STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST LAFAYETTE ALF OPERATIONS	3575 SENIOR PLACE, WEST LAFAYETTE, , 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 467470. Intake 467470-State deficiencies related to the allegations are cited at R241, R246, R248 and R297. Survey dates: May 1 and 4, 2026 Facility number: 014094 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 11, 2026.	R 0000	Allegation of Substantial Compliance West Lafayette Assited Living has or will have substantially corrected the alleged deficiencies and achieved substantial compliance on or before the date specified herein. The Plan of Correction constitutes West Lafayette Assisted Living's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before June 30, 2026.	

			The statements made on this plan of correction are to correct the deficiencies continue to remain in substantial compliance with Indiana state requirements for health facilities found at 410 IAC 16.2, West Lafayette Assisted Living (herein after referred to as "community") has taken or will take the actions set forth in this plan of correction	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a	R 0092	West Lafayette Assisted Living was cited for not conducting 2 live fire drills within the year and one fire drill was not completed. West Lafayette Assisted Living's intention is to conduct scheduled fire and disaster drills in accordance with ISDH guidelines. The community will complete a bi-weekly audit of monthly fire drills for the next three months. The Executive Director (ED) will review and sign off monthly to verify that all required fire drills have been completed. West Lafayette Assisted Living has also scheduled two live fire drills in coordination with the local fire department. The community will rotate drills among all three shifts each month to ensure staff participation across all working hours. The first live fire drill is	08/31/2026

	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 conduct monthly fire drills and to ensure an attempt was made to hold fire drills in conjunction with the local fire department. This deficient practice had the potential to affect 67 of 67 residents residing in the facility. Findings include: During the record review, on 5/4/26 at 12:03 p.m., the monthly fire drill logs were missing documentation of fire drills in the following months: February 2026 and April 2026. During the record review, on 5/4/26 at 12:03 p.m., there was no documentation to indicate the local fire department was invited to attend any facility fire drills in the past year. During an interview, on 5/4/26 at 1:34 p.m., the Executive Director indicated the facility did not have documentation of fire drills completed for the months of February or April of 2026 and did not have documentation to indicate the fire department had been invited to attend any		scheduled for May 28, 2026, at 3:00 p.m. The second live fire drill is scheduled for September 2026.	

	facility fire drills. A current facility policy, titled "Fire Drills", undated and received from the Director of Nursing on 5/4/26 at 2:40 p.m., indicated "...It is the policy...to ensure the effectiveness of the Emergency Preparedness plan, fire drills will be conducted on a monthly basis...Fire drills will be conducted at each community on a monthly basis...." There was no facility policy provided at the time of exit conference related to inviting the local fire department to facility fire drills.			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe	R 0148	The facility was cited for not ensuring proper temperatures in the hallways on the third floor. The Maintenance Director and Executive Director (ED) will monitor and document temperatures throughout the building for the next three months. Cameras are being installed near thermostats to ensure that residents and staff do not tamper with or damage the thermostat lock boxes in order to change temperatures. Thermostat lock boxes and cameras have been ordered and will be installed upon arrival. The Maintenance Director and	08/22/2026

	functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to ensure hallway temperatures were maintained at a comfortable level on 1 of 3 floors (third floor) and failed to ensure the carpet was secured to the floor in 1 of 1 room reviewed for environment (Room 307). Findings include: 1. During an interview, on 5/1/26 at 10:25 a.m., Resident B indicated he had concerns with the temperature in the building. The resident notified the former Maintenance Director, and he did nothing about it. The hallways were extremely hot in the summer and freezing in the winter. The residents had to wear winter gear because it was extremely cold. Resident B indicated it was worst on the third floor. During an interview, on 5/1/26 at 12:18 p.m., the Maintenance Director indicated he was new, he did not know where the		ED will document temperatures weekly in all hallways and common areas for one month. This monitoring period will be completed by June 22, 2026. The Maintenance Director and ED will document temperatures bi-weekly in all hallways and common areas for one month. This monitoring period will be completed by July 22, 2026. The Maintenance Director and ED will document temperatures monthly in all hallways and common areas for one month. This monitoring period will be completed by August 22, 2026.	

	thermometer was to test the hall temperatures, and it was cold in the halls. During an interview, on 5/1/26 at 12:35 p.m., the Maintenance Director indicated he could not find a thermometer to test the hallways, the thermometer hanging on the wall next to the third-floor nurses' station was set at 60 degrees, and the temperature was 62 degrees which was too cold. During an interview, on 5/4/26 at 10:26 a.m., the Physician's Medical Assistant indicated she was sitting by the fireplace to get warm. The third floor was normally chilly. During an interview, on 5/4/26 at 11:07 a.m., the Executive Director (ED) indicated the facility temperatures should be between 71 and 81 degrees. During a tour with the ED, on 5/4/26 at 11:10 a.m., the hallway temperatures were as follows: a. The hallway temperature by the third-floor elevator was 66.7 degrees. b. The hallway temperature across from the medication room by Room 312 was 64.6 degrees. c. The hallway temperature by			

	the nurses' station was 64.5 degrees. d. The thermostat by the nurses' station was reading 63.1 degrees. e. The hallway temperature outside Room 301 was 68.1 degrees. f. The hallway temperature outside Room 304 was 68.5 degrees. 2. During an observation, on 5/4/26 at 11:10 a.m., the ED observed Room 307. There was not a carpet strip down to secure the carpet between the kitchen and living room. She indicated there was no work order and she was not aware the resident had tripped on the raised carpet. A current facility policy, titled "Room Temperature Regulation", undated and provided by the DON on 5/4/26 at 9:36 a.m., indicated "...A resident's room temperature and humidity should be maintained between approximately 71 and 81 degrees Fahrenheit...The Executive Director should notify the District/Regional Director of Operations and Regional Asset Manager when the temperature falls outside the "safe and comfortable range." The District/Regional Director of			

	Operations in conjunction with the Regional Asset Manager should determine the course of action required to protect the residents' health and safety...Document All Action Taken. The community should document all action taken and should maintain documentation at the community of action taken during the current calendar year and the preceding calendar year...."			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure medications were available and administered according to the physician's orders for 1 of 6 residents reviewed for pharmacy services. (Resident 19) This deficient practice resulted in Resident 19 having an increase in swelling to the bilateral lower extremities,	R 0241	The community was cited for failing to ensure medications were available and administered according to physician orders for 1 of 6 residents reviewed. As part of the Plan of Correction, all Qualified Medication Aides (QMAs) have been re-educated on medication administration procedures, documentation of PRN medications administered, physician order compliance, and ensuring medications are available for administration as ordered. To ensure continued compliance, medication cart audits will be conducted according to the following schedule: •	09/22/2026

	shortness of breath, was sent to the emergency room, and admitted to the hospital. Findings include: During an interview, on 5/4/26 at 11:27 a.m., the Director of Nursing (DON) indicated Resident 19's medications had not been provided in an acceptable time frame. Resident 19 went without medication for such a duration, it resulted in a hospital admission for pulmonary edema. The DON indicated an Emergency Drug Kit (EDK), typically provided by pharmacies, was not available in the community. The clinical record for Resident 19 was reviewed on 5/1/26 at 12:42 p.m. The diagnoses included, but were not limited to, congestive heart failure, hypertension, endocarditis, and chronic obstructive pulmonary disease. A physician's order, dated 6/6/25, indicated to administer diltiazem (a medication used to treat high blood pressure) 120 milligrams (mg) once a day.		Twice weekly for one month, to be completed by June 22, 2026 • Weekly for one month, to be completed by July 22, 2026 • Bi-weekly for one month, to be completed by August 22, 2026 • Monthly for one month, to be completed by September 22, 2026 These audits will monitor medication availability, medication administration practices, and adherence to physician orders. In addition, a town hall meeting was conducted with all residents to reinforce the community's responsibility to follow physician orders and to educate residents on the importance of medication compliance and physician-directed care. The community also ordered and received an Emergency Drug Kit (EDK). All nurses and QMAs have been trained on the	

	A physician's order, dated 6/7/25, indicated to administer furosemide (a medication used to treat fluid retention and high blood pressure) 40 mg once a day for hypertension and edema. A physician's order, dated 6/6/25, indicated to administer lisinopril (a medication used to treat blood pressure and heart failure) 5 mg once a day for hypertension. A physician's order, dated 6/6/25, indicated to administer triamterene-hydrochlorothiazide (a medication used to treat fluid retention and high blood pressure) 75-50 mg once a day for hypertension and edema. A physician's order, dated 6/19/25, indicated to administer extended-release potassium chloride (a medication used to treat low potassium) 20 mEq (milliequivalent) once a day for heart failure. The Medication Administration Record (MAR), dated February 2026, indicated the resident did not receive the diltiazem, furosemide, lisinopril, or potassium chloride extended release as ordered due to the medications were unavailable on the following dates at 9:00 a.m.: 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25, 2/14/25, and		proper use and access procedures for the EDK to help ensure medications are available when needed and physician orders can be carried out without delay.	

	2/15/25. The MAR, dated February 2026, indicated the resident did not receive triamterene-hydrochlorothiazide as ordered due to the medication was unavailable on the following dates at 8:00 a.m.: 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25, 2/14/25, and 2/15/25. An observation note, dated 2/10/26 at 9:30 a.m., indicated the Director of Nursing (DON) had been notified Resident 19 did not have all the prescribed medications. An observation note, dated 2/12/26 at 9:30 a.m., indicated the DON completed a medication review with hospice, and all orders had been faxed to the facility pharmacy for profiling and to the resident's pharmacy for dispensing. An observation note, dated 2/15/26 at 9:30 a.m., indicated the resident had swelling to her bilateral lower extremities, shortness of breath, and no medications were available. The DON indicated hospice had been notified of the resident's status and the resident was sent to the emergency room. An observation note, dated 2/16/26 at 1:45 p.m., indicated the resident had been sent to			

	the hospital due to shortness of breath and swelling of both legs and feet. An employee counseling form, dated 2/18/26, signed by the Executive Director (ED) and the DON, indicated substandard performance with coaching and a verbal warning for the DON. The documentation indicated the DON had not ensured the resident's medications were in the building in an appropriate time frame. A typed statement from the facility indicated the resident returned from a rehabilitation facility on 2/4/26. The DON was aware Resident 19 was out of medications on 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, and 2/15/26. During an interview, on 5/4/26 at 10:11 a.m., the ED indicated the medications had not been provided within an acceptable time frame. The DON had been written up, and the incident had been reported. The community was responsible for ensuring residents had their medications. During an interview, on 5/4/26 at 12:44 p.m., QMA 2 indicated the DON should be notified if a resident was without medication. A current facility policy, titled "How To Medication			

	Administration Record", undated and provided by the ED on 5/4/26 at 12:45 p.m., indicated "...medications that are unavailable must be circled and documented on the back side of the MAR...The doctor must be contacted to get a change of order or to get directions on any medication that has been circled for more than 3 days...." A facility policy related to pharmacy services and physicians' orders was requested and not provided. This citation relates to Intake 467470.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure as needed (PRN)	R 0246	The community was cited for failing to ensure medications were available and administered according to physician orders for 1 of 1 residents reviewed. As part of the Plan of Correction, all Qualified Medication Aides (QMAs) have been re-educated on medication administration procedures, documentation of PRN medications administered, physician order compliance, and ensuring medications are available for administration as ordered.	09/22/2026

	medications administered by a qualified medication aide (QMA) received appropriate authorization for the administration and the date and time of the authorization was documented for 1 of 1 resident reviewed for as needed medications. (Resident E) Findings include: The clinical record for Resident E was reviewed on 5/4/26 at 9:51 a.m. The diagnoses included, but were not limited to, diabetes, bipolar disorder, anxiety, depression, and heart disease. A physician's order, dated 3/7/26, indicated to administer one (1) tablet of Torsemide (a medication used to treat excess fluid retention) 20 milligrams (mg) once daily as needed in the evening for a weight gain greater than two (2) pounds. QMA 4 administered one (1) tablet of Torsemide 20 mg on 3/11/26 at 11:02 a.m. There was no documentation to show a licensed staff member was contacted, and authorization was obtained prior to the administration of the as needed (PRN) medication. During an interview, on 5/4/26 at 12:28 p.m., the Director of Nursing (DON) indicated the QMAs would reach out to her by		To ensure continued compliance, medication cart audits will be conducted according to the following schedule: • Twice weekly for one month, to be completed by June 22, 2026 • Weekly for one month, to be completed by July 22, 2026 • Bi-weekly for one month, to be completed by August 22, 2026 • Monthly for one month, to be completed by September 22, 2026 These audits will monitor medication availability, medication administration practices, and adherence to physician orders. In addition, a town hall meeting was conducted with all residents to reinforce the community's responsibility to follow physician orders and to educate residents on the importance of medication compliance and physician-directed care. The community also ordered and received an Emergency Drug Kit (EDK). All nurses and QMAs have been trained on the proper use and access procedures for the EDK to help ensure medications are available when needed and	

	phone to administer as needed medication to the residents, but there was no documentation of this communication in the medical record. A current facility policy, titled "Medication Administration Policy and Procedure," undated and provided by the Executive Director on 5/6/26 at 4:14 p.m., indicated "...medications are administered only by staff authorized under state regulations...licensed nursing oversight is provided as required by regulation...." This citation relates to Intake 467470.		physician orders can be carried out without delay.	
R 0248	Health Services - Deficiency 410 IAC 16.2-5-4(f) (f) The facility shall have available on the premises or on call the services of a licensed nurse at all times. Based on interview and record review, the facility failed to ensure a licensed nurse was available to administer medications as ordered by the physician for 1 of 10 residents reviewed for the administration of medication. (Resident B) Findings include: During an interview, on 5/1/26 at	R 0248	The community was cited for failing to ensure medications were available and administered according to physician orders for 1 of 10 residents reviewed. As part of the Plan of Correction, all Qualified Medication Aides (QMAs) have been re-educated on medication administration procedures, documentation of PRN medications administered, physician order compliance, and ensuring medications are available for administration as ordered. To ensure continued compliance, medication cart audits will be conducted	09/22/2026

	10:45 a.m., Resident B indicated he had a diagnosis of diabetes mellitus and would receive his insulin hours before or after the time the medication was ordered. There were days the facility did not have trained staff to administer insulin, and he would receive his scheduled 8:00 p.m. insulin around 6:00 a.m., the next day. The clinical record for Resident B was reviewed on 5/4/26 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertension, and cognitive impairment. A physician's order, dated 1/9/26 at 4:30 p.m., indicated to administer 55 units of Lantus (a long-acting insulin) subcutaneously twice a day at 8:00 a.m. and 8:00 p.m. A medication history document indicated Resident B received the scheduled Lantus on the following dates and times: a. On 4/14/26 at 6:00 a.m. b. On 4/20/26 at 4:49 p.m. c. On 4/24/26 at 3:37 p.m. d. On 4/25/26 at 4:26 p.m. e. On 4/26/26 at 4:04 p.m. f. On 4/29/26 at 5:51 a.m.		according to the following schedule: • Twice weekly for one month, to be completed by June 22, 2026 • Weekly for one month, to be completed by July 22, 2026 • Bi-weekly for one month, to be completed by August 22, 2026 • Monthly for one month, to be completed by September 22, 2026 These audits will monitor medication availability, medication administration practices, and adherence to physician orders. In addition, a town hall meeting was conducted with all residents to reinforce the community's responsibility to follow physician orders and to educate residents on the importance of medication compliance and physician-directed care. The community also ordered and received an Emergency Drug Kit (EDK). All nurses and QMAs have been trained on the proper use and access procedures for the EDK to help ensure medications are available when needed and physician orders can be carried out without delay.	

	g. On 5/1/26 at 3:46 p.m. During an interview, on 5/4/26 at 11:27 a.m., the Director of Nursing (DON) indicated she was the only nurse for the building and not all the Qualified Medication Aides (QMA) could administer insulin. The QMA should notify her, and she would call another certified QMA into the facility to administer the insulin. A current facility policy, titled "Insulin Injection/Glucometer Readings - 20", dated 11/2023 and provided by the DON on 5/4/26 at 12:45 p.m., indicated "...only Licensed Nurses can draw insulin into syringes...Unlicensed trained personnel can provide insulin injections as state regulations allow...Check MAR and the 7 Rights of Medication Administration: Right drug, Right resident, Right dose, Right time, Right Route, Right MAR, Right Documentation, and Right to Refuse...Document administration...There are a variety of types of insulin. The physician will prescribe a specific and individualized regimen for each individual receiving insulin. Refer to the MAR for insulin order and dosage times..."Regular" insulin is typically administered 30 minutes prior to a meal or snack. This allows the insulin to			

	begin its important work as glucose is being absorbed into the body...If mealtime is delayed or resident refuses to eat the meal, consult the nurse. Delayed consumption of food following insulin injection can cause a serious potentially harmful situation called Hypoglycemia (low blood sugar)...." This citation relates to Intake 467470.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were administered as ordered by the physician and medications were available without interruption for 2 of 5 residents observed during medication administration. (Resident 8 and 10)	R 0297	The community was cited for failing to ensure medications were available and administered according to physician orders for 2 of 5 residents reviewed. As part of the Plan of Correction, all Qualified Medication Aides (QMAs) have been re-educated on medication administration procedures, documentation of PRN medications administered, physician order compliance, and ensuring medications are available for administration as ordered. To ensure continued compliance, medication cart audits will be conducted according to the following schedule: • Twice weekly for one month, to be completed by June 22, 2026	09/22/2026

	Findings include: 1. The clinical record for Resident 8 was reviewed on 5/4/26 at 1:29 p.m. The diagnoses included, but were not limited to, dementia, depression, and gastro-esophageal reflux disease. A physician's order, dated 6/1/25, indicated to administer fluticasone propionate (a nasal spray) 50 microgram, two sprays in each nostril daily. A physician's order, dated 2/3/26, indicated to administer tramadol (a medication for pain) 50 milligrams, one tablet by mouth twice a day. During the observation of the medication administration, on 5/4/26 at 9:32 a.m., fluticasone and tramadol were unavailable to administer to Resident 8. During an interview, on 5/4/26 at 9:36 a.m., Qualified Medication Aide (QMA) 2 indicated she was unsure what to do about the missing medications as this was the first time she had worked in this building as an agency nurse. She would ask the Director of Nursing (DON) what to do. During an interview, on 5/4/26 at 9:49 a.m., the DON indicated she was not aware Resident 8		• Weekly for one month, to be completed by July 22, 2026 • Bi-weekly for one month, to be completed by August 22, 2026 • Monthly for one month, to be completed by September 22, 2026 These audits will monitor medication availability, medication administration practices, and adherence to physician orders. In addition, a town hall meeting was conducted with all residents to reinforce the community's responsibility to follow physician orders and to educate residents on the importance of medication compliance and physician-directed care. The community also ordered and received an Emergency Drug Kit (EDK). All nurses and QMAs have been trained on the proper use and access procedures for the EDK to help ensure medications are available when needed and physician orders can be carried out without delay.	

	was out of his medication and she would reorder it. She instructed QMA 2 to document the medications for Resident 8 were unavailable and it would be ordered through the pharmacy. 2. The clinical record for Resident 10 was reviewed on 5/4/26 at 1:32 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic polyneuropathy, major depressive disorder, polyneuropathy, fibromyalgia, pain in the right shoulder, right knee and lower back, anemia, extrapyramidal and movement disorder, and chronic obstructive pulmonary disease (COPD). A physician's order, dated 11/6/25, indicated to administer metformin (a medication for diabetes mellitus) 500 mg, one tablet twice a day. A physician's order, dated 3/18/26, indicated to administer Journavx (a non-opioid pain medication) 50 milligrams (mg), one tablet every 12 hours. A physician's order, dated 2/23/26, indicated to administer pramipexole (a medication used to improve motor control) 0.5 mg one tablet twice a day. A physician's order, dated			

	2/17/26, indicated to administer Vitron-C (an iron and vitamin C supplement) 65-125 mg one tablet once a day. During the observation of the medication administration, on 5/4/26 at 9:46 a.m., metformin, Journavx, pramipexole and Vitron-C were unavailable to administer to Resident 10. During an interview, on 5/4/26 at 9:48 a.m., the DON indicated she was the only nurse in the building and dealt with 12 to 15 different pharmacies. She was the one who completed medication cart audits weekly to re-order medications which were missing. She did not keep a record of her cart audits. The DON indicated she just started last November, and she knew the cart audits were working "because there are actually meds in the cart now." She indicated things had improved a lot but were probably not up to state approved standards yet. During an interview, on 5/4/26 at 12:44 p.m., QMA 2 indicated the DON should be notified if a resident was without medication. A facility policy regarding unavailable or missing medications was not provided by the exit date of 5/4/26. This citation relates to Intake			

	467470.			
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 interview and record review, the facility failed to ensure an annual health statement was documented in the residents record to indicate the residents were free from communicable disease for 4 of 10 residents reviewed for the annual health statement. (Resident 22, E, C, and B) Findings include: 1. The clinical record for Resident 22 was reviewed on 5/1/26 at 1:29 p.m. The diagnoses included, but were not limited to, hypertension and chronic kidney disease. There was no documentation in the Electronic Health Record (EHR) to indicate Resident 22 had an annual health statement. During an interview, on 5/4/26 at	R 0409	The community was cited for failing to ensure an annual health statement documenting that residents were free from communicable diseases was maintained in the resident records for 4 of 10 residents reviewed. The Plan of Correction is as follows: All residents, upon admission, will be required to have a Physician Plan of Care that includes documentation stating the resident is free from communicable diseases. This document will be uploaded into the resident's electronic health record (EHR) upon admission. Annual TB screenings will continue to be completed for all residents moving forward. An audit of all resident records was completed. Following the audit, the Director of Nursing (DON) contacted each resident's physician to obtain completed health screening documentation verifying the resident is free from communicable diseases. All residents have now had TB	08/21/2026

	12:34 p.m., the Director of Nursing (DON) indicated the annual health statement was not completed for Resident 22. 2. The clinical record for Resident E was reviewed on 5/4/26 at 9:51 a.m. The diagnoses included, but were not limited to, diabetes, bipolar disorder, anxiety, depression, and heart disease. There was no documentation in the EHR to indicate Resident E had an annual health statement. During an interview, on 5/4/26 at 12:34 p.m., the Director of Nursing (DON) indicated the annual health statement was not completed for Resident E. 3. The clinical record for Resident C was reviewed on 5/1/26 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes, sleep apnea, lung disease, and depression. There was no documentation in the EHR to indicate Resident C had an annual health statement. During an interview, on 5/4/26 at 12:34 p.m., the Director of Nursing (DON) indicated the annual health statement was not completed for Resident C. 4. The clinical record for Resident B was reviewed on		screenings completed. To ensure ongoing compliance, the DON or designee will audit resident records weekly for one month, bi-weekly for one month, and monthly thereafter for one additional month to verify required communicable disease documentation and annual TB screenings are current and maintained in the resident records.	

	5/4/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertension, and cognitive impairment. There was no documentation in the EHR to indicate Resident B had an annual health statement. During an interview, on 5/4/26 at 11:27 a.m., the DON indicated she could not find any record of the annual health statement. The facility could not provide the annual health statement for Resident B. A facility policy regarding an annual health statement was not provided by the exit date of 5/4/26.			

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 SIGNATUREKristie Cottrell	TITLEExecutive Director	(X6) DATE05/22/2026