STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN OAKS OF GOSHEN	282 JOHNSTON STREET, GOSHEN, , 46528

(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: March 27 & 28, 2025 Facility number: 015205 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 4/2/2025	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the	R 0120	The The The community was alleged to be out of compliance by failing to ensure required dementia training and in-services were completed for 1 0f 5 employees reviewed for in-services.	05/16/2025

	needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		ARequired in-services were completed by Housekeeper 3. B Employee files were audited for completion of required dementia training. C The Business Office Manager was educated by the administrator/ designee regarding dementia training. System review and change to request necessary training being completed before staff provide resident care. D An audit will be completed by the Business Office Manager weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

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. (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 admission weights were completed and documented in the residents record for 1 of 8 residents reviewed for admission weights (Resident 5). Finding includes: A record review was completed on 3/26/2025, at 1:18 P.M. for Resident 5. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked	R 0216	The community was alleged to be out of compliance by failing to ensure admission weights were completed and documented in the resident's record for 1 of 8 residents reviewed for admission weights. A Resident no longer resides in facility B A house wide audit completed to ensure residents admission weights were obtained. C Nursing staff were educated by DON/ designee on obtaining admission weights. D An audit will be completed by DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	05/16/2025

	documentation that an admission weight was completed. During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated the resident should have had an admission weight completed and documented in their record. On 3/27/2025 at 9:10 A.M., a policy regarding admission weights was requested but one was not provided prior to the survey exit. Based on record review and interview, the facility failed to ensure admission weights were completed and documented in the residents record for 1 of 8 residents reviewed for admission weights (Resident 5). Finding includes: A record review was completed on 3/26/2025, at 1:18 P.M. for Resident 5. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that an admission weight was completed.			

	During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated the resident should have had an admission weight completed and documented in their record. On 3/27/2025 at 9:10 A.M., a policy regarding admission weights was requested but one was not provided prior to the survey exit.			
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.	R 0217	The community was alleged to be out of compliance by failing to ensure service plans were completed, with dates and signed by residents or their representatives for 6 of 8 residents reviewed for service plans. A Service care plans were completed and signed for residents 2,3,4,5,6, and 8. Resident 5 no longer resides in facility. B A house wide audit was completed to ensure residents had an up to date service care plan signed by resident or their representative. C	05/16/2025

	(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 nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder. A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and 2/27/2025. A signature line for Resident 9 was not signed by Resident 9 and there was just an "X" on the signature line. During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan. Based on record review and		Nursing staff were educated by DON/ designee on Service Care Plans. D An audit will be completed by DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

	interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8) Findings include: 1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative. A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative. During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not.			

	4. A record review was completed for Resident 5 on 3/26/2025 at 1:18 P.M.. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that a service place had been completed. 5. A record review was completed for Resident 6 on 3/26/2025 at 11:05 A.M. The resident was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that a service plan had been completed. 6. A record review was completed for Resident 8 on 3/26/2025 at 2:06 P.M. The resident was admitted to the facility on 9/3/2024. Resident 8's record lacked documentation that a service plan had been completed. During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans. On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy			

	currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and with any changes in resident needs. D. 4. 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...." 2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status. Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative. During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative. 3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep			

disorder and seizure disorder.

A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and 2/27/2025. A signature line for Resident 9 was not signed by Resident 9 and there was just an "X" on the signature line.

During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan.

Based on record review and interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8)

Findings include:

1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression.

A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative.

A document titled, "Rsp

	[Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative. During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not. 4. A record review was completed for Resident 5 on 3/26/2025 at 1:18 P.M.. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that a service place had been completed. 5. A record review was completed for Resident 6 on 3/26/2025 at 11:05 A.M. The resident was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that a service plan had been completed. 6. A record review was completed for Resident 8 on 3/26/2025 at 2:06 P.M. The resident was admitted to the facility on 9/3/2024. Resident 8's record lacked documentation that a service plan had been completed. During an interview, on			

	3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans. On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and with any changes in resident needs. D. 4. 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...." 2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status. Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative.			

During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative.

3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder.

A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and 2/27/2025. A signature line for Resident 9 was not signed by Resident 9 and there was just an "X" on the signature line.

During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan.

Based on record review and interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8)

Findings include:

1. The record for Resident 2 was completed on 3/26/2025 at

	1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative. A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative. During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not. 4. A record review was completed for Resident 5 on 3/26/2025 at 1:18 P.M.. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that a service place had been completed. 5. A record review was completed for Resident 6 on 3/26/2025 at 11:05 A.M. The resident was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that a service			

plan had been completed.

6. A record review was completed for Resident 8 on 3/26/2025 at 2:06 P.M. The resident was admitted to the facility on 9/3/2024.

Resident 8's record lacked documentation that a service plan had been completed.

During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans.

On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and with any changes in resident needs. D. 4. 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...."

2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to,

cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status.

Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative.

During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative.

3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder.

A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and 2/27/2025. A signature line for Resident 9 was not signed by Resident 9 and there was just an "X" on the signature line.

During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan.

Based on record review and interview, the facility failed to

ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8)

Findings include:

1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression.

A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative.

A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative.

During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not.

4. A record review was completed for Resident 5 on 3/26/2025 at 1:18 P.M.. The resident was admitted to the facility on 11/30/2024.

Resident 5's record lacked documentation that a service place had been completed.

5. A record review was completed for Resident 6 on 3/26/2025 at 11:05 A.M. The resident was admitted to the facility on 8/29/2024.

Resident 6's record lacked documentation that a service plan had been completed.

6. A record review was completed for Resident 8 on 3/26/2025 at 2:06 P.M. The resident was admitted to the facility on 9/3/2024.

Resident 8's record lacked documentation that a service plan had been completed.

During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans.

On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and

with any changes in resident needs. D. 4. 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...."

2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status.

Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative.

During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative.

3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder.

A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and 2/27/2025. A signature line for Resident 9 was not signed by

Resident 9 and there was just an "X" on the signature line.

During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan.

Based on record review and interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8)

Findings include:

1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression.

A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative.

A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative.

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2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status.

Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative.

During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative.

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	Resident 8's record lacked documentation that a service plan had been completed. During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans. On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and with any changes in resident needs. D. 4. 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...." 2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status. Resident 4's service plans were completed on 6/9/2024 and			

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Based on record review and interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8)

Findings include:

1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression.

A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative.

A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative.

During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not.

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Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative.

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3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder.

A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and

	2/27/2025. A signature line for Resident 9 was not signed by Resident 9 and there was just an "X" on the signature line. During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan. Based on record review and interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8) Findings include: 1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative.			

	A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative. During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not. 4. A record review was completed for Resident 5 on 3/26/2025 at 1:18 P.M.. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that a service place had been completed. 5. A record review was completed for Resident 6 on 3/26/2025 at 11:05 A.M. The resident was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that a service plan had been completed. 6. A record review was completed for Resident 8 on 3/26/2025 at 2:06 P.M. The resident was admitted to the facility on 9/3/2024. Resident 8's record lacked documentation that a service plan had been completed.			

	During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans. On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and with any changes in resident needs. D. 4. 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...." 2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status.			

	Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative. During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative.			
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 record review and interviews, the facility failed to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. (Residents 3 & 2)	R 0241	The community was alleged to be out of compliance by failing to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. A QMA Scope of Practice was reviewed immediately with QMAs B Audit initiated to identify proper documentation of wound care C Nursing staff were educated by DON / designee on	05/16/2025

	Findings include: 1. A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation. A Physician's Order, dated 3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg. The Medication Administration Record, dated March 2025, indicated a QMA had administered the treatment on 3/20/2025, 3/21/2025, 3/24/2025, 3/26/2025 and 3/27/2025. There were no progress notes or wound care notes in the medical record related to the left leg wound. The wound was identified as a venous stasis ulcer. During the survey, Resident 3 refused to have the leg wound observed as the dressing was intact and did not want the dressing disturbed. During an interview, on 3/27/2025 at 11:20 A.M., the Director of Nursing indicated QMA's should not be providing treatments that involve a debriding agent.		Qualified Medication Aides (QMA) Scope of Practice. D An audit will be completed for wound care documentation by DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

	2. The record for Resident 2 was reviewed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A Nurse Practitioner's Note, dated 3/14/2025, indicated Resident 2 had a stage 2 pressure ulcer/chronic nonhealing wound on their abdomen.The note further indicated: " Plan: Order for bacitracin (antibiotic ointment), apply dime sized amount to skin breakdown area. Order medihoney calcium alginate dressing, 1 to be applied to wound area 3 x weekly until improved. The placement of the mepilex is no longer prophylactic at this time, it has to be connected to a nurse placing it for now. " A Physician's Order, dated 1/4/2024, indicated to apply a mepilex boarder 6" x 6" to abdominal wound three times weekly on Monday, Wednesday and Friday. A Physician's Order, dated 3/14/2025, indicated to apply medihoney 4' x 5" dressing topically to abdominal wound every Monday, Wednesday and Friday then apply mepilex over the dressing for 14 days. A Treatment Administration Record, (TAR) dated February			

2025, indicated QMA 5 provided the ordered treatment on 3/19, 3/24 and 3/26.

During an interview, on 3/27/2025 at 10:32 A.M., the Director of Nursing indicated a QMA should not have provided the ordered treatments to the abdominal wound.

On 3/27/2025 at 10:43 A.M., the Director of Nursing provided the policy titled, "Qualified Medication Aide - Scope of Practice", and indicated the policy was the one currently used by the facility. The policy indicated "...The following tasks shall NOT be included in the QMA scope of practice: ...(6) Administer a treatment that involved advanced skin conditions, including stage II, III and IV decubitus ulcers...."

On 3/27/2025 at 12:45 P.M., the Director of Nursing indicated the facility did not have a policy for wound care.

Based on record review and interviews, the facility failed to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. (Residents 3 & 2)

Findings include:

1. A record review for Resident

	3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation. A Physician's Order, dated 3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg. The Medication Administration Record, dated March 2025, indicated a QMA had administered the treatment on 3/20/2025, 3/21/2025, 3/24/2025, 3/26/2025 and 3/27/2025. There were no progress notes or wound care notes in the medical record related to the left leg wound. The wound was identified as a venous stasis ulcer. During the survey, Resident 3 refused to have the leg wound observed as the dressing was intact and did not want the dressing disturbed. During an interview, on 3/27/2025 at 11:20 A.M., the Director of Nursing indicated QMA's should not be providing treatments that involve a debriding agent. 2. The record for Resident 2 was reviewed on 3/26/2025 at 1:42 P.M. Diagnoses included,			

but were not limited to diabetes, abdominal hernia, obesity and depression.

A Nurse Practitioner's Note, dated 3/14/2025, indicated Resident 2 had a stage 2 pressure ulcer/chronic nonhealing wound on their abdomen.The note further indicated: " Plan: Order for bacitracin (antibiotic ointment), apply dime sized amount to skin breakdown area. Order medihoney calcium alginate dressing, 1 to be applied to wound area 3 x weekly until improved. The placement of the mepilex is no longer prophylactic at this time, it has to be connected to a nurse placing it for now. "

A Physician's Order, dated 1/4/2024, indicated to apply a mepilex boarder 6" x 6" to abdominal wound three times weekly on Monday, Wednesday and Friday.

A Physician's Order, dated 3/14/2025, indicated to apply medihoney 4' x 5" dressing topically to abdominal wound every Monday, Wednesday and Friday then apply mepilex over the dressing for 14 days.

A Treatment Administration Record, (TAR) dated February 2025, indicated QMA 5 provided the ordered treatment on 3/19, 3/24 and 3/26.

During an interview, on 3/27/2025 at 10:32 A.M., the Director of Nursing indicated a QMA should not have provided the ordered treatments to the abdominal wound.

On 3/27/2025 at 10:43 A.M., the Director of Nursing provided the policy titled, "Qualified Medication Aide - Scope of Practice", and indicated the policy was the one currently used by the facility. The policy indicated "...The following tasks shall NOT be included in the QMA scope of practice: ...(6) Administer a treatment that involved advanced skin conditions, including stage II, III and IV decubitus ulcers...."

On 3/27/2025 at 12:45 P.M., the Director of Nursing indicated the facility did not have a policy for wound care.

Based on record review and interviews, the facility failed to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. (Residents 3 & 2)

Findings include:

1. A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial

fibrillation.

A Physician's Order, dated 3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg.

The Medication Administration Record, dated March 2025, indicated a QMA had administered the treatment on 3/20/2025, 3/21/2025, 3/24/2025, 3/26/2025 and 3/27/2025.

There were no progress notes or wound care notes in the medical record related to the left leg wound. The wound was identified as a venous stasis ulcer.

During the survey, Resident 3 refused to have the leg wound observed as the dressing was intact and did not want the dressing disturbed.

During an interview, on 3/27/2025 at 11:20 A.M., the Director of Nursing indicated QMA's should not be providing treatments that involve a debriding agent.

2. The record for Resident 2 was reviewed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression.

	A Nurse Practitioner's Note, dated 3/14/2025, indicated Resident 2 had a stage 2 pressure ulcer/chronic nonhealing wound on their abdomen.The note further indicated: " Plan: Order for bacitracin (antibiotic ointment), apply dime sized amount to skin breakdown area. Order medihoney calcium alginate dressing, 1 to be applied to wound area 3 x weekly until improved. The placement of the mepilex is no longer prophylactic at this time, it has to be connected to a nurse placing it for now. " A Physician's Order, dated 1/4/2024, indicated to apply a mepilex boarder 6" x 6" to abdominal wound three times weekly on Monday, Wednesday and Friday. A Physician's Order, dated 3/14/2025, indicated to apply medihoney 4' x 5" dressing topically to abdominal wound every Monday, Wednesday and Friday then apply mepilex over the dressing for 14 days. A Treatment Administration Record, (TAR) dated February 2025, indicated QMA 5 provided the ordered treatment on 3/19, 3/24 and 3/26. During an interview, on 3/27/2025 at 10:32 A.M., the Director of Nursing indicated a			

QMA should not have provided the ordered treatments to the abdominal wound.

On 3/27/2025 at 10:43 A.M., the Director of Nursing provided the policy titled, "Qualified Medication Aide - Scope of Practice", and indicated the policy was the one currently used by the facility. The policy indicated "...The following tasks shall NOT be included in the QMA scope of practice: ...(6) Administer a treatment that involved advanced skin conditions, including stage II, III and IV decubitus ulcers...."

On 3/27/2025 at 12:45 P.M., the Director of Nursing indicated the facility did not have a policy for wound care.

Based on record review and interviews, the facility failed to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. (Residents 3 & 2)

Findings include:

1. A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation.

A Physician's Order, dated

	3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg. The Medication Administration Record, dated March 2025, indicated a QMA had administered the treatment on 3/20/2025, 3/21/2025, 3/24/2025, 3/26/2025 and 3/27/2025. There were no progress notes or wound care notes in the medical record related to the left leg wound. The wound was identified as a venous stasis ulcer. During the survey, Resident 3 refused to have the leg wound observed as the dressing was intact and did not want the dressing disturbed. During an interview, on 3/27/2025 at 11:20 A.M., the Director of Nursing indicated QMA's should not be providing treatments that involve a debriding agent. 2. The record for Resident 2 was reviewed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A Nurse Practitioner's Note, dated 3/14/2025, indicated Resident 2 had a stage 2			

pressure ulcer/chronic nonhealing wound on their abdomen.The note further indicated: " Plan: Order for bacitracin (antibiotic ointment), apply dime sized amount to skin breakdown area. Order medihoney calcium alginate dressing, 1 to be applied to wound area 3 x weekly until improved. The placement of the mepilex is no longer prophylactic at this time, it has to be connected to a nurse placing it for now. "

A Physician's Order, dated 1/4/2024, indicated to apply a mepilex boarder 6" x 6" to abdominal wound three times weekly on Monday, Wednesday and Friday.

A Physician's Order, dated 3/14/2025, indicated to apply medihoney 4' x 5" dressing topically to abdominal wound every Monday, Wednesday and Friday then apply mepilex over the dressing for 14 days.

A Treatment Administration Record, (TAR) dated February 2025, indicated QMA 5 provided the ordered treatment on 3/19, 3/24 and 3/26.

During an interview, on 3/27/2025 at 10:32 A.M., the Director of Nursing indicated a QMA should not have provided the ordered treatments to the abdominal wound.

	On 3/27/2025 at 10:43 A.M., the Director of Nursing provided the policy titled, "Qualified Medication Aide - Scope of Practice", and indicated the policy was the one currently used by the facility. The policy indicated "...The following tasks shall NOT be included in the QMA scope of practice: ...(6) Administer a treatment that involved advanced skin conditions, including stage II, III and IV decubitus ulcers...." On 3/27/2025 at 12:45 P.M., the Director of Nursing indicated the facility did not have a policy for wound care.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This deficient practice had the potential to affect 100 of 100 residents who consumed food from the	R 0273	The community was alleged to be out of compliance by failing to store food under sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This deficient practice had the potential to affect 100 of 100 residents who consumed food from the kitchen. A The foods that were expired were discarded immediately. The foods that were not labeled appropriately, were labeled as such.	05/16/2025

	kitchen. Findings include: During a tour in the kitchen, with the Dietary Manager, on 3/26/2025 at 9:33 A.M., the following was observed in the walk-in freezer: - two gallon size zip lock bags with cut up pieces of pork with an opened date of 9/16 and used by date of 10/16. - A container of cut peppers with a used by date of 3/25/2025. During an interview, on 3/26/2025 at 9:42 A.M., the Dietary Manager indicated foods should have a used by date labeled on them and the expired foods should have been removed. In the dry storage area the following was observed: - An opened and undated gallon of liquid vanilla with a sticky substance on the outside of the container along with runs of a brown color down the sides. - An opened box of pancake mix not sealed tightly.		B Kitchen was audited for items not stored according to professional standards. No other items were identified. C The Dietary staff were educated by the Dietary Manager on proper storage of food. D An audit will be completed by the Dietary Manager/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

During an interview, on 3/26/2025 at 9:45 A.M., the Dietary Manager indicated the vanilla had been opened a couple days ago and should have been dated.

During a follow-up tour of the kitchen, on 3/26/2025 at 10:55 A.M., the following was observed:

- the cooking surface of 6 skillets had no observable Teflon coating left.

During an interview, on 3/26/2025 at 11:01 A.M., the Dietary Manager indicated the skillets should not have been used.

During an interview, on 3/27/2025 at 11:12 A.M., the Dietary Manager indicated the facility did not have a policy for utensil cleaning and indicated the facility followed the State Regulations.

On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled," Refrigerated Storage", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation ...."

On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a

	policy titled, " Ready-to-Eat Hazardous Food, Date Marking ", and indicated the policy was the one currently used by the facility. The policy indicated "...All ready-to eat potentially hazardous foods prepared on site and held for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises... Ready-to-eat potentially hazardous foods prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in the kitchen and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises or discarded...." On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled, "Dry Food Storage", and indicated the policy was the one currently used by the facility. The policy indicated "... a) Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be in a clean, covered container except during periods of preparation or service... f). The delivery date shall be written or identified on each product..." Based on observation, record review, and interview, the facility failed to store food under			

	sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This deficient practice had the potential to affect 100 of 100 residents who consumed food from the kitchen. Findings include: During a tour in the kitchen, with the Dietary Manager, on 3/26/2025 at 9:33 A.M., the following was observed in the walk-in freezer: - two gallon size zip lock bags with cut up pieces of pork with an opened date of 9/16 and used by date of 10/16. - A container of cut peppers with a used by date of 3/25/2025. During an interview, on 3/26/2025 at 9:42 A.M., the Dietary Manager indicated foods should have a used by date labeled on them and the expired foods should have been removed. In the dry storage area the following was observed: - An opened and undated gallon of liquid vanilla with a sticky substance on the outside of the container along with runs of a brown color down the sides.			

	- An opened box of pancake mix not sealed tightly. During an interview, on 3/26/2025 at 9:45 A.M., the Dietary Manager indicated the vanilla had been opened a couple days ago and should have been dated. During a follow-up tour of the kitchen, on 3/26/2025 at 10:55 A.M., the following was observed: - the cooking surface of 6 skillets had no observable Teflon coating left. During an interview, on 3/26/2025 at 11:01 A.M., the Dietary Manager indicated the skillets should not have been used. During an interview, on 3/27/2025 at 11:12 A.M., the Dietary Manager indicated the facility did not have a policy for utensil cleaning and indicated the facility followed the State Regulations.			

	On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled," Refrigerated Storage", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation ...." On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled, " Ready-to-Eat Hazardous Food, Date Marking ", and indicated the policy was the one currently used by the facility. The policy indicated "...All ready-to eat potentially hazardous foods prepared on site and held for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises... Ready-to-eat potentially hazardous foods prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in the kitchen and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises or discarded...." On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled, "Dry Food Storage", and indicated the policy was the one currently used by the			

	facility. The policy indicated "... a) Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be in a clean, covered container except during periods of preparation or service... f). The delivery date shall be written or identified on each product..."			
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 record review and interview, the facility failed to ensure physician ordered medications were available for 1 of 8 residents reviewed for medications. (Resident 2) Finding includes:	R 0297	The community was alleged to be out of compliance by failing to ensure physician ordered medications were available for 1 of 8 residents reviewed for medications. A Medication for resident 2 was received from pharmacy. B An house wide audit completed to ensure physician ordered medication were available. C Nursing staff were educated by DON / designee on obtaining physician ordered medication. D	05/16/2025

	The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A MAR (Medication Administration Record), dated March 2025, indicated Resident 2 received Sertraline (antidepressant) 100 mg (milligram) 1 tablet every evening. On 3/13, 3/14, 3/15 and 3/16 on the MAR, the medication was initialed with an O (other). Under the Notes section on the MAR, the documentation indicated: 3/13 other- Not available. 3/14 -other. 3/15- other- Awaiting pharmacy delivery. 3/16 other- Awaiting pharmacy delivery. During an interview, on 3/27/2025 at 10:36 A.M., the Director of Nursing indicated the EDK (emergency drug kit) only contained minimal medications like Tylenol and Ibuprofen. The DON indicated the staff should have called the pharmacy and the physician about the medication unavailability. She indicated the pharmacy had delivered the next cycle (roll) of medications, which had started on 3/17/2025. On 3/27/2025 at 11:47 A.M., the Director of Nursing provided a policy titled, "Medication Management, Administration &		An audit will be completed by the DON/designee twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

	Storage (Indiana and Ohio Only), and indicated the policy was the one currently used by the facility. The policy indicated "... B. Medication Administration: Medication administration will be administered as ordered by the resident's provider...6... If the Community is offering medication administration services for a resident, for quality and safety purposes, the resident will have all medications packaged in pharmacy prepared pill package and in the same scheduling cycle as the Community's primary pharmacy...." Based on record review and interview, the facility failed to ensure physician ordered medications were available for 1 of 8 residents reviewed for medications. (Resident 2) Finding includes: The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A MAR (Medication Administration Record), dated March 2025, indicated Resident 2 received Sertraline (antidepressant) 100 mg (milligram) 1 tablet every evening. On 3/13, 3/14, 3/15			

	and 3/16 on the MAR, the medication was initialed with an O (other). Under the Notes section on the MAR, the documentation indicated: 3/13 other- Not available. 3/14 -other. 3/15- other- Awaiting pharmacy delivery. 3/16 other- Awaiting pharmacy delivery. During an interview, on 3/27/2025 at 10:36 A.M., the Director of Nursing indicated the EDK (emergency drug kit) only contained minimal medications like Tylenol and Ibuprofen. The DON indicated the staff should have called the pharmacy and the physician about the medication unavailability. She indicated the pharmacy had delivered the next cycle (roll) of medications, which had started on 3/17/2025. On 3/27/2025 at 11:47 A.M., the Director of Nursing provided a policy titled, "Medication Management, Administration & Storage (Indiana and Ohio Only), and indicated the policy was the one currently used by the facility. The policy indicated "... B. Medication Administration: Medication administration will be administered as ordered by the resident's provider...6... If the Community is offering medication administration services for a resident, for quality and safety purposes, the resident will have all			

	medications packaged in pharmacy prepared pill package and in the same scheduling cycle as the Community's primary pharmacy...."			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure the clinical record reagarding wound documentation was complete and accurate for 1 of 7 residents reviewed. (Resident 3) Finding includes: A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation. A Physician's Order, dated	R 0349	The community was alleged to be out of compliance by failing to ensure the clinical record regarding wound documentation was complete and accurate for 1 of 7 residents. A Resident 3 wound record was obtained from MMMD and Goshen Wound Care. B A house wide audit was completed to ensure wound documentation records were obtained for residents receiving wound care. C Nursing staff were educated by DON / designee on obtaining wound documentation from outside providers. D An audit will be completed by the DON/designee twice a week for 4 weeks, weekly for 4 weeks, and	05/16/2025

	3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg. There were no progress notes or wound care notes in the medical record related to the left leg wound. During an interview, on 3/27/2025 at 1:30 P.M., the facility Nurse Practitioner indicated Resident 3 had started seeing wound care specialists about two and a half weeks ago. The Nurse Practitioner indicated he put "everything on here on pause" when a specialist was involved. He indicated, "I am in the dark as far as what they [wound care specialist] are doing", and he was not aware of the wound care specialist's recommendations for the left leg wound. He indicated during visits here, the Resident's legs were wrapped in dressings. He could not provide any progress notes he had created related to Resident 3's leg wound. A policy was requested for an accurate and complete medical record, on 3/27/2025 at 1:48 P.M. The Director of Nursing indicated at 2:07 P.M., the facility did not have a policy for an accurate and complete medical record and followed the state regulations.		monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

Based on record review and interview, the facility failed to ensure the clinical record reagarding wound documentation was complete and accurate for 1 of 7 residents reviewed. (Resident 3)

Finding includes:

A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation.

A Physician's Order, dated 3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg.

There were no progress notes or wound care notes in the medical record related to the left leg wound.

During an interview, on 3/27/2025 at 1:30 P.M., the facility Nurse Practitioner indicated Resident 3 had started seeing wound care specialists about two and a half weeks ago. The Nurse Practitioner indicated he put "everything on here on pause" when a specialist was involved. He indicated, "I am in the dark as far as what they [wound care specialist] are doing", and he was not aware of the wound care specialist's recommendations for the left leg

	wound. He indicated during visits here, the Resident's legs were wrapped in dressings. He could not provide any progress notes he had created related to Resident 3's leg wound. A policy was requested for an accurate and complete medical record, on 3/27/2025 at 1:48 P.M. The Director of Nursing indicated at 2:07 P.M., the facility did not have a policy for an accurate and complete medical record and followed the state regulations.			
R 0378	Mental Health Screening-Deficiency 410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder.	R 0378	The community was alleged to be out of compliance by failing to screen and obtain a history of treatment and behaviors for a resident with a major mental illness prior to admission. A Mental health records were obtained for resident 9. B A house wide audit was completed to ensure major mental health records were obtained for residents with a diagnosis of major mental health illness.	05/16/2025

	(E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on record review and interview, the facility failed to screen and obtain a history of treatment and behaviors for a resident with a major mental illness prior to admission. (Resident 9) Finding includes: A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: personality disorder, generalized anxiety, major depressive disorder and sleep disorder.		C Nursing staff were educated by DON / designee on obtaining major mental health records from mental health facilities for residents with a major mental health diagnosis prior to admission. D An audit will be completed by the DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

Resident 9 admitted to the facility on 8/5/2024.

A Pre-Admission Evaluation indicated Resident 9 had anxiety, depression and a mood disorder. The evaluation indicated the resident was being seen by a local "psychological provider."

Resident 9 received the following medications according to Physican Orders:

-alprazolam (antianxiety medication) 1 milligram four times a day

-Suboxone (narcotic analgesic) 12-3 milligrams twice daily

-citalopram (antidepressant) 20 milligrams at bedtime

-Suboxone 8-2 milligrams three times daily

-mirtazapine (antidepressant) 45 milligrams at bedtime

-trazadone (antidepressant) 50 milligrams at bedtime

An Assisted Living Facilities/Adult Care Home Assessment and Care Screening completed by the facility, on 2/13/2025, indicated Resident 9 had indicators for delirium and becoming agitated or disoriented which impacted ptoentially endangered his safety or required protection by

	others. Resident 9 had exhibited persistent anger with himself or others for 1-5 days of the 30-day assessment period. In addition, Resident 9 had indicators of depressed, sad or anxious moods that were not easily altered. Resident 9 also had exhibited verbally abusive behaviors and intimidating behaviors in the past seven days and had a history of these behaviors in the past six months. The facility had requested mental health history records from the local psychological facility on 3/7/2025. During an interview, on 3/27/2025 at 11:04 A.M., the Director of Nursing indicated the facility was aware of Resident 9 having been seen by the local mental health provider, but records had not been obtained from the facility prior to Resident 9's admission. She indicated an initial screening of Resident 9's mental health had not been completed prior to admission. A policy was requested for mental health screening, on 3/27/2025 at 1:48 P.M. The Director of nursing indicated at 2:07 P.M., the facility did not have a policy for mental health screening and followed the state regulations for this policy. Based on record review and			

interview, the facility failed to screen and obtain a history of treatment and behaviors for a resident with a major mental illness prior to admission. (Resident 9)

Finding includes:

A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: personality disorder, generalized anxiety, major depressive disorder and sleep disorder.

Resident 9 admitted to the facility on 8/5/2024.

A Pre-Admission Evaluation indicated Resident 9 had anxiety, depression and a mood disorder. The evaluation indicated the resident was being seen by a local "psychological provider."

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The facility had requested mental health history records from the local psychological facility on 3/7/2025.

During an interview, on 3/27/2025 at 11:04 A.M., the Director of Nursing indicated the facility was aware of Resident 9 having been seen by the local mental health provider, but

	records had not been obtained from the facility prior to Resident 9's admission. She indicated an initial screening of Resident 9's mental health had not been completed prior to admission. A policy was requested for mental health screening, on 3/27/2025 at 1:48 P.M. The Director of nursing indicated at 2:07 P.M., the facility did not have a policy for mental health screening and followed the state regulations for this policy.			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more	R 0383	The community was alleged to be out of compliance by failing to develop, in cooperation with a mental health facility a comprehensive care plan for a major mental illness for 1 of 9 residents reviewed for mental illness. A A comprehensive care plan was developed in cooperation with resident 9’s mental health facility. B A house wide audit was completed to ensure comprehensive care plans for major mental health in cooperation with mental health facility	05/16/2025

	independent living arrangements. Based on record review and interview, the facility failed to develop, in cooperation with a mental health facility a comprehensive care plan for mental illness for 1 of 9 residents reviewed for mental illness. (Resident 9) Finding includes: A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder. Resident 9 admitted to the facility on 8/5/2024. A Service Plan, dated 2/27/2025, indicated Resident 9 needed monitoring related to a history of mood disturbances with a history of anger and physical aggression. Resident 9 presented with behaviors episodically with delusional ideation, as his dog talks to him, and needed support related to anxiety and depression. Resident 9's service plan was not developed in collaboration with the local mental health facility Resident 9 attended as the records for Resident 9 had not been requested until 3/7/2025.		were obtained for residents with a diagnosis of major mental health illness. C Nursing staff were educated by DON/ designee on developing, in cooperation with a mental health facility, a comprehensive care plan for residents who have a major mental health illness diagnosis. D An audit will be completed by the DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

During an interview, on 3/27/2025 at 11:04 A.M., the Director of Nursing indicated a comprehensive mental health care plan was not developed in collaboration with Resident 9's mental health provider.

A policy was requested for comprehensive care planning for mental health, on 3/27/2025 at 1:48 P.M. The Director of nursing indicated at 2:07 P.M., the facility did not have a policy for a comprehensive mental health care plan and followed the state regulations for this policy.

Based on record review and interview, the facility failed to develop, in cooperation with a mental health facility a comprehensive care plan for mental illness for 1 of 9 residents reviewed for mental illness. (Resident 9)

Finding includes:

A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder.

Resident 9 admitted to the facility on 8/5/2024.

A Service Plan, dated 2/27/2025, indicated Resident 9 needed monitoring related to a history of mood disturbances

	with a history of anger and physical aggression. Resident 9 presented with behaviors episodically with delusional ideation, as his dog talks to him, and needed support related to anxiety and depression. Resident 9's service plan was not developed in collaboration with the local mental health facility Resident 9 attended as the records for Resident 9 had not been requested until 3/7/2025. During an interview, on 3/27/2025 at 11:04 A.M., the Director of Nursing indicated a comprehensive mental health care plan was not developed in collaboration with Resident 9's mental health provider. A policy was requested for comprehensive care planning for mental health, on 3/27/2025 at 1:48 P.M. The Director of nursing indicated at 2:07 P.M., the facility did not have a policy for a comprehensive mental health care plan and followed the state regulations for this policy.			
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i) (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for	R 0412	The community was alleged to be out of compliance by failing to ensure residents received an annual TB risk assessment for 1 of 8 residents reviewed for TB compliance.	05/16/2025

	infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on record review and interview, the facility failed to ensure residents received annual TB (tuberculosis) risk assessments for 1 of 8 residents reviewed for TB compliance (Resident 6). Finding includes: A record review was completed for Resident 6 on 3/26/2025 at 11:06 A.M. Resident 6 was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that an annual TB risk assessment had been completed. During an interview, on 3/27/25 at 9:05 A.M., the DON indicated the resident should have had an annual TB risk assessment. On 3/27/2025 at 9:39 A.M., the DON provided a policy titled "Tuberculosis Skin Testing and Follow-up for Employees and Residents," dated 8/2023 and		A Resident 6 annual TB risk assessment was completed. B A house wide audit was completed to ensure all residents had a annual TB risk assessment completed. C Nursing staff were educated by DON/ designee on completing Annual TB risk assessments for all residents D An audit will be completed by the DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

indicated it was the policy currently being used by the facility. The policy indicated "...E.1. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats and weight loss..."

Based on record review and interview, the facility failed to ensure residents received annual TB (tuberculosis) risk assessments for 1 of 8 residents reviewed for TB compliance (Resident 6).

Finding includes:

A record review was completed for Resident 6 on 3/26/2025 at 11:06 A.M. Resident 6 was admitted to the facility on 8/29/2024.

Resident 6's record lacked documentation that an annual TB risk assessment had been completed.

During an interview, on 3/27/25 at 9:05 A.M., the DON indicated the resident should have had an annual TB risk assessment.

On 3/27/2025 at 9:39 A.M., the DON provided a policy titled "Tuberculosis Skin Testing and Follow-up for Employees and Residents," dated 8/2023 and indicated it was the policy

	currently being used by the facility. The policy indicated "...E.1. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats and weight loss..."			

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