audit training transcripts monthly to ensure assigned courses are completed. The DMC or her representative will audit training records monthly X90 to ensure compliance. Results of these audits will be reported to the QA for further monitoring.	

R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on observation and interview, the facility failed to ensure menus were approved by a registered dietitian. This deficient practice had the potential to impact 15 of 15 residents who received meals from the facility. Finding includes: During an observation of the kitchen on 4/21/23 at 10:15 a.m., a week-at-a-glance style menu was posted. The menu lacked documentation of approval by a registered dietitian (RD). Review of the weekly menu for 4/21/25 to 4/27/25, provided by the Interim Administrator following the entrance conference on 4/21/25, lacked indication that the menus had been approved by a registered dietician. During an interview with the Interim Director on 4/22/25 at 11:04 a.m., he indicated the current weekly menus were not certified by an RD, but he would try and find previous menus certified by an RD as well as	R 0269	Menus have been reviewed and signed by the Registered Dietician The community policy “Registered Dietician” has been reviewed without change. The DSD will ensure the menus have been reviewed and signed by the Registered Dietician prior to use. Menus that have not been reviewed and signed by the RD will not be put in rotation. The RD will make quarterly onsite visits to the community. The DMC or her representative will audit the menus weekly X30 days, then bi-weekly X30 days, then monthly X 60 days to ensure the menus being used have been reviewed et signed by the RD. Results of these audits and a summary of the quarterly RD visits will be reported to the QA for further action.	05/11/2025

	documentation from the last RD visit. During an interview with the Interim Director on 4/22/25 at 3:41 p.m. he indicated that the weekly menus were completed by the Dietary Manager. The RD visited quarterly. He was unable to find previous menus certified by an RD or documentation from the last RD visit. No RD documentation or policy regarding RD certified menus was provided prior to facility exit on 4/22/25. Based on observation and interview, the facility failed to ensure menus were approved by a registered dietitian. This deficient practice had the potential to impact 15 of 15 residents who received meals from the facility. Finding includes: During an observation of the kitchen on 4/21/23 at 10:15 a.m., a week-at-a-glance style menu was posted. The menu lacked documentation of approval by a registered dietitian (RD). Review of the weekly menu for 4/21/25 to 4/27/25, provided by the Interim Administrator following the entrance conference on 4/21/25, lacked indication that the menus had been approved by a registered			

	dietician. During an interview with the Interim Director on 4/22/25 at 11:04 a.m., he indicated the current weekly menus were not certified by an RD, but he would try and find previous menus certified by an RD as well as documentation from the last RD visit. During an interview with the Interim Director on 4/22/25 at 3:41 p.m. he indicated that the weekly menus were completed by the Dietary Manager. The RD visited quarterly. He was unable to find previous menus certified by an RD or documentation from the last RD visit. No RD documentation or policy regarding RD certified menus was provided prior to facility exit on 4/22/25.			

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 standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute foods under safe sanitary conditions regarding dating and labeling foods, disposing of outdated items, and cleaning equipment. This deficient practice had the potential to impact 15 of 15 residents who received meals from the facility kitchen. Finding includes: During a kitchen observation beginning on 4/21/25 at 10:15 a.m. accompanied by the Dietary Cook who assisted with kitchen supervision, a countertop deep fryer was caked in a brownish-yellow substance on the control knobs, fryer baskets, and sides just above the fryer oil. The fryer oil was black and opaque, with unidentifiable particles floating in it. The Dietary Cook indicated the fryer was cleaned, "whenever", but was unsure of the last time it was cleaned.	R 0273	The fryer has been removed. The squirt bottles have been emptied, cleaned, re-stocked, labeled and dated. The breadcrumbs, Spanish rice, biscuit mix, dented cans, lemon bar crust mix, butterscotch chips, carton with cracked egg, ranch dressing, mushrooms and pasteurized eggs have been destroyed. The container with the lemons and bananas has been cleaned. All food has been audited to ensure proper storage. All food is labeled, dated, and properly stored. Community policies “Commercial Kitchen Equipment Maintenance and Use,” and “Community Food – Labeling and Dating,” have been reviewed without change. All kitchen employees will be re-educated on these policies related to kitchen equipment and food storage. The DSD will conduct audits of the kitchen weekly X30 days, then bi-weekly X30 days, then	05/14/2025

	Several undated squirt bottles were on a tray beside the grill, containing, in separate bottles, a thick yellow liquid, white crystalline particles, and a clear liquid. The cook indicated the bottles contained liquid butter, salt, and water. She was unsure of when the ingredients were placed in the bottles. In the dry storage area, a large paper bag, labeled as panko breadcrumbs, was opened and undated, and breadcrumbs were able to be seen without manipulating the bag. A box of "Spanish rice" was opened at the top, undated, and the rice was able to be observed without manipulating the package. A gray rectangular bin contained a single bunch of bananas and six lemons, the bottom of which was covered with unknown debris. A box containing buttermilk biscuit mix was opened and undated. A can containing diced peaches was observed with an approximately one centimeter (cm) dent along the bottom seal of the can, exposing the inner seal. A box of lemon bar crust mix was opened and dated 8/6/23 with package best by date of 8/16/23.		monthly X30 days to ensure all the kitchen equipment is clean and food is properly stored, labeled, and dated. Results of these audits will be reported to the QA committee for further monitoring.	

	A plastic package of butterscotch chips was opened and unlabeled. During observation of the walk-in fridge, a carton containing 12 eggs had one egg cracked circumferentially, and a clear desiccated material was along the bottom half of the egg. No date was observed on the carton. A large plastic jar of ranch dressing was observed with a dried white substance along the upper portion of the jar. A large container of mushrooms was unlabeled and undated. A carton of pasteurized eggs was open and undated, and a yellow liquid was seen inside without manipulation of the container. The Dietary Cook indicated these items should have been disposed of. During a second kitchen observation on 4/22/25 at 10:51 a.m., the deep fryer remained caked with the brownish-yellow substance. The oil was a deep olive green and the bottom of the fryer trough was able to be seen. The liquid butter squirt bottle and Spanish rice was undated. The panko breadcrumbs bag was rolled closed, but remained undated. The large jar of ranch dressing remained with a dried white substance surrounding the upper portion of it. The can of diced peaches with the dent on			

	the bottom remained in the dry storage area. During a concurrent interview with the Dietary Cook, she indicated she was not responsible for the cleanliness of kitchen equipment or the dating and storage of food. An undated, current facility policy titled, "GENERAL FOOD PREPARATION AND HANDLING," provided by the Interim Director on 4/22/25 at 11:31 a.m. indicated the following,: "...2. The kitchen and equipment area clean...." An undated, current facility titled, "FOOD STORAGE," provided by the Interim Director on 4/22/25 at 11:31 a.m. indicated the following,:"...6. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables and frozen products must be refrigerated immediately to ensure nutritive value and quality...8. Refrigeration:...d. All foods should be covered, labeled and dated...." Based on observation, interview, and record review, the facility failed to store, prepare, and distribute foods under safe sanitary conditions regarding dating and labeling foods, disposing of outdated items, and cleaning equipment. This deficient practice had the potential to impact 15 of 15			

residents who received meals from the facility kitchen.

Finding includes:

During a kitchen observation beginning on 4/21/25 at 10:15 a.m. accompanied by the Dietary Cook who assisted with kitchen supervision, a countertop deep fryer was caked in a brownish-yellow substance on the control knobs, fryer baskets, and sides just above the fryer oil. The fryer oil was black and opaque, with unidentifiable particles floating in it. The Dietary Cook indicated the fryer was cleaned, "whenever", but was unsure of the last time it was cleaned.

Several undated squirt bottles were on a tray beside the grill, containing, in separate bottles, a thick yellow liquid, white crystalline particles, and a clear liquid. The cook indicated the bottles contained liquid butter, salt, and water. She was unsure of when the ingredients were placed in the bottles.

In the dry storage area, a large paper bag, labeled as panko breadcrumbs, was opened and undated, and breadcrumbs were able to be seen without manipulating the bag.

A box of "Spanish rice" was opened at the top, undated, and the rice was able to be observed without manipulating the

	package. A gray rectangular bin contained a single bunch of bananas and six lemons, the bottom of which was covered with unknown debris. A box containing buttermilk biscuit mix was opened and undated. A can containing diced peaches was observed with an approximately one centimeter (cm) dent along the bottom seal of the can, exposing the inner seal. A box of lemon bar crust mix was opened and dated 8/6/23 with package best by date of 8/16/23. A plastic package of butterscotch chips was opened and unlabeled. During observation of the walk-in fridge, a carton containing 12 eggs had one egg cracked circumferentially, and a clear desiccated material was along the bottom half of the egg. No date was observed on the carton. A large plastic jar of ranch dressing was observed with a dried white substance along the upper portion of the jar. A large container of mushrooms was unlabeled and undated. A carton of pasteurized eggs was open and undated, and a yellow liquid was seen inside without manipulation of the container.			

	The Dietary Cook indicated these items should have been disposed of. During a second kitchen observation on 4/22/25 at 10:51 a.m., the deep fryer remained caked with the brownish-yellow substance. The oil was a deep olive green and the bottom of the fryer trough was able to be seen. The liquid butter squirt bottle and Spanish rice was undated. The panko breadcrumbs bag was rolled closed, but remained undated. The large jar of ranch dressing remained with a dried white substance surrounding the upper portion of it. The can of diced peaches with the dent on the bottom remained in the dry storage area. During a concurrent interview with the Dietary Cook, she indicated she was not responsible for the cleanliness of kitchen equipment or the dating and storage of food. An undated, current facility policy titled, "GENERAL FOOD PREPARATION AND HANDLING," provided by the Interim Director on 4/22/25 at 11:31 a.m. indicated the following,: "...2. The kitchen and equipment area clean...." An undated, current facility titled, "FOOD STORAGE," provided by the Interim Director on 4/22/25 at 11:31 a.m.			

	indicated the following,:"...6. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables and frozen products must be refrigerated immediately to ensure nutritive value and quality...8. Refrigeration:...d. All foods should be covered, labeled and dated...."			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to verify by statement annually that residents were free from infectious tuberculosis for 2 of 7 residents reviewed for annual health statements. (Resident 14 and Resident 13) Findings include: Resident 14's clinical record was reviewed on 4/21/25 at 11:45 a.m. and lacked an annual health statement. Resident 13's clinical record was reviewed on 4/22/25 at	R 0409	The annual health statements of resident 14 and resident 13 have been updated to show that they have no evidence of communicable disease. All residents' records have been audited to ensure they have an annual health statement showing they have no evidence of communicable disease. Community policy "TB Control Plan" was reviewed without change. Staff will be re-educated on the importance of all residents having an annual health statement showing they have no evidence of communicable disease signed by each resident's primary care physician. The resident's medical record will be reviewed with each	05/11/2025

	10:28 a.m. and lacked an annual health statement. During an interview, on 4/22/25 at 2:39 p.m., the DON indicated she was unable to locate current health statements for Resident 13 and Resident 14. During an interview, on 4/22/25 at 4:27 p.m., the Nurse Consultant indicated she had contacted the corporate office for a policy on the annual health statements, but she had not received it. No policy for annual health statements was provided prior to survey exit on 4/22/25. Based on record review and interview, the facility failed to verify by statement annually that residents were free from infectious tuberculosis for 2 of 7 residents reviewed for annual health statements. (Resident 14 and Resident 13) Findings include: Resident 14's clinical record was reviewed on 4/21/25 at 11:45 a.m. and lacked an annual health statement. Resident 13's clinical record was reviewed on 4/22/25 at 10:28 a.m. and lacked an annual health statement. During an interview, on 4/22/25 at 2:39 p.m., the DON indicated		evaluation to ensure an annual health statement showing they have not evidence of communicable disease is documented. The Director of Nursing or her designee will audit 5 charts weekly X30 days, then another 5 charts bi-weekly X60 days, then another 5 charts monthly X30 days to ensure annual health statements showing no evidence of communicable disease signed by the primary physician is in place in the residents' charts. Results of these audits will be reported to the QA committee for further monitoring and action. A percentage of 95% compliance would be the acceptable threshold.	

	she was unable to locate current health statements for Resident 13 and Resident 14. During an interview, on 4/22/25 at 4:27 p.m., the Nurse Consultant indicated she had contacted the corporate office for a policy on the annual health statements, but she had not received it. No policy for annual health statements was provided prior to survey exit on 4/22/25.			

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