

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2025	
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF DANVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S ARBOR LANE, DANVILLE, , 46122					
(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: June 2 and 3, 2025. Facility number: 014518 Residential Census: 60 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 5, 2025.	R 0000					
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status.	R 0216	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 3 – suffered no adverse effect r/t this deficient practice.A self medication administration evaluation to accompany the order was completed. Resident's physician agrees that resident may self-manage, administer and store			06/30/2025	

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(2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure a resident was assessed for self-administrating medications for 1 of 5 residents reviewed for medication self-administration evaluations (Resident 3). Findings include: On 6/2/25 at 11:00 a.m., Resident 3 was observed as she washed dishes in her apartment. She indicated her husband had recently passed away, so she was trying to adjust to a new normal. Resident 3 indicated she took care of most of her husband's needs when he was alive. On 6/2/25 at 12:00 p.m. Resident 3's medical record was reviewed. She was a Resident who resided in an assisted living apartment whose diagnoses included but were not limited to multiple sclerosis (a	all her medications and treatments. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;To identify other residents who could be affected by this practice, all residents that self-medicate were audited for semi- completion and by physician order. Corrections were made immediately. Biannual tracking completed for all other self-medication administration evaluation through community's EMR system and external auditing tool. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. A Policy update for the Community was changing to semi-annual and upon change in condition from annually for administration evaluations. HWD and all licensed educated on the company's medication administration policy and procedure, with special emphasis on evaluating residents for medication .How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and HWD and all licensed nurse educated on the company's medication administration policy and procedure, with special emphasis on evaluating residents for medication self-administration .Community's EMR system identifies due dates of evaluations and is correct following the policy update. An auditing and tracking tool has been put into place as well to be completed by and designated
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neurological disease where the body's immune system mistakenly attacks the protective coating of nerve fibers in the brain and spinal cord) and supraventricular tachycardia (a rapid heart rhythm that originates in the heart's upper chambers).

A medication self-administration evaluation, dated 6/25/24, indicated Resident 3 could safely self-administer medications.

A progress note, dated 6/25/24 indicated Resident 3 was being assessed to administer her husband's medications.

Upon review there were no other medication self-administration evaluations in the Residents medical record.

On 6/3/25 at 1:30 p.m. the Executive Director provided a copy of a current facility policy titled "Medication Administration, Supervision of Resident Self-Administration" dated 11/21/24. This policy indicated, "...Residents who self-administer medication must be assessed annually or after a significant change in status to verify that they are able to continue self-administering medication ...".

Regulation 410 IAC 16.2-5-2(a) indicated, "...An evaluation of the individual needs of each

personnel. This will be reviewed weekly by the Regional Director of Health Services for a period of 3 months. Then bi-weekly for a period of 3 months. By what date be completed. All evaluations accompanied by a order will be completed by June 30, 2025.

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resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request"

Based on observation, interview, and record review, the facility failed to ensure a resident was assessed for self-administrating medications for 1 of 5 residents reviewed for medication self-administration evaluations (Resident 3).

Findings include:

On 6/2/25 at 11:00 a.m., Resident 3 was observed as she washed dishes in her apartment. She indicated her husband had recently passed away, so she was trying to adjust to a new normal. Resident 3 indicated she took care of most of her husband's needs when he was alive.

On 6/2/25 at 12:00 p.m. Resident 3's medical record was reviewed. She was a Resident who resided in an assisted living apartment whose diagnoses included but were not limited to multiple sclerosis (a neurological disease where the body's immune system mistakenly attacks the protective coating of nerve fibers in the brain and spinal cord) and supraventricular

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Regulation 410 IAC 16.2-5-2(a) indicated, "...An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's or

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	facility's request"			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview, the facility failed to date bottles and eye drops when opened for 1 of 1 medication carts observed and 1 of 1 medication rooms. Findings include: 1. Resident 9 had a bottle of lorazepam (used to treat anxiety) in the refrigerator with no date to indicate when it was opened. It was sent 8/3/24. 2. Resident 10 had a bottle of lorazepam in the refrigerator with no date to indicate when it was opened. It was sent 2/9/24. 3. Resident 11 had a bottle of atropine (used to dilate the pupils) with no date to indicate when it was opened. 4. Resident 12 had a bottle of	R 0300	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All medication with expired or unidentified open dates according to company policy compliance. All medication storage and refrigeration storage areas have been assessed and organized with open labels audited for ease of identification and separation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All unlabeled medications were disposed of. Medication storage areas will be audited and organized with proper labeling and designated areas for each type of medication per company policy. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Daily audit of all storage and refrigeration areas by designated personnel to maintain designated medication areas with label with open date and appropriate identification. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; HWD and unit audit daily for assurance of completion and monitoring storage areas for 3 months and then bi-weekly for 3 months. By what date be	06/30/2025

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tobramycin 0.3% eye drops (used to treat bacterial infections) with no date to indicate when it was opened.

5. Resident 13 had a bottle of latanoprost 0.005% eye drops with no date to indicate when it was opened.

6. Resident 14 had a bottle of latanoprost unopened in the medication cart instead of being left in the refrigerator until opened and an opened bottle of latanoprost with no date to indicate when it was opened.

7. Resident 2 had a bottle of Systane (lubricant) with no date to indicate when it was opened.

On 6/3/25 at 1:59 p.m., during an interview, the Executive Director (ED) indicated they would be working on dating medications.

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A policy titled, "Medication Storage," was provided by the ED on 6/3/25 at 10:13 a.m. It indicated, "...Medications will be stored in accordance with pharmacy label instructions"

Based on observation and interview, the facility failed to date bottles and eye drops when opened for 1 of 1 medication carts observed and 1 of 1 medication rooms.

completed. All medication storage areas will be audited with proper labeling and designated areas by June 30, 2025

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Findings include:

1. Resident 9 had a bottle of lorazepam (used to treat anxiety) in the refrigerator with no date to indicate when it was opened. It was sent 8/3/24.

2. Resident 10 had a bottle of lorazepam in the refrigerator with no date to indicate when it was opened. It was sent 2/9/24.

3. Resident 11 had a bottle of atropine (used to dilate the pupils) with no date to indicate when it was opened.

4. Resident 12 had a bottle of tobramycin 0.3% eye drops (used to treat bacterial infections) with no date to indicate when it was opened.

5. Resident 13 had a bottle of latanoprost 0.005% eye drops with no date to indicate when it was opened.

6. Resident 14 had a bottle of latanoprost unopened in the medication cart instead of being left in the refrigerator until opened and an opened bottle of latanoprost with no date to indicate when it was opened.

7. Resident 2 had a bottle of Systane (lubricant) with no date to indicate when it was opened.

On 6/3/25 at 1:59 p.m., during an interview, the Executive Director (ED) indicated they

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	would be working on dating medications. . A policy titled, "Medication Storage," was provided by the ED on 6/3/25 at 10:13 a.m. It indicated, "...Medications will be stored in accordance with pharmacy label instructions"			
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug.	R 0306	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Medication storage areas audited with no findings of identified discharged residents' medications. Reviewed medication deposition policy and log tool with HWD and nursing staff. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;all medications will be disposed of according to company policies and logged according to 410 IAC 16.2-5-6 with audits and tracking completed by HWD and designated personnel biweekly for 3 months and once per month thereafter, or at resident discharge from community.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;an audit of all medication and storage areas completed with appropriate dispositions and documentation	06/30/2025

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(9) The signature of a witness, if any, to the disposal of the drug.

Based on record review and interview, the facility failed to provide documentation of drug disposal/disposition for 2 of 2 residents reviewed (Residents 5 and 6).

Findings include:

1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to heart failure and multiple fractures of the ribs.

Her record lacked documentation of the disposition of her medications at the time of discharge from the facility. The medications included: alendronate (a medication for rheumatoid arthritis), atorvastatin (a medication for high cholesterol), calcium (a supplement), folic acid (a supplement), methotrexate (for arthritis), multivitamins (a supplement), prednisone (for arthritis), vitamin C (a supplement), aspirin (for heart health), antidiarrheal capsules, and hydrocodone (a narcotic pain reliever).

2. On 6/2/25 at 12:23 p.m., a record review was completed for Resident 6. She had the following diagnoses which

according to company policies and 410 IAC 16.2-5-6. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Initial audit of medication storage areas to be completed by Community's contracted Pharmacist then thereafter Regional Director of Clinician Services monthly for 2 months and HWD monthly. Discharged tracking through Community's EMR system for residents' medication disposition within 30 days of discharge date. HWD will audit every new admission. By what date be completed. Medication storage areas to be audited, organized and medication disposition if deemed necessary will be completed by June 30, 2025.

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included but were not limited to hypertension, Alzheimer's disease, high cholesterol, chronic kidney disease, and diabetes type 2.

Her record lacked documentation of the disposition of her medications at the time of discharge from the facility. The medications included: aspirin (for heart health), carvedilol (for hypertension), centrum silver (a supplement), clopidogrel (for blood clots), donepezil (used to treat dementia), doxycycline (used to treat infections), famotidine (used to treat stomach ulcers), Januvia (for diabetes), losartan potassium (for hypertension), memantine (used to treat dementia), multivitamin (a supplement), pioglitazone (used to treat diabetes), probiotic (a supplement), quetiapine (used for insomnia), raloxifene (used for arthritis), rosuvastatin (used for high cholesterol), timolol (used to treat high blood pressure), and acetaminophen (used to treat pain).

On 6/3/25 at 1:59 p.m., the Executive Director (ED) provided dispositions for controlled substances for Resident 6 but was unable to locate disposition for the rest of her medications.

A policy titled, "Medication Management/Medication

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Disposition," was provided by the ED on 6/3/25 at 1:59 p.m. It indicated, " ...As part of the Medication Management Program, the health and wellness director (HWD) or licensed nurse designee will conduct medication disposition (e.g. destroyed, returned to pharmacy, returned to family, etc"

Based on record review and interview, the facility failed to provide documentation of drug disposal/disposition for 2 of 2 residents reviewed (Residents 5 and 6).

Findings include:

1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to heart failure and multiple fractures of the ribs.

Her record lacked documentation of the disposition of her medications at the time of discharge from the facility. The medications included: alendronate (a medication for rheumatoid arthritis), atorvastatin (a medication for high cholesterol), calcium (a supplement), folic acid (a supplement), methotrexate (for arthritis), multivitamins (a supplement), prednisone (for arthritis), vitamin C (a

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2. On 6/2/25 at 12:23 p.m., a record review was completed for Resident 6. She had the following diagnoses which included but were not limited to hypertension, Alzheimer's disease, high cholesterol, chronic kidney disease, and diabetes type 2.

Her record lacked documentation of the disposition of her medications at the time of discharge from the facility. The medications included: aspirin (for heart health), carvedilol (for hypertension), centrum silver (a supplement), clopidogrel (for blood clots), donepezil (used to treat dementia), doxycycline (used to treat infections), famotidine (used to treat stomach ulcers), Januvia (for diabetes), losartan potassium (for hypertension), memantine (used to treat dementia), multivitamin (a supplement), pioglitazone (used to treat diabetes), probiotic (a supplement), quetiapine (used for insomnia), raloxifene (used for arthritis), rosuvastatin (used for high cholesterol), timolol (used to treat high blood pressure), and acetaminophen (used to treat pain).

On 6/3/25 at 1:59 p.m., the

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	Executive Director (ED) provided dispositions for controlled substances for Resident 6 but was unable to locate disposition for the rest of her medications. A policy titled, "Medication Management/Medication Disposition," was provided by the ED on 6/3/25 at 1:59 p.m. It indicated, " ...As part of the Medication Management Program, the health and wellness director (HWD) or licensed nurse designee will conduct medication disposition (e.g. destroyed, returned to pharmacy, returned to family, etc"			
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	R 0410	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice residents with expired or past due TB assessments and test PCP notified and orders received for assessment and test completion done by local laboratory services company with negative .How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;Community EMR system tracked for due dates of TB and communicable diseases assessments. External tracking tool updated and audited by HWD and designated personnel for further monitoring of due dates and	06/30/2025

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 record review and interview, the facility failed to provide a first and second step PPD (tuberculosis testing) for 2 of 3 residents reviewed for TB test (Resident 5 and 7).

Findings include:

1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to heart disease, and multiple fractures of the ribs.

Her record lacked documentation of a first or second step PPD.

On 6/3/25 at 1:05 p.m., an interview was conducted with the Executive Director (ED), he indicated most of their records were stored electronically. He would find and send the results via email.

On 6/4/25 at 10:46 a.m., the email was received and did not contain PPDs or other acceptable testing as proof of

completion weekly for 6 months. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; monitoring Community's EMR system to identify due dates for assessments and completion. Editing external tracking tool by HWD and designated personnel for information. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place HWD and designated personnel will monitor due dates in tracking log and rectify with PCC EMR system for the most up to date information completed weekly for 6 months. HWD or designated personnel will audit every new admission to policy is followed. By what date be completed. TB tests, assessments and orders will be current and up to date according to policies and guidelines by June 30, 2025.

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TB testing for Resident 5.

2. On 6/2/25 at 12:17 p.m., Resident 7's medical record was reviewed. She was admitted to the facility on 3/25/25 with diagnoses which included, but were not limited to, vascular dementia and a history of urinary tract infections.

The record lacked documentation of an initial TB skin test, and no chest x-ray was on file.

At the time of exit on 6/3/26 at 2:10 p.m., the facility was unable to provide documentation for an initial first and second step TB skin test.

After the survey exit, the ED provided an e-mail on 6/3/25 at 3:13 p.m. with a copy of a chest x-ray for Resident 7. The x-ray was dated 5/2/25 but not provide a statement that Resident 7 was free from evidence of TB.

At the time of exit on 6/3/25 at 2:10 p.m., the Executive Director, (ED) provided a copy of current facility policy titled, "Communicable Disease - Tuberculosis," reviewed 10/16/23. The policy indicated, "The Community will establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and

Prevention (CDC) and the state health department ... prior to moving into a community, and annually thereafter, each resident is 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 TB in an infectious stage ... each prospective resident has a TB skin test completed within three (3) months prior to moving in or upon moving in and read at 48-72 hours"

Based on record review and interview, the facility failed to provide a first and second step PPD (tuberculosis testing) for 2 of 3 residents reviewed for TB test (Resident 5 and 7).

Findings include:

1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to heart disease, and multiple fractures of the ribs.

Her record lacked documentation of a first or second step PPD.

On 6/3/25 at 1:05 p.m., an interview was conducted with the Executive Director (ED), he indicated most of their records were stored electronically. He would find and send the results

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via email.

On 6/4/25 at 10:46 a.m., the email was received and did not contain PPDs or other acceptable testing as proof of TB testing for Resident 5.

2. On 6/2/25 at 12:17 p.m., Resident 7's medical record was reviewed. She was admitted to the facility on 3/25/25 with diagnoses which included, but were not limited to, vascular dementia and a history of urinary tract infections.

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"The Community will establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the state health department ... prior to moving into a community, and annually thereafter, each resident is 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 TB in an infectious stage ... each prospective resident has a TB skin test completed within three (3) months prior to moving in or upon moving in and read at 48-72 hours"

Based on record review and interview, the facility failed to provide a first and second step PPD (tuberculosis testing) for 2 of 3 residents reviewed for TB test (Resident 5 and 7).

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The record lacked documentation of an initial TB skin test, and no chest x-ray was on file.

At the time of exit on 6/3/26 at 2:10 p.m., the facility was unable to provide documentation for an initial first and second step TB skin test.

After the survey exit, the ED provided an e-mail on 6/3/25 at 3:13 p.m. with a copy of a chest x-ray for Resident 7. The x-ray was dated 5/2/25 but not provide a statement that Resident 7 was free from evidence of TB.

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2:10 p.m., the Executive Director, (ED) provided a copy of current facility policy titled, "Communicable Disease - Tuberculosis," reviewed 10/16/23. The policy indicated, "The Community will establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the state health department ... prior to moving into a community, and annually thereafter, each resident is 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 TB in an infectious stage ... each prospective resident has a TB skin test completed within three (3) months prior to moving in or upon moving in and read at 48-72 hours"

Based on record review and interview, the facility failed to provide a first and second step PPD (tuberculosis testing) for 2 of 3 residents reviewed for TB test (Resident 5 and 7).

Findings include:

1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to

heart disease, and multiple fractures of the ribs.

Her record lacked documentation of a first or second step PPD.

On 6/3/25 at 1:05 p.m., an interview was conducted with the Executive Director (ED), he indicated most of their records were stored electronically. He would find and send the results via email.

On 6/4/25 at 10:46 a.m., the email was received and did not contain PPDs or other acceptable testing as proof of TB testing for Resident 5.

2. On 6/2/25 at 12:17 p.m., Resident 7's medical record was reviewed. She was admitted to the facility on 3/25/25 with diagnoses which included, but were not limited to, vascular dementia and a history of urinary tract infections.

The record lacked documentation of an initial TB skin test, and no chest x-ray was on file.

At the time of exit on 6/3/26 at 2:10 p.m., the facility was unable to provide documentation for an initial first and second step TB skin test.

After the survey exit, the ED provided an e-mail on 6/3/25 at 3:13 p.m. with a copy of a chest

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OMB NO. 0938-0391

x-ray for Resident 7. The x-ray was dated 5/2/25 but not provide a statement that Resident 7 was free from evidence of TB.

At the time of exit on 6/3/25 at 2:10 p.m., the Executive Director, (ED) provided a copy of current facility policy titled, "Communicable Disease - Tuberculosis," reviewed 10/16/23. The policy indicated, "The Community will establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the state health department ... prior to moving into a community, and annually thereafter, each resident is 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 TB in an infectious stage ... each prospective resident has a TB skin test completed within three (3) months prior to moving in or upon moving in and read at 48-72 hours"

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