STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR RESIDENCES OF NORTHWOODS	2501 FRIENDSHIP BLVD, KOKOMO, , 46901

(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: July 8 and 9, 2025 Facility number: 014019 Residential Census: 63 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 11, 2025.	R 0000	This plan of Correction constitutes Five Star Residences of North Woods written allegation of compliance for the alleged deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. The facility respectfully requests that paper compliance/desk review be granted.	
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	R 0092	1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. At least every 6 months, the facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of the training and drill shall be documented with the names and signatures of the participants as well as invitation to fire	08/08/2025

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure an attempt was made to hold fire drills in conjunction with the local fire department at least every six (6) months during the 12 months of fire drills reviewed. Findings include: During review of the twelve-monthly fire drills, there was no documentation to indicate the local fire department had been invited to participate in any of the facility fire drills. During an interview, on 7/9/25 at		department. 3. The maintenance director shall be educated that at least every 6 months, the facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of the training and drill shall be documented with the names and signatures of the participants. 4.The monthly fire and disaster drill will be reviewed by the ED or designee to ensurethat at least every 6 months, the facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of the training and drill shall be documented with the names and signatures of the participants.	

	9:05 a.m., the Executive Director (ED) indicated the facility did not have documentation which showed the local fire department had been contacted and asked to participate in any of the twelve fire drills. During an interview, on 7/9/25 at 11:18 a.m., the Maintenance Director indicated the fire department had not been invited to attend drills in the last 12 months. They should have been here twice in the last year. During an interview, on 7/9/25 at 11:35 a.m., the ED indicated the facility did not have a policy on including the local fire department in their drills. Based on interview and record review, the facility failed to ensure an attempt was made to hold fire drills in conjunction with the local fire department at least every six (6) months during the 12 months of fire drills reviewed. Findings include: During review of the twelve-monthly fire drills, there was no documentation to indicate the local fire department had been invited to participate in any of the facility fire drills. During an interview, on 7/9/25 at 9:05 a.m., the Executive Director (ED) indicated the			

	facility did not have documentation which showed the local fire department had been contacted and asked to participate in any of the twelve fire drills. During an interview, on 7/9/25 at 11:18 a.m., the Maintenance Director indicated the fire department had not been invited to attend drills in the last 12 months. They should have been here twice in the last year. During an interview, on 7/9/25 at 11:35 a.m., the ED indicated the facility did not have a policy on including the local fire department in their drills.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing	R 0120	1. No residents were affected by the deficient practice. CNA 2, LPN 2, LPN 3, LPN 4 and LPN 5 will complete resident rights and dementia training. 2. No other residents have the potential to be affected by the deficient practice. 3. HR to complete an audit of current and new employee files to identify employees with any missing resident rights and/or dementia training. Those employees that are identified as missing or needing the training shall complete the training and have the training documented in the employee file within 30 days of identifying the deficiency. HR	08/08/2025

	personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure in-service records were maintained and the annual in-service training were documented for 5 of 5 employees reviewed for in-service training. (CNA 2, LPN		shall utilize a monthly checklist to keep track ofrequired orientation paperwork. 4. This monthly checklist will be reviewed by the ED or designee to ensure facility staff are in compliance with required orientation paperwork.	

	2, LPN 3, LPN 4, and LPN 5) Findings include: The employee records were reviewed on 7/8/25 at 2:30 p.m., and indicated the following: 1. CNA 2 did not have annual resident rights or dementia in-services completed. 2. LPN 2 did not have annual resident rights or dementia in-services completed. 3. LPN 3 did not have an annual resident rights or dementia in-services completed. 4. LPN 4 did not have an annual resident rights or dementia in-services completed. 5. LPN 5 did not have an annual resident rights or dementia in-services completed. During an interview, on 7/9/25 at 11:15 a.m., the Executive Director (ED) indicated he was unable to locate the annual in-services for the employees. A policy was not provided at the time of exit. Based on interview and record review, the facility failed to ensure in-service records were maintained and the annual in-service training were documented for 5 of 5 employees reviewed for			

	in-service training. (CNA 2, LPN 2, LPN 3, LPN 4, and LPN 5) Findings include: The employee records were reviewed on 7/8/25 at 2:30 p.m., and indicated the following: 1. CNA 2 did not have annual resident rights or dementia in-services completed. 2. LPN 2 did not have annual resident rights or dementia in-services completed. 3. LPN 3 did not have an annual resident rights or dementia in-services completed. 4. LPN 4 did not have an annual resident rights or dementia in-services completed. 5. LPN 5 did not have an annual resident rights or dementia in-services completed. During an interview, on 7/9/25 at 11:15 a.m., the Executive Director (ED) indicated he was unable to locate the annual in-services for the employees. A policy was not provided at the time of exit.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be	R 0121	1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the	08/08/2025

	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: (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. (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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.		deficient practice. The facility shall administer annual tuberculosis health risk screenings on CNA 2, LPN 2, LPN 3, LPN 4 and LPN 5 as well as any new hires moving forward. 3. The facility shall administer annual tuberculosis health risk screeningsfor all new hires. These tests will be documented and retained in employee files. The new hire will not have resident contact until after the reading of the first step of the TB screening process. The new hire will be given a date in which the second step must be administered and read by an authorized healthcare provider. If the new hire fails to obtain second step on date given, then he/she will be removed from the schedule until the second step is completed. 4. New hire TB tests will be reviewed monthly by the ED or designee to ensure facility staff are in compliance with health screening and TB tests requirements.	

	(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 record review and interview, the facility failed to ensure employees had annual tuberculosis health risk screenings completed for 5 of 5 employees reviewed for annual tuberculosis screenings. (CNA 2, LPN 2, LPN 3, LPN 4 and LPN 5). Findings include: The employee records were reviewed on 7/8/25 at 2:30 p.m., and indicated the following: 1. CNA 2 did not have an annual tuberculosis health risk screening completed. 2. LPN 2 did not have an annual tuberculosis health risk screening completed. 3. LPN 3 did not have an annual tuberculosis health risk screening completed. 4. LPN 4 did not have an annual tuberculosis health risk screening completed. 5. LPN 5 did not have an annual tuberculosis health risk screening completed.			

	During an interview, on 7/9/25 at 11:15 a.m., the Executive Director (ED) indicated they did not have the annual tuberculosis health risk screening completed. A current facility policy, titled "Administering TB Skin Test," dated 10/1/17 and received from the DON on 7/9/25 at 10:18 a.m., did not address annual tuberculosis health risk screenings. Based on record review and interview, the facility failed to ensure employees had annual tuberculosis health risk screenings completed for 5 of 5 employees reviewed for annual tuberculosis screenings. (CNA 2, LPN 2, LPN 3, LPN 4 and LPN 5). Findings include: The employee records were reviewed on 7/8/25 at 2:30 p.m., and indicated the following: 1. CNA 2 did not have an annual tuberculosis health risk screening completed. 2. LPN 2 did not have an annual tuberculosis health risk screening completed. 3. LPN 3 did not have an annual tuberculosis health risk screening completed. 4. LPN 4 did not have an annual			

	tuberculosis health risk screening completed. 5. LPN 5 did not have an annual tuberculosis health risk screening completed. During an interview, on 7/9/25 at 11:15 a.m., the Executive Director (ED) indicated they did not have the annual tuberculosis health risk screening completed. A current facility policy, titled "Administering TB Skin Test," dated 10/1/17 and received from the DON on 7/9/25 at 10:18 a.m., did not address annual tuberculosis health risk screenings.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or	R 0123	1. No residents were affected by the deficient practice. CNA 2 and LPN 5 will have initial orientation checklist completed and placed in employee files. LPN 3 and LPN 5 will sign job descriptions with copies placed in employee files 2. No other residents have the potential to be affected by the deficient practice. 3. HR to complete an audit of current and new employee files to identify employees with any missing initial orientation and/or signed job descriptions in the employee file. Those employees that are identified as missing or	08/08/2025

	registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure current and accurate personnel records were maintained related to orientation and job descriptions for 3 of 5 employees reviewed for employee files. (CNA 2, LPN 3 and LPN 5) Findings include: The employee records were reviewed on 7/8/25 at 2:30 p.m., and indicated the following: 1. An initial orientation checklist was not located for CNA 2. 2. A signed job description was not located for LPN 3.		needing these items shall have the missing items completed and put in the employee file within 30 days of identifying the deficiency. HR shall utilize a monthly checklist to keep track ofrequired orientation paperwork. 4. This monthly checklist will be reviewed by the ED or designee to ensure facility staff are in compliance with required orientation paperwork.	

	3. An initial orientation checklist or a signed job description was not located for LPN 5. During an interview, on 7/9/25 at 11:15 a.m., the Executive Director (ED) indicated the facility could not locate documentation of the initial checklists and signed job descriptions. A policy was not provided at the time of exit. Based on record review and interview, the facility failed to ensure current and accurate personnel records were maintained related to orientation and job descriptions for 3 of 5 employees reviewed for employee files. (CNA 2, LPN 3 and LPN 5) Findings include: The employee records were reviewed on 7/8/25 at 2:30 p.m., and indicated the following: 1. An initial orientation checklist was not located for CNA 2. 2. A signed job description was not located for LPN 3. 3. An initial orientation checklist or a signed job description was not located for LPN 5. During an interview, on 7/9/25 at 11:15 a.m., the Executive Director (ED) indicated the			

	facility could not locate documentation of the initial checklists and signed job descriptions. A policy was not provided at the time of exit.			
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 ensure food items were dated upon opening, food preparation areas were maintained, and trash was contained inside the dumpster for 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 63 of 63 residents who received food from the kitchen. Findings include: During the kitchen observation on 7/8/25 at 9:17 a.m., with the Dietary Manager (DM), the following were observed: 1. The refrigerator had an open container of Cole slaw, relish, and lemon juice with no open	R 0273	1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice.The coleslaw, relish, lemon juice bag of spinach observed to be out of compliance were discarded during survey. The spices on the spice shelf with no dates were discarded and replaced with spices with open dates. The air conditioner was repaired and the cold water restored during the survey. The trash around dumpster was put in dumpster and lid closed during the survey. 3.Cooks/Chef to be re-educated to ensure that proper labeling is completed when opening items. Dietary staff re-educated on use of work requisitions when they observe a piece of equipment not working appropriately. Maintenance staff to be re-educated on ensuring that dumpster area remains clutter free and trash in dumpster with lid closed. This education to be documented and retained with in-services. 4. Food Service Director or designee shall randomly monitor open dates on food items weekly for 13 weeks and document observation/re-educate as needed.	08/08/2025

	date. 2. A bag of spinach was discolored, leaking, with no open date. 3. The spice shelf had multiple containers with no open dates. 4. The air conditioner was dripping water into a bucket by the food preparation table. b. The cold water was turned off under the three compartments sink in the dishwashing station. c. There was trash on the ground next to the outside dumpster and it was not covered. During an interview, on 7/8/25 at 9:17 a.m., the DM indicated all food items were to be dated when received and then dated when opened. During an interview, on 7/8/25 at 2:19 p.m., the Executive Director (ED) indicated the trash should not have been on the ground next to the dumpster. The ED was not aware the air conditioner leaked or the cold-water pipe under the three-compartment sink was turned off. During an interview, on 7/9/25 at 11:23 a.m., the Maintenance Director indicated he was not aware of the cold-water pipe being shut off or the air		After 13 weeks, Food Service Director and Executive Director will determine if continued monitoring is needed. Facility Director or designee shall monitor dumpster area at least 3 times/week for 13 weeks and document observation/re-educate as needed. After 13 weeks, Facility Director and Executive Director will determine if continued monitoring is needed.	

	conditioner dripping by the food preparation table. During an interview, on 7/9/25 at 11:40 a.m., the Maintenance Director indicated his assistant had turned the cold water off under the sink as the pipe was leaking. The air conditioner was dripping condensation caused by hot and cold temperatures combining. The air conditioner dripped when the stove was on due to the heat from the stove. A current facility policy, titled "Storage of Food and Supplies," dated 12/7/20 and received from the Executive Director on 7/7/25 at 2:14 p.m., indicated "...To establish standardized storage methods in all operations and exceed all health and safety regulations...Any food item must have a time recorded opened and dated when the food is prepared or opened...Fruit and vegetable storage to sort produce daily and remove spoiled pieces...." A current facility policy, titled "Dumpster," dated 7/8/24 and received from the ED on 7/8/25 at 2:14 p.m., indicated "...Check for overflow. Ensure the dumpster is filled evenly to ensure the door and lid close properly. If the dumpster is overflowing, communicate to the Facilities Leader to notify Waste Management...Throw the trash			

	in the dumpster and make sure that there is no loose trash around the dumpster area. Close all doors and lids properly...The Facilities Manager performs a daily walkthrough of the dumpster area...." A current facility policy, titled "Safety and Sanitation," received from the ED on 7/8/25 at 2:14 p.m., indicated "...Sanitizing contact surfaces...Reducing the potential of food borne illness and maintaining a clean, sanitary work environment are fundamental to a quality food service operation...." A current facility policy, titled "Food Safety," received from the ED on 7/8/25 at 2:15 p.m., indicated "...To ensure food safety standards are met according to local & state regulations...Preventing Contamination...Preventing Temperature Abuse...Sanitation...Facility and Equipment Standards...." Based on observation, interview and record review, the facility failed to ensure food items were dated upon opening, food preparation areas were maintained, and trash was contained inside the dumpster for 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 63 of 63			

	residents who received food from the kitchen. Findings include: During the kitchen observation on 7/8/25 at 9:17 a.m., with the Dietary Manager (DM), the following were observed: 1. The refrigerator had an open container of Cole slaw, relish, and lemon juice with no open date. 2. A bag of spinach was discolored, leaking, with no open date. 3. The spice shelf had multiple containers with no open dates. 4. The air conditioner was dripping water into a bucket by the food preparation table. b. The cold water was turned off under the three compartments sink in the dishwashing station. c. There was trash on the ground next to the outside dumpster and it was not covered. During an interview, on 7/8/25 at 9:17 a.m., the DM indicated all food items were to be dated when received and then dated when opened. During an interview, on 7/8/25 at 2:19 p.m., the Executive Director (ED) indicated the trash			

	should not have been on the ground next to the dumpster. The ED was not aware the air conditioner leaked or the cold-water pipe under the three-compartment sink was turned off. During an interview, on 7/9/25 at 11:23 a.m., the Maintenance Director indicated he was not aware of the cold-water pipe being shut off or the air conditioner dripping by the food preparation table. During an interview, on 7/9/25 at 11:40 a.m., the Maintenance Director indicated his assistant had turned the cold water off under the sink as the pipe was leaking. The air conditioner was dripping condensation caused by hot and cold temperatures combining. The air conditioner dripped when the stove was on due to the heat from the stove. A current facility policy, titled "Storage of Food and Supplies," dated 12/7/20 and received from the Executive Director on 7/7/25 at 2:14 p.m., indicated "...To establish standardized storage methods in all operations and exceed all health and safety regulations...Any food item must have a time recorded opened and dated when the food is prepared or opened...Fruit and vegetable storage to sort produce daily and remove			

	spoiled pieces...." A current facility policy, titled "Dumpster," dated 7/8/24 and received from the ED on 7/8/25 at 2:14 p.m., indicated "...Check for overflow. Ensure the dumpster is filled evenly to ensure the door and lid close properly. If the dumpster is overflowing, communicate to the Facilities Leader to notify Waste Management...Throw the trash in the dumpster and make sure that there is no loose trash around the dumpster area. Close all doors and lids properly...The Facilities Manager performs a daily walkthrough of the dumpster area...." A current facility policy, titled "Safety and Sanitation," received from the ED on 7/8/25 at 2:14 p.m., indicated "...Sanitizing contact surfaces...Reducing the potential of food borne illness and maintaining a clean, sanitary work environment are fundamental to a quality food service operation...." A current facility policy, titled "Food Safety," received from the ED on 7/8/25 at 2:15 p.m., indicated "...To ensure food safety standards are met according to local & state regulations...Preventing Contamination...Preventing Temperature			

	Abuse...Sanitation...Facility and Equipment Standards...."			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure 2-step Mantoux tuberculosis tests were completed within three months of admission for 4 of 7 residents reviewed for tuberculosis.	R 0410	1. Residents 58, 66, 55 and 67 were affected by the deficient practice. Residents 58, 66, 55 and 67 will have a first and second step TB test completed with results documented in medical record. 2. All residents have potential to be affected by the deficient practice. All new residents will have a TB test completed up to three months prior to admission or upon admission with results documented in medical record. 3. The facility will ensure first and second step TB tests are completed for all new residents upon admission. Director of Resident Care will review all new residents TB test results prior to admission to facility to ensure a valid test has been completed. If second step needs to be given after admission, the Director of Resident Care will place this on the Medication Administration Record for date for it to be given and read. Documentation will be completed in the residents medical record.	08/08/2025

	(Resident 58, 66, 55 and 67) Findings include: 1. The clinical record for Resident 58 was reviewed on 7/8/25 at 11:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus, chronic pain, hypertension, major depressive disorder, and acute osteomyelitis. The clinical record did not include a result for any tuberculosis skin tests, an Interferon Gamma Release Assay (blood test to detect tuberculosis), or a chest x-ray. 2. The clinical record for Resident 66 was reviewed on 7/8/25 at 11:25 p.m. The diagnoses included, but were not limited to, congestion obstruction pulmonary disorder, diabetes mellitus, hypertension, and atrial fibrillation. The clinical record did not include the second step tuberculosis test. 3. The clinical record for Resident 55 was reviewed on 7/8/25 at 12:07 p.m. The diagnoses included, but were not limited to, unspecified dementia, hypertension, chronic pain, and atrial fibrillation.		4. New resident TB tests will be reviewed monthly by the ED or designee to ensure facility is in compliance with TB tests requirements.	

The clinical record did not include the second step tuberculosis test.

4. The clinical record for Resident 67 was reviewed on 7/8/25 at 1:45 p.m. The diagnoses included, but were not limited to, hypertension, hyperlipidemia, aortic valve stenosis, and emphysema.

The clinical record did not include the second step tuberculosis test.

During an interview, on 7/8/25 at 11:32 a.m., the Director of Nursing (DON) indicated the tuberculosis testing was missing. The facility did not have a physician, and the pharmacy would not send tuberculosis testing solution without a physician's identification number.

A current facility policy, titled "Administering TB Skin Test," dated as revised on 10/20/14 and received from the DON on 7/9/25 at 10:18 a.m., indicated "...Skin testing is the standard method of identifying persons infected with TB...Read the test 48 to 72 hours after the injection...."

Based on interview and record review, the facility failed to ensure 2-step Mantoux tuberculosis tests were completed within three months of admission for 4 of 7 residents

reviewed for tuberculosis. (Resident 58, 66, 55 and 67)

Findings include:

1. The clinical record for Resident 58 was reviewed on 7/8/25 at 11:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus, chronic pain, hypertension, major depressive disorder, and acute osteomyelitis.

The clinical record did not include a result for any tuberculosis skin tests, an Interferon Gamma Release Assay (blood test to detect tuberculosis), or a chest x-ray.

2. The clinical record for Resident 66 was reviewed on 7/8/25 at 11:25 p.m. The diagnoses included, but were not limited to, congestion obstruction pulmonary disorder, diabetes mellitus, hypertension, and atrial fibrillation.

The clinical record did not include the second step tuberculosis test.

3. The clinical record for Resident 55 was reviewed on 7/8/25 at 12:07 p.m. The diagnoses included, but were not limited to, unspecified dementia, hypertension, chronic pain, and atrial fibrillation.

The clinical record did not include the second step

tuberculosis test.

4. The clinical record for Resident 67 was reviewed on 7/8/25 at 1:45 p.m. The diagnoses included, but were not limited to, hypertension, hyperlipidemia, aortic valve stenosis, and emphysema.

The clinical record did not include the second step tuberculosis test.

During an interview, on 7/8/25 at 11:32 a.m., the Director of Nursing (DON) indicated the tuberculosis testing was missing. The facility did not have a physician, and the pharmacy would not send tuberculosis testing solution without a physician's identification number.

A current facility policy, titled "Administering TB Skin Test," dated as revised on 10/20/14 and received from the DON on 7/9/25 at 10:18 a.m., indicated "...Skin testing is the standard method of identifying persons infected with TB...Read the test 48 to 72 hours after the injection...."

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