STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE PARK ASSISTED LIVING	503 S MURPHY AVE, BRAZIL, , 47834

(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 14 and 15, 2025 Facility number: 014623 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 21, 2025.	R 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully request paper compliance.	
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	The admission weights for residents 213 and 214 were recorded in residents' electronic medical records. An audit was conducted on all admits/re-admits in the past 90 days and no other occurrence of deficient practice was found.The Director of Nursing will audit all new admits and re-admits will have weights obtained and recorded in residents' electronic medical record on admission x 6 months.The	08/14/2025

	(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 record review and interview, the facility failed to ensure an admission weight was documented in a resident's electronic medical record (record) upon admission, for 2 of 7 resident's records reviewed (Residents 213 and 214). Findings include: 1. Resident 213's record was reviewed on 7/14/25 at 2:25 p.m. The census indicated the resident had been admitted on 6/27/25, for diagnoses which included, but were not limited to, nontraumatic perforation of the intestine (a hole that forms in the wall of the intestine without being caused by an external injury or accident) and atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls which can cause arteries to narrow, blocking blood flow).		Administrator or designee will audit all new admits and re-admits will have weights obtained and recorded in residents' electronic medical record on admission x 6 months.	

	The vital signs (basic measurements that indicate the body's essential functions) section of the record lacked documentation of an admission weight for the resident. A physician's order, dated 6/27/25, indicated to obtain the resident's height and weight, one time. The June 2025, Treatment Administration Record (TAR) lacked documentation that the resident's weight had been obtained as ordered on 6/27/25. Documentation by the nurse, dated 6/27/25 at 6:00 p.m., indicated not administered, resident unavailable. A physician's order, pre-dated 12/14/25, indicated to obtain vital signs and weight, once a day on the 5th of the month. A follow-up review of the resident's medical record, on 7/15/25 at 9:16 a.m., indicated a weight of 175.4 had been added to the vital section of the record, and had been dated 7/4/25 at 3:58 p.m. During an interview, on 7/15/25 at 9:10 a.m., the Director of Nursing (DON) provided an undated document, titled, "Monthly Weights and Vitals." The document had a handwritten statement at the top which indicated, "Due by July 5th." She indicated there was a			

	physician's order for weights monthly on the 5th of the month. The document indicated the resident's weight was 175.4 but lacked the date the weight had been obtained. The DON indicated they had put the resident's weights from the document in the resident record under vital signs at the time they were notified of the admission weight not being observed. Admission weights should be documented in the record when they were obtained. 2. Resident 214's record was reviewed on 7/15/25 at 10:25 a.m. The census indicated the resident had been admitted on 6/27/25, for diagnoses which included, but were not limited to, unspecified asthma with acute exacerbation (a chronic lung disease where the breathing tubes become inflamed, swell, and produce extra mucus [thick secretions], making it difficult to breathe) and type 2 diabetes (a disease that occurs when the bodies blood sugar is too high). The vital signs (basic measurements that indicate the body's essential functions) section of the record lacked documentation of an admission weight for the resident. The historical review of the physician's orders lacked documentation of an order to obtain an admission weight on			

	the resident. A physician's order, pre-dated 12/14/25, indicated to obtain vital signs and weight, once a day on the 5th of the month. A follow-up review of the resident's medical record, on 7/15/25 at 10:43 a.m., indicated a weight of 253.4 had been added to the vital section of the record. The documentation indicated the weight had been obtained on 7/4/25. During an interview, on 7/15/25 at 9:10 a.m., the Director of Nursing (DON) provided an undated document, titled, "Monthly Weights and Vitals." The document had a handwritten statement at the top which indicated, "Due by July 5th." She indicated there was a physician's order for weights monthly on the 5th of the month. The document indicated the resident's weight was 253.4 but lacked the date the weight had been obtained. The DON indicated they had put the resident's weights from the document in the resident record under vital signs at the time they were notified of the admission weight not being observed. Admission weights should be documented in the record when they were obtained. On 7/15/25 at 10:41 a.m., the DON provided a document,			

dated 1/1/25, titled, "Weights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: Weights will be obtained upon admission..."

Based on record review and interview, the facility failed to ensure an admission weight was documented in a resident's electronic medical record (record) upon admission, for 2 of 7 resident's records reviewed (Residents 213 and 214).

Findings include:

1. Resident 213's record was reviewed on 7/14/25 at 2:25 p.m. The census indicated the resident had been admitted on 6/27/25, for diagnoses which included, but were not limited to, nontraumatic perforation of the intestine (a hole that forms in the wall of the intestine without being caused by an external injury or accident) and atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls which can cause arteries to narrow, blocking blood flow).

The vital signs (basic measurements that indicate the body's essential functions) section of the record lacked documentation of an admission weight for the resident.

A physician's order, dated

	6/27/25, indicated to obtain the resident's height and weight, one time. The June 2025, Treatment Administration Record (TAR) lacked documentation that the resident's weight had been obtained as ordered on 6/27/25. Documentation by the nurse, dated 6/27/25 at 6:00 p.m., indicated not administered, resident unavailable. A physician's order, pre-dated 12/14/25, indicated to obtain vital signs and weight, once a day on the 5th of the month. A follow-up review of the resident's medical record, on 7/15/25 at 9:16 a.m., indicated a weight of 175.4 had been added to the vital section of the record, and had been dated 7/4/25 at 3:58 p.m. During an interview, on 7/15/25 at 9:10 a.m., the Director of Nursing (DON) provided an undated document, titled, "Monthly Weights and Vitals." The document had a handwritten statement at the top which indicated, "Due by July 5th." She indicated there was a physician's order for weights monthly on the 5th of the month. The document indicated the resident's weight was 175.4 but lacked the date the weight had been obtained. The DON indicated they had put the			

resident's weights from the document in the resident record under vital signs at the time they were notified of the admission weight not being observed. Admission weights should be documented in the record when they were obtained.

2. Resident 214's record was reviewed on 7/15/25 at 10:25 a.m. The census indicated the resident had been admitted on 6/27/25, for diagnoses which included, but were not limited to, unspecified asthma with acute exacerbation (a chronic lung disease where the breathing tubes become inflamed, swell, and produce extra mucus [thick secretions], making it difficult to breathe) and type 2 diabetes (a disease that occurs when the bodies blood sugar is too high).

The vital signs (basic measurements that indicate the body's essential functions) section of the record lacked documentation of an admission weight for the resident.

The historical review of the physician's orders lacked documentation of an order to obtain an admission weight on the resident.

A physician's order, pre-dated 12/14/25, indicated to obtain vital signs and weight, once a day on the 5th of the month.

A follow-up review of the

resident's medical record, on 7/15/25 at 10:43 a.m., indicated a weight of 253.4 had been added to the vital section of the record. The documentation indicated the weight had been obtained on 7/4/25.

During an interview, on 7/15/25 at 9:10 a.m., the Director of Nursing (DON) provided an undated document, titled, "Monthly Weights and Vitals." The document had a handwritten statement at the top which indicated, "Due by July 5th." She indicated there was a physician's order for weights monthly on the 5th of the month. The document indicated the resident's weight was 253.4 but lacked the date the weight had been obtained. The DON indicated they had put the resident's weights from the document in the resident record under vital signs at the time they were notified of the admission weight not being observed. Admission weights should be documented in the record when they were obtained.

On 7/15/25 at 10:41 a.m., the DON provided a document, dated 1/1/25, titled, "Weights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: Weights will be obtained upon admission..."

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential	R 0217	Residents 210, 205, 219, 225, and 236 service plans were reviewed and discussed with residents. Agreed upon service plans were signed and dated by those residents identified. No copy of the service plan was requested at this time. An audit was completed on all current residents residing in the facility to ensure service plams were agreed upon, signed and dated. Copies of service plans were provided to the residents as requested. Licensed staff were re-educated on service plan process on 7/25/2025. DON or designee will ensure service plans are discussed, signed and copies were provided to the residents as requested on admission, and with any significant changes. The Administrator or designee will audit all new admissions to ensure all resident service plans have been discussed, signed and copies provided to residents as requested on admission x 6 months. Results will be reviewed monthly by IDT team for further recommendations x 6 months.	08/14/2025

	nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were agreed upon, signed, and dated for 5 of 7 residents reviewed for service plans. (Residents 210, 205, 219, 225 and 236). Findings include: 1. On 7/14/25 at 11:08 a.m., during interview Resident 210 indicated she did not recall reviewing or signing a specific service plan from the most recent admission or one annually thereafter. On 7/14/25 at 1:00 p.m., the medical record of Resident 210 was reviewed. The record indicated the resident was admitted to the facility on 4/12/2019. The admitting diagnoses included but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high) and hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure). On 7/15/25 at 9:10 a.m., the Administrator provided a			

	document titled "Residential service plan" dated 01/03/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 1 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident. The medical record lacked documentation of a written service plan or annual review with the resident of a service plan. 2. On 7/14/25 at 10:45 a.m., during interview Resident 205 indicated she did not recall reviewing or signing a specific service plan upon admission to the facility or one annually thereafter. On 7/14/25 at 1:30 p.m., the medical record of Resident 205 was reviewed. The record indicated that the resident was admitted to the facility on 5/1/2023. The admitting diagnoses included, but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (also known as high or raised blood pressure, is a condition in			

which the blood vessels have persistently raised pressure) and hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. Also called underactive thyroid).

On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 1/9/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 3 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident.

The medical record lacked documentation of a written service plan or annual review with the resident of a service plan.

3. Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

	A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan. The electronic record lacked documentation the resident agreed to or signed a service plan since her admission to the facility. 4. Resident 225's record was reviewed on 7/14/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, essential primary hypertension (elevated blood pressure) and bilateral preglaucoma (a condition where an individual exhibits signs that suggest they may be developing glaucoma in both eyes). The facility census information indicated that the resident was admitted to the facility on 2/10/24. A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature. A level of service determination assessment dated 6/3/24 indicated Resident 225 had a			

	score of 2 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature. 5. Resident 236's closed record was reviewed on 7/14/25 at 11:53 a.m. The census indicated the resident had been admitted on 2/4/24, for diagnoses which included, but were not limited to, unspecified dementia with anxiety (a decline in mental ability severe enough to interfere with daily life accompanied with feelings of sever anxiousness) and chronic pain syndrome (a condition where pain persists for more than three to six months). An initial level of service evaluation, dated 2/4/24, lacked documentation of a resident score level. The service plan lacked documentation the resident agreed with or signed the plan. The service evaluation had been reviewed on 2/28/25. The service plan lacked documentation the resident agreed with or signed the plan. During an interview, on 7/14/25 at 1:52 p.m., the Director of Nursing (DON) indicated the residents would sign their service plan on admission. Service plans were completed			

quarterly and if anything had changed, the residents would sign the plans again. Each plan would be reviewed with the resident, but unless there was a change, they do not require the resident to sign them. At the same time, she was not able to produce any signed service plans which had been signed at admission or any updated plans that had been signed recently.

During an interview, on 7/15/25 at 9:10 a.m., the Administrator reviewed the service plan and blank signature page and indicated she was unsure why the actual service plan was not signed.

On 7/14/25 at 2:41 p.m., the DON provided a document, dated 1/1/25, titled, "Service Plan," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedure: ...The service plan will be reviewed and signed by the resident...."

Based on record review and interview, the facility failed to ensure service plans were agreed upon, signed, and dated for 5 of 7 residents reviewed for service plans. (Residents 210, 205, 219, 225 and 236).

Findings include:

1. On 7/14/25 at 11:08 a.m., during interview Resident 210 indicated she did not recall

	reviewing or signing a specific service plan from the most recent admission or one annually thereafter. On 7/14/25 at 1:00 p.m., the medical record of Resident 210 was reviewed. The record indicated the resident was admitted to the facility on 4/12/2019. The admitting diagnoses included but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high) and hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 01/03/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 1 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident. The medical record lacked documentation of a written service plan or annual review			

	with the resident of a service plan. 2. On 7/14/25 at 10:45 a.m., during interview Resident 205 indicated she did not recall reviewing or signing a specific service plan upon admission to the facility or one annually thereafter. On 7/14/25 at 1:30 p.m., the medical record of Resident 205 was reviewed. The record indicated that the resident was admitted to the facility on 5/1/2023. The admitting diagnoses included, but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure) and hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. Also called underactive thyroid). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 1/9/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the			

residents service evaluation score was level 3 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident.

The medical record lacked documentation of a written service plan or annual review with the resident of a service plan.

3. Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

The electronic record lacked documentation the resident agreed to or signed a service plan since her admission to the facility.

4. Resident 225's record was reviewed on 7/14/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, essential

	primary hypertension (elevated blood pressure) and bilateral preglaucoma (a condition where an individual exhibits signs that suggest they may be developing glaucoma in both eyes). The facility census information indicated that the resident was admitted to the facility on 2/10/24. A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature. A level of service determination assessment dated 6/3/24 indicated Resident 225 had a score of 2 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature. 5. Resident 236's closed record was reviewed on 7/14/25 at 11:53 a.m. The census indicated the resident had been admitted on 2/4/24, for diagnoses which included, but were not limited to, unspecified dementia with anxiety (a decline in mental ability severe enough to interfere with daily life accompanied with feelings of			

	sever anxiousness) and chronic pain syndrome (a condition where pain persists for more than three to six months). An initial level of service evaluation, dated 2/4/24, lacked documentation of a resident score level. The service plan lacked documentation the resident agreed with or signed the plan. The service evaluation had been reviewed on 2/28/25. The service plan lacked documentation the resident agreed with or signed the plan. During an interview, on 7/14/25 at 1:52 p.m., the Director of Nursing (DON) indicated the residents would sign their service plan on admission. Service plans were completed quarterly and if anything had changed, the residents would sign the plans again. Each plan would be reviewed with the resident, but unless there was a change, they do not require the resident to sign them. At the same time, she was not able to produce any signed service plans which had been signed at admission or any updated plans that had been signed recently. During an interview, on 7/15/25 at 9:10 a.m., the Administrator reviewed the service plan and blank signature page and indicated she was unsure why			

	the actual service plan was not signed. On 7/14/25 at 2:41 p.m., the DON provided a document, dated 1/1/25, titled, "Service Plan," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedure: ...The service plan will be reviewed and signed by the resident...." Based on record review and interview, the facility failed to ensure service plans were agreed upon, signed, and dated for 5 of 7 residents reviewed for service plans. (Residents 210, 205, 219, 225 and 236). Findings include: 1. On 7/14/25 at 11:08 a.m., during interview Resident 210 indicated she did not recall reviewing or signing a specific service plan from the most recent admission or one annually thereafter. On 7/14/25 at 1:00 p.m., the medical record of Resident 210 was reviewed. The record indicated the resident was admitted to the facility on 4/12/2019. The admitting diagnoses included but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high) and hypertension (also known as high or raised blood pressure, is			

	a condition in which the blood vessels have persistently raised pressure). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 01/03/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 1 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident. The medical record lacked documentation of a written service plan or annual review with the resident of a service plan. 2. On 7/14/25 at 10:45 a.m., during interview Resident 205 indicated she did not recall reviewing or signing a specific service plan upon admission to the facility or one annually thereafter. On 7/14/25 at 1:30 p.m., the medical record of Resident 205 was reviewed. The record indicated that the resident was admitted to the facility on 5/1/2023. The admitting diagnoses included, but were			

	not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure) and hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. Also called underactive thyroid). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 1/9/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 3 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident. The medical record lacked documentation of a written service plan or annual review with the resident of a service plan. 3. Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not			

limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

The electronic record lacked documentation the resident agreed to or signed a service plan since her admission to the facility.

4. Resident 225's record was reviewed on 7/14/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, essential primary hypertension (elevated blood pressure) and bilateral preglaucoma (a condition where an individual exhibits signs that suggest they may be developing glaucoma in both eyes).

The facility census information indicated that the resident was admitted to the facility on 2/10/24.

A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that

the resident agreed with the plan and lacked the resident's signature.

A level of service determination assessment dated 6/3/24 indicated Resident 225 had a score of 2 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

5. Resident 236's closed record was reviewed on 7/14/25 at 11:53 a.m. The census indicated the resident had been admitted on 2/4/24, for diagnoses which included, but were not limited to, unspecified dementia with anxiety (a decline in mental ability severe enough to interfere with daily life accompanied with feelings of sever anxiousness) and chronic pain syndrome (a condition where pain persists for more than three to six months).

An initial level of service evaluation, dated 2/4/24, lacked documentation of a resident score level. The service plan lacked documentation the resident agreed with or signed the plan.

The service evaluation had been reviewed on 2/28/25. The service plan lacked documentation the resident agreed with or signed the plan.

	During an interview, on 7/14/25 at 1:52 p.m., the Director of Nursing (DON) indicated the residents would sign their service plan on admission. Service plans were completed quarterly and if anything had changed, the residents would sign the plans again. Each plan would be reviewed with the resident, but unless there was a change, they do not require the resident to sign them. At the same time, she was not able to produce any signed service plans which had been signed at admission or any updated plans that had been signed recently. During an interview, on 7/15/25 at 9:10 a.m., the Administrator reviewed the service plan and blank signature page and indicated she was unsure why the actual service plan was not signed. On 7/14/25 at 2:41 p.m., the DON provided a document, dated 1/1/25, titled, "Service Plan," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedure: ...The service plan will be reviewed and signed by the resident...." Based on record review and interview, the facility failed to ensure service plans were agreed upon, signed, and dated for 5 of 7 residents reviewed for service plans. (Residents 210,			

	205, 219, 225 and 236). Findings include: 1. On 7/14/25 at 11:08 a.m., during interview Resident 210 indicated she did not recall reviewing or signing a specific service plan from the most recent admission or one annually thereafter. On 7/14/25 at 1:00 p.m., the medical record of Resident 210 was reviewed. The record indicated the resident was admitted to the facility on 4/12/2019. The admitting diagnoses included but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high) and hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 01/03/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 1 and indicated the cost of services. The document lacked evidence of an			

	actual service plan or evidence of a written plan being provided to the resident. The medical record lacked documentation of a written service plan or annual review with the resident of a service plan. 2. On 7/14/25 at 10:45 a.m., during interview Resident 205 indicated she did not recall reviewing or signing a specific service plan upon admission to the facility or one annually thereafter. On 7/14/25 at 1:30 p.m., the medical record of Resident 205 was reviewed. The record indicated that the resident was admitted to the facility on 5/1/2023. The admitting diagnoses included, but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure) and hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. Also called underactive thyroid). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential			

service plan" dated 1/9/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 3 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident.

The medical record lacked documentation of a written service plan or annual review with the resident of a service plan.

3. Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

The electronic record lacked documentation the resident agreed to or signed a service plan since her admission to the

facility.

4. Resident 225's record was reviewed on 7/14/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, essential primary hypertension (elevated blood pressure) and bilateral preglaucoma (a condition where an individual exhibits signs that suggest they may be developing glaucoma in both eyes).

The facility census information indicated that the resident was admitted to the facility on 2/10/24.

A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

A level of service determination assessment dated 6/3/24 indicated Resident 225 had a score of 2 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

5. Resident 236's closed record was reviewed on 7/14/25 at 11:53 a.m. The census indicated the resident had been admitted on 2/4/24, for

	diagnoses which included, but were not limited to, unspecified dementia with anxiety (a decline in mental ability severe enough to interfere with daily life accompanied with feelings of sever anxiousness) and chronic pain syndrome (a condition where pain persists for more than three to six months). An initial level of service evaluation, dated 2/4/24, lacked documentation of a resident score level. The service plan lacked documentation the resident agreed with or signed the plan. The service evaluation had been reviewed on 2/28/25. The service plan lacked documentation the resident agreed with or signed the plan.			

	During an interview, on 7/14/25 at 1:52 p.m., the Director of Nursing (DON) indicated the residents would sign their service plan on admission. Service plans were completed quarterly and if anything had changed, the residents would sign the plans again. Each plan would be reviewed with the resident, but unless there was a change, they do not require the resident to sign them. At the same time, she was not able to produce any signed service plans which had been signed at admission or any updated plans that had been signed recently. During an interview, on 7/15/25 at 9:10 a.m., the Administrator reviewed the service plan and blank signature page and indicated she was unsure why the actual service plan was not signed. On 7/14/25 at 2:41 p.m., the DON provided a document, dated 1/1/25, titled, "Service Plan," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedure: ...The service plan will be reviewed and signed by the resident...." Based on record review and interview, the facility failed to ensure service plans were agreed upon, signed, and dated for 5 of 7 residents reviewed for service plans. (Residents 210,			

	205, 219, 225 and 236). Findings include: 1. On 7/14/25 at 11:08 a.m., during interview Resident 210 indicated she did not recall reviewing or signing a specific service plan from the most recent admission or one annually thereafter. On 7/14/25 at 1:00 p.m., the medical record of Resident 210 was reviewed. The record indicated the resident was admitted to the facility on 4/12/2019. The admitting diagnoses included but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high) and hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential service plan" dated 01/03/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 1 and indicated the cost of services. The document lacked evidence of an			

	actual service plan or evidence of a written plan being provided to the resident. The medical record lacked documentation of a written service plan or annual review with the resident of a service plan. 2. On 7/14/25 at 10:45 a.m., during interview Resident 205 indicated she did not recall reviewing or signing a specific service plan upon admission to the facility or one annually thereafter. On 7/14/25 at 1:30 p.m., the medical record of Resident 205 was reviewed. The record indicated that the resident was admitted to the facility on 5/1/2023. The admitting diagnoses included, but were not limited to, diabetes type 2 (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure) and hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. Also called underactive thyroid). On 7/15/25 at 9:10 a.m., the Administrator provided a document titled "Residential			

service plan" dated 1/9/24 and indicated it was the signed service plan for resident 210. The document indicated the facility would make available a residential service plan. The document indicated the residents service evaluation score was level 3 and indicated the cost of services. The document lacked evidence of an actual service plan or evidence of a written plan being provided to the resident.

The medical record lacked documentation of a written service plan or annual review with the resident of a service plan.

3. Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

The electronic record lacked documentation the resident agreed to or signed a service plan since her admission to the

facility.

4. Resident 225's record was reviewed on 7/14/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, essential primary hypertension (elevated blood pressure) and bilateral preglaucoma (a condition where an individual exhibits signs that suggest they may be developing glaucoma in both eyes).

The facility census information indicated that the resident was admitted to the facility on 2/10/24.

A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

A level of service determination assessment dated 6/3/24 indicated Resident 225 had a score of 2 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

5. Resident 236's closed record was reviewed on 7/14/25 at 11:53 a.m. The census indicated the resident had been admitted on 2/4/24, for

	diagnoses which included, but were not limited to, unspecified dementia with anxiety (a decline in mental ability severe enough to interfere with daily life accompanied with feelings of sever anxiousness) and chronic pain syndrome (a condition where pain persists for more than three to six months). An initial level of service evaluation, dated 2/4/24, lacked documentation of a resident score level. The service plan lacked documentation the resident agreed with or signed the plan. The service evaluation had been reviewed on 2/28/25. The service plan lacked documentation the resident agreed with or signed the plan.			

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The medical record lacked documentation of a written service plan or annual review with the resident of a service plan.

3. Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

The electronic record lacked documentation the resident agreed to or signed a service plan since her admission to the

facility.

4. Resident 225's record was reviewed on 7/14/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, essential primary hypertension (elevated blood pressure) and bilateral preglaucoma (a condition where an individual exhibits signs that suggest they may be developing glaucoma in both eyes).

The facility census information indicated that the resident was admitted to the facility on 2/10/24.

A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

A level of service determination assessment dated 6/3/24 indicated Resident 225 had a score of 2 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

5. Resident 236's closed record was reviewed on 7/14/25 at 11:53 a.m. The census indicated the resident had been admitted on 2/4/24, for

	diagnoses which included, but were not limited to, unspecified dementia with anxiety (a decline in mental ability severe enough to interfere with daily life accompanied with feelings of sever anxiousness) and chronic pain syndrome (a condition where pain persists for more than three to six months). An initial level of service evaluation, dated 2/4/24, lacked documentation of a resident score level. The service plan lacked documentation the resident agreed with or signed the plan. The service evaluation had been reviewed on 2/28/25. The service plan lacked documentation the resident agreed with or signed the plan.			

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The medical record lacked documentation of a written service plan or annual review with the resident of a service plan.

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Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

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The facility census information indicated that the resident was admitted to the facility on 2/10/24.

A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

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Census information indicated the resident was admitted to the facility on 1/1/23.

A level of service evaluation, dated 1/2/23, indicated the resident scored 12 on evaluation. The service plan lacked documentation the resident agreed with or signed the plan.

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The facility census information indicated that the resident was admitted to the facility on 2/10/24.

A level of service determination assessment dated 2/10/24 indicated Resident 225 had a score of 0 and was a residential level 1 resident. The service plan lacked documentation that the resident agreed with the plan and lacked the resident's signature.

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R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that	R 0407	Consent obtained for Resident 219 for flu vaccination for 2025/2026 season. Vaccination will be given during season.	08/14/2025

includes the following:

(1) A system that enables the facility to analyze patterns of known infectious symptoms.

(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.

(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.

(4) Reporting communicable disease to public health authorities.

Based on record review and interview, the facility failed to ensure an influenza vaccination was administered to a resident who consented to receive the vaccine for 1 of 3 residents reviewed for infection control (Resident 219).

Findings include:

Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

Census information indicated the resident was admitted to the facility on 1/1/23.

An Influenza Resident Education/Consent form was signed by the resident on 10/29/24. The form indicated

An audit was conducted for all current residents in the facility for immunizations received and obtained consents. No other resident were identified.

The DON or designee will audit each resident to ensure they have received the vaccine upon consent.

The Administrator will audit all residents to ensure they have been offered and received the influenza vaccination during the influenza season.

the resident requested to receive the influenza vaccine through the facility.

The electronic preventative health record indicated the resident's most recent influenza vaccine was administered on 11/17/23. The record lacked documentation the resident received an influenza vaccine, as requested, during the 2024-2025 influenza season.

During an interview, on 7/14/25 at 1:52 p.m., the Director of Nursing (DON) indicated each resident was offered an influenza vaccine annually. If they consented to the vaccine, then it should have been administered during the annual influenza vaccine clinic. The clinic was held in November 2024. The DON indicated she was not sure how the resident's influenza vaccine administration was missed during the influenza vaccine clinic or how they ensured each resident who requested an influenza vaccine received one.

On 7/14/25 at 1:51 p.m., the DON provided a document titled, "Infection Prevention and Control Program," dated October 2023, and indicated it was the policy current being used by the facility. The policy indicated, "...Vaccination Procedures: Educating...Residents on

Vaccines...Residents or their representatives will be educated and offered resident vaccines listed below...Influenza...Obtaining Vaccines: Vaccines will be ordered from either our LTC [long-term care] pharmacy, local or state heath agency or other arrangements will be made with a vaccine provider to administer the vaccine to the residents...Documenting the vaccine for Residents: The community will track and securely document the required vaccinations of all residents...."

Based on record review and interview, the facility failed to ensure an influenza vaccination was administered to a resident who consented to receive the vaccine for 1 of 3 residents reviewed for infection control (Resident 219).

Findings include:

Resident 219's record was reviewed on 7/14/25 at 1:15 p.m. Diagnosis on the resident's profile included, but were not limited to, other specified arthritis.

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The electronic preventative health record indicated the resident's most recent influenza vaccine was administered on 11/17/23. The record lacked documentation the resident received an influenza vaccine, as requested, during the 2024-2025 influenza season.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE