STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF SOUTH BEND	955 HICKORY ROAD, SOUTH BEND, , 46615

(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 Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00459606. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00457398 and IN00458551 completed on 5/1/2025. Complaint IN00457398 - Corrected. Complaint IN00458551 - Not corrected Complaint IN00459606 - State deficiencies related to the allegations are cited at R407. Survey dates: July 1 and July 2,2025. Facility number: 016149 Census Bed Type: Residential: 15	R 0000	PLEASE SEE ATTACHED DOCUMENTATION AS WELL.	

	Census Payor Type: Other: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/8/2025			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart;	R 0119	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -No residents effected 2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -Residents could possibly be effected due to non-compliance with a specialized population training. Moving forward all Dementia trainings for staff will be uploaded into VGM Training and will be completed within the 60 days of employment. DON will ensure all staff are up to date on dementia orientation and job specific orientation. DON and Administrator will complete audits on employee charts to ensure that all required orientation is completed within 30 days. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	07/31/2025

	(B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure a general orientation to the facility was completed for 2 of 5 employees whose records were reviewed. (CNA 2 & CNA 5) Findings include: 1. CNA 2's employee personnel file review was completed on 7/2/2025 at 3:07 P.M. CNA 2's hire date was 5/17/2025. CNA 2's employee file lacked the documentation that general orientation had been completed upon hire.		-A General Orientation policy will be implemented and executed effective immediately. 4. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -Monthly audit of new hire employee files, check with corporate to ensure digital staff files are up to date. We will follow the newly implemented orientation policy.	

	2. CNA 5's employee personnel file review was completed on 7/2/2025 at 3:10 P.M. CNA 5's date of hire was 5/6/2025. CNA 5's employee file lacked the documentation that general orientation had been completed upon hire. During an interview, on 7/2/2025 at 4:30 P.M., the Administrator indicated general orientation had been completed by the home office staff but she was unable to locate any documentation indicating CNA 2 or CNA 5 had completed general orientation. During an interview, on 7/2/2025 at 4:30 P.M., the Administrator indicated the facility did not have a policy regarding general orientation for employees. Based on record review and interview, the facility failed to ensure a general orientation to the facility was completed for 2 of 5 employees whose records were reviewed. (CNA 2 & CNA 5) Findings include: 1. CNA 2's employee personnel file review was completed on 7/2/2025 at 3:07 P.M. CNA 2's hire date was 5/17/2025. CNA 2's employee file lacked the documentation that general orientation had been completed upon hire.			

	2. CNA 5's employee personnel file review was completed on 7/2/2025 at 3:10 P.M. CNA 5's date of hire was 5/6/2025. CNA 5's employee file lacked the documentation that general orientation had been completed upon hire. During an interview, on 7/2/2025 at 4:30 P.M., the Administrator indicated general orientation had been completed by the home office staff but she was unable to locate any documentation indicating CNA 2 or CNA 5 had completed general orientation. During an interview, on 7/2/2025 at 4:30 P.M., the Administrator indicated the facility did not have a policy regarding general orientation for employees.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience,	R 0123	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -No Residents effected 2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -Residents could possibly be effected due to lack of job specific training. Moving forward all new staff will have job specific orientation checklist completed. DON will ensure all staff are up to date on dementia orientation and	07/31/2025

	and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure specific orientation was available for 2 of 5 employee records reviewed. (CNA 2 & CNA 5) Findings include: 1. CNA 2's employee personnel file review was completed on 7/2/2025 at 3:07 P.M. CNA 2's hire date was 5/17/2025. CNA 2's employee file lacked the documentation that a specific job orientation had been completed upon hire. 2. CNA 5's employee personnel file review was completed on 7/2/2025 at 3:10 P.M. CNA 5's date of hire was 5/6/2025. CNA		job specific orientation. DON and Administrator will complete audits on employee charts to ensure that all required orientation is completed within 30 days. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. -Going forward all new staff will have a job specific checklist completed 4. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -monthly audit of new employee files moving forward.	

	5's employee file lacked the documentation that a specific job orientation had been completed upon hire. During an interview on 7/2/2025 at 4:30 P.M., the Administrator indicated the facility did not have documentation indicating a specific job orientation had been completed for CNA 2 or CNA 5. During an interview, on 7/2/2025 at 4:30 P.M., the Administrator indicated the facility did not have a policy regarding specific job orientation requirements. Based on record review and interview, the facility failed to ensure specific orientation was available for 2 of 5 employee records reviewed. (CNA 2 & CNA 5) Findings include: 1. CNA 2's employee personnel file review was completed on 7/2/2025 at 3:07 P.M. CNA 2's hire date was 5/17/2025. CNA 2's employee file lacked the documentation that a specific job orientation had been completed upon hire.			

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R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to	R 0246	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -Resident 5 and Resident 7 charts were reviewed for adverse effects, none noted. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -all residents with PRN orders are at risk. Corrective action is education for QMAs on medication administration and the proper policy and procedures for administering PRN medications. 3. What measures will be put into	07/31/2025

	ensure a Qualified Medication Aides (QMAs) received prior authorization to administer an as needed (PRN) medication from a qualified licensed professional for 2 out of 7 residents reviewed. (Residents 5 & 7) Findings include: 1. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Diagnoses included, but were not limited to: dementia with visual hallucinations, hyperosmolality and hypernatremia. A Medication Administration Record (MAR), dated 7/2025, indicated Resident 5 had been administered 0.5 milligrams (mg) of lorazepam (anit anxiety medication), on 7/1/2025 at 4:22 A.M. from QMA 8. Resident 5's record lacked the documentation that a licensed nurse had been contacted and had given approval to QMA 8 to administer the PRN medication. During an interview on 7/2/2025 at 9:33 A.M., QMA 7 indicated the process for giving a PRN medication was to ask the Director of Nursing (DON) before administering the mediation. QMA 7 indicated a note should either have been added to the MAR or to the progress notes indicating approval from the DON had		place and what systemic changes will be made to ensure that the deficient practice does not recur. -Re-education of all QMAs on medication administration and PRN policy and procedures. 4. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -DHW will audit PRN administrations 3x a week x4 weeks,then 1x week x4weeks	

	been given. QMA 7 was unable to locate a note in Resident 5' record indicating the DON had given approval to give Resident 5 0.5 mgs of lorazepam on 7/1/2025 at 4:22 A.M. 2. Resident 7's record review was completed on 7/2/2024 at 9:00 A.M. Diagnoses included, but were not limited to: dementia and constipation. A MAR entry, dated 6/2025, indicated Resident 7 had been administered 10 mg of bisacodyl (laxative), on 6/8/2025 at 4:52 P.M. from QMA 9. During an interview, on 7/2/2025 at 3:45 P.M., the DON indicated she was not able to find a record that QMA 8 had received approval prior to administering the PRN medication to Resident 5 on 7/1/2025 at 4:22 A.M. The DON also indicated there was nothing in the record to show QMA 9 had received prior approval to administer a PRN medication to Resident 7 on 6/8/2025 at 4:52 P.M. On 7/1/2025 at 11:00 A.M., the Administrator provided a policy dated, 4/29/2025, titled, "Chapters Living Medication Aide Policy." The Administrator indicated it was the policy currently used by the facility. The policy indicated, "...PRN medications may only be given with prior RN/LPN assessment			

	and authorization...." Based on record review and interview, the facility failed to ensure a Qualified Medication Aides (QMAs) received prior authorization to administer an as needed (PRN) medication from a qualified licensed professional for 2 out of 7 residents reviewed. (Residents 5 & 7) Findings include: 1. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Diagnoses included, but were not limited to: dementia with visual hallucinations, hyperosmolality and hypernatremia. A Medication Administration Record (MAR), dated 7/2025, indicated Resident 5 had been administered 0.5 milligrams (mg) of lorazepam (anit anxiety medication), on 7/1/2025 at 4:22 A.M. from QMA 8. Resident 5's record lacked the documentation that a licensed nurse had been contacted and had given approval to QMA 8 to administer the PRN medication. During an interview on 7/2/2025 at 9:33 A.M., QMA 7 indicated the process for giving a PRN medication was to ask the Director of Nursing (DON) before administering the mediation. QMA 7 indicated a			

	note should either have been added to the MAR or to the progress notes indicating approval from the DON had been given. QMA 7 was unable to locate a note in Resident 5' record indicating the DON had given approval to give Resident 5 0.5 mgs of lorazepam on 7/1/2025 at 4:22 A.M. 2. Resident 7's record review was completed on 7/2/2024 at 9:00 A.M. Diagnoses included, but were not limited to: dementia and constipation. A MAR entry, dated 6/2025, indicated Resident 7 had been administered 10 mg of bisacodyl (laxative), on 6/8/2025 at 4:52 P.M. from QMA 9. During an interview, on 7/2/2025 at 3:45 P.M., the DON indicated she was not able to find a record that QMA 8 had received approval prior to administering the PRN medication to Resident 5 on 7/1/2025 at 4:22 A.M. The DON also indicated there was nothing in the record to show QMA 9 had received prior approval to administer a PRN medication to Resident 7 on 6/8/2025 at 4:52 P.M. On 7/1/2025 at 11:00 A.M., the Administrator provided a policy dated, 4/29/2025, titled, "Chapters Living Medication Aide Policy." The Administrator indicated it was the policy			

	currently used by the facility. The policy indicated, "...PRN medications may only be given with prior RN/LPN assessment and authorization...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to store food in a safe and sanitary manner related to dating and discarding food in 1 of 1 kitchen observed. This had the potential to affect 17 out of 17 residents who received their meals from the kitchen. Findings include: During an observation of the kitchen, with the Director of Culinary Services (DCS), on 7/1/2025 at 9:45 A.M., the following was observed: -A container of chicken and rice soup did not have a made-on or use by date. -A container of sour kraut had an opened-on date of 6/10/2025 and had a use by date of	R 0273	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -No Residents Effected 2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All food will be stored in a safe and sanitary manor relating to dating and discarding of food. -Immediate actions taken were audit of kitchen to ensure all dating and storage of food complied with Indiana state regulations for assisted living. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. -All food will have an opened on or made on date sticker, and a use by date label. 4. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -DCS will do weekly kitchen sanitation inspections moving forward.	07/31/2025

	7/10/2025. -A container of canned apples had an opened-on date of 6/23/2025 and a use by date of 7/25/2025. -A pitcher of apple juice did not have a made on or use by date. -A container with cut up watermelon had a made-on date as 4/18/2025. -An opened package of shredded mozzarella cheese did not have an opened on or use by date. -An opened package of American cheese did not have an opened-on or use by date. -A package of shredded carrots with an expiration date of 6/12/2025. During an interview on 7/1/2025 at 9:52 A.M., the DCS indicated all food that was opened should have been marked with an opened-on/made-on date and all leftovers should have been thrown away after three days. It was unclear why some of the opened food's use by date had been marked a month after the opened date. On 7/1/2025 at 10:50 A.M., the DCS provided an undated policy title, "Chapters Living Food and Handling and Labeling Policy", and indicated it was the policy		-Kitchen staff was given State Regulations regarding proper food storage and dating. -Food Safety and Sanitation class added to culinary staff training, to be completed by 7/14	

currently used by the facility. The policy indicated, "Label all containers with product name and preparation/use-by date ...Leftovers must be consumed or discarded with 3 days..."

Based on observation, interview and record review, the facility failed to store food in a safe and sanitary manner related to dating and discarding food in 1 of 1 kitchen observed. This had the potential to affect 17 out of 17 residents who received their meals from the kitchen.

Findings include:

During an observation of the kitchen, with the Director of Culinary Services (DCS), on 7/1/2025 at 9:45 A.M., the following was observed:

-A container of chicken and rice soup did not have a made-on or use by date.

-A container of sour kraut had an opened-on date of 6/10/2025 and had a use by date of 7/10/2025.

-A container of canned apples had an opened-on date of 6/23/2025 and a use by date of 7/25/2025.

-A pitcher of apple juice did not have a made on or use by date.

-A container with cut up watermelon had a made-on date

	as 4/18/2025. -An opened package of shredded mozzarella cheese did not have an opened on or use by date. -An opened package of American cheese did not have an opened-on or use by date. -A package of shredded carrots with an expiration date of 6/12/2025. During an interview on 7/1/2025 at 9:52 A.M., the DCS indicated all food that was opened should have been marked with an opened-on/made-on date and all leftovers should have been thrown away after three days. It was unclear why some of the opened food's use by date had been marked a month after the opened date. On 7/1/2025 at 10:50 A.M., the DCS provided an undated policy title, "Chapters Living Food and Handling and Labeling Policy", and indicated it was the policy currently used by the facility. The policy indicated, "Label all containers with product name and preparation/use-by date ...Leftovers must be consumed or discarded with 3 days..."			

R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. 2. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Diagnoses included, but were not limited to: dementia with visual hallucinations, osteoarthritis, hyperosmolality and	R 0356	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -Resident 4 and Resident 5 information added to emergency binder. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -Emergency binder was audited by DHW to ensure compliance with all residents -Emergency binder will be updated weekly and with new admissions moving forward. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. -DHW updating the emergency binder weekly and with each new admission. 4. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -DHW to audit weekly x4 weeks and then monthly thereafter.	07/31/2025

hypernatremia.

A review of the facility Emergency Binder was completed on 7/2/2025 at 1:05 P.M. The emergency binder did not contain any information for Resident 5.

During an interview on 7/2/2025 at 3:15 P.M., the Administrator confirmed the emergency file did not contain Resident 5's information. The Administrator indicated the facility did not have a policy regarding their emergency binder requirements.

Based on record review and interview, the facility failed to ensure the Emergency binder was complete and accurate with all required resident information for 2 of 5 residents whose emergency information was reviewed. (Resident 4 and X)

Findings include:

1. On 7/2/2025 at 11:20 A.M., Resident 4's Emergency/Transfer Information was reviewed in the Emergency binder and was missing the resident's picture, hospital preference and physician preference. There were no other documents in the Emergency binder for Resident 4.

During an interview, on 7/2/2025 at 11:45 A.M., the Executive Director (ED) indicated Resident 4's picture was available in the

	Electronic Medical Record (EMR) system. The ED indicated the resident's hospital and doctor preferences were on also on the Resident 4's Face Sheet in the EMR. There was no explanation given as to why the information was missing in the facility's Emergency Binder. 2. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Diagnoses included, but were not limited to: dementia with visual hallucinations, osteoarthritis, hyperosmolality and hypernatremia. A review of the facility Emergency Binder was completed on 7/2/2025 at 1:05 P.M. The emergency binder did not contain any information for Resident 5. During an interview on 7/2/2025 at 3:15 P.M., the Administrator confirmed the emergency file did not contain Resident 5's information. The Administrator indicated the facility did not have a policy regarding their emergency binder requirements. Based on record review and interview, the facility failed to ensure the Emergency binder was complete and accurate with all required resident information for 2 of 5 residents whose emergency information was reviewed. (Resident 4 and X)			

Findings include:

1. On 7/2/2025 at 11:20 A.M., Resident 4's Emergency/Transfer Information was reviewed in the Emergency binder and was missing the resident's picture, hospital preference and physician preference. There were no other documents in the Emergency binder for Resident 4.

During an interview, on 7/2/2025 at 11:45 A.M., the Executive Director (ED) indicated Resident 4's picture was available in the Electronic Medical Record (EMR) system. The ED indicated the resident's hospital and doctor preferences were on also on the Resident 4's Face Sheet in the EMR. There was no explanation given as to why the information was missing in the facility's Emergency Binder.

2. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Diagnoses included, but were not limited to: dementia with visual hallucinations, osteoarthritis, hyperosmolality and hypernatremia.

A review of the facility Emergency Binder was completed on 7/2/2025 at 1:05 P.M. The emergency binder did not contain any information for Resident 5.

During an interview on 7/2/2025

at 3:15 P.M., the Administrator confirmed the emergency file did not contain Resident 5's information. The Administrator indicated the facility did not have a policy regarding their emergency binder requirements.

Based on record review and interview, the facility failed to ensure the Emergency binder was complete and accurate with all required resident information for 2 of 5 residents whose emergency information was reviewed. (Resident 4 and X)

Findings include:

1. On 7/2/2025 at 11:20 A.M., Resident 4's Emergency/Transfer Information was reviewed in the Emergency binder and was missing the resident's picture, hospital preference and physician preference. There were no other documents in the Emergency binder for Resident 4.

During an interview, on 7/2/2025 at 11:45 A.M., the Executive Director (ED) indicated Resident 4's picture was available in the Electronic Medical Record (EMR) system. The ED indicated the resident's hospital and doctor preferences were on also on the Resident 4's Face Sheet in the EMR. There was no explanation given as to why the information was missing in the facility's Emergency Binder.

	2. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Diagnoses included, but were not limited to: dementia with visual hallucinations, osteoarthritis, hyperosmolality and hypernatremia. A review of the facility Emergency Binder was completed on 7/2/2025 at 1:05 P.M. The emergency binder did not contain any information for Resident 5. During an interview on 7/2/2025 at 3:15 P.M., the Administrator confirmed the emergency file did not contain Resident 5's information. The Administrator indicated the facility did not have a policy regarding their emergency binder requirements. Based on record review and interview, the facility failed to ensure the Emergency binder was complete and accurate with all required resident information for 2 of 5 residents whose emergency information was reviewed. (Resident 4 and X) Findings include: 1. On 7/2/2025 at 11:20 A.M., Resident 4's Emergency/Transfer Information was reviewed in the Emergency binder and was missing the resident's picture, hospital preference and physician preference. There were no other			

	documents in the Emergency binder for Resident 4. During an interview, on 7/2/2025 at 11:45 A.M., the Executive Director (ED) indicated Resident 4's picture was available in the Electronic Medical Record (EMR) system. The ED indicated the resident's hospital and doctor preferences were on also on the Resident 4's Face Sheet in the EMR. There was no explanation given as to why the information was missing in the facility's Emergency Binder.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that 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 interviews, the facility failed to	R 0407	1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -All residents could have been effected by this deficiency. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -Infection trends will be analyzed to determine residents at risk. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. -Direct care staff will be re-education on infection prevention practices. Infection control log will be updated with each new case. Infections will be	07/31/2025

	establish an infection control program that included a system to analyze patterns of known infectious symptoms, provide orientation and in-service education on infection prevention and control, offered health information to residents regarding infection transmission and immunizations and reported any communicable disease to the public health authorities. This deficient practice affected 17 of 17 residents in the facility. Finding includes: During an interview, on 7/1/2025 at 11:20 A.M., the Interim Director of Health and Wellness (Interim DHW) indicated she has not monitored or tracked any infections and has had no role regarding Infection Control. She indicated she had been "helping" the facility for the past 3 weeks while they waiting on a new Wellness Director to start working at the facility. During an interview, on 7/2/2025 at 1:40 P.M., the Executive Director (ED) indicated the corporate nurse had not monitored, analyzed or tracked any infections in the facility and the facility had not had a permanent DHW to complete this task. The ED indicated the facility should have been tracking, analyzing and reporting infections.		analyzed for trends. 4. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -Infection control log will be reviewed weekly by the new DHW. DHW will track and analyze data for infection control in the facility.	

	On 7/1/2025 at 2:30 P.M., the ED provided a policy titled, "Chapters Living Infection Control Policy," dated 4/28/2025 and indicated the policy was the one currently used by the facility. The policy indicated "...Infection Preventionist/Nurse/Designee oversees infection control practices, education, monitoring, and reporting...Infection Surveillance...maintain a line listing/log of all infectious cases. Analyze patterns and trends monthly..." This citation relates to complaint IN00459606. Based on record review and interviews, the facility failed to establish an infection control program that included a system to analyze patterns of known infectious symptoms, provide orientation and in-service education on infection prevention and control, offered health information to residents regarding infection transmission and immunizations and reported any communicable disease to the public health authorities. This deficient practice affected 17 of 17 residents in the facility. Finding includes: During an interview, on 7/1/2025 at 11:20 A.M., the Interim Director of Health and Wellness (Interim DHW) indicated she			

	has not monitored or tracked any infections and has had no role regarding Infection Control. She indicated she had been "helping" the facility for the past 3 weeks while they waiting on a new Wellness Director to start working at the facility. During an interview, on 7/2/2025 at 1:40 P.M., the Executive Director (ED) indicated the corporate nurse had not monitored, analyzed or tracked any infections in the facility and the facility had not had a permanent DHW to complete this task. The ED indicated the facility should have been tracking, analyzing and reporting infections. On 7/1/2025 at 2:30 P.M., the ED provided a policy titled, "Chapters Living Infection Control Policy," dated 4/28/2025 and indicated the policy was the one currently used by the facility. The policy indicated "...Infection Preventionist/Nurse/Designee oversees infection control practices, education, monitoring, and reporting...Infection Surveillance...maintain a line listing/log of all infectious cases. Analyze patterns and trends monthly..." This citation relates to complaint IN00459606.			

R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure residents received a two step Tuberculin skin test upon admission for 2 of 7 residents who were reviewed. (Residents 4 and 5) Finding includes: 1. Resident 5's record review was completed on 7/1/205 at	R 0410	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -Resident 4 and Resident 5 will be given a 2 step PPD. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -DHW to audit all current residents and administer PPDs as indicated. 3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. -All new admissions will have a PPD 3 months prior to admission or upon admission, administered by DHW or licensed Nurse on staff. 4.How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? -DHW to do monthly audit of new admission PPDs moving forward, this will also be added to the Marketing admission checklist. -DHW/Nurse Staff given TB IDOH regulations and facility policy on TB for education.	07/31/2025

	2:55 P.M. Resident 5 was admitted on 6/6/2025. Diagnoses included, but were not limited to: dementia with visual hallucinations, hyperosmolality and hypernatremia. Resident 5's record lacked the documentation to show Resident 5 had received a 1st and 2nd step Tuberculin skin test. During an interview on 7/2/2025 at 11:05 A.M., the Administrator indicated Resident 5 had had a chest X-ray prior to admission and she did not think Resident 5 needed to have a two step Tuberculin skin test completed. 2. The record review for Resident 4 was completed on 7/1/2025 at 2:40 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, depression, polycythemia vera and glaucoma. A Resident Face Sheet, undated, indicated Resident 4 had been admitted to the facility on 2/18/2025.			

A chest x-ray had been completed for Resident 4 on 5/14/2024, nine months prior to the resident's admission. There were no further chest X-ray documentation or Tuberculin skin testing documentation completed for Resident 4.

During an interview, on 7/2/2025 at 1:40 P.M., the Executive Director (ED) indicated she thought Resident 4 did not need to have a tuberculin skin test completed because the resident had had a chest x-ray prior to admission.

Based on record review and interview, the facility failed to ensure residents received a two step Tuberculin skin test upon admission for 2 of 7 residents who were reviewed. (Residents 4 and 5)

Finding includes:

1. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Resident 5 was admitted on 6/6/2025. Diagnoses included, but were not limited to: dementia with visual hallucinations, hyperosmolality and hypernatremia.

Resident 5's record lacked the documentation to show Resident 5 had received a 1st and 2nd step Tuberculin skin test.

During an interview on 7/2/2025 at 11:05 A.M., the Administrator indicated Resident 5 had had a chest X-ray prior to admission and she did not think Resident 5 needed to have a two step Tuberculin skin test completed.

2. The record review for Resident 4 was completed on 7/1/2025 at 2:40 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, depression, polycythemia vera and glaucoma.

A Resident Face Sheet, undated, indicated Resident 4 had been admitted to the facility on 2/18/2025.

A chest x-ray had been completed for Resident 4 on 5/14/2024, nine months prior to the resident's admission. There were no further chest X-ray documentation or Tuberculin skin testing documentation completed for Resident 4.

During an interview, on 7/2/2025 at 1:40 P.M., the Executive Director (ED) indicated she thought Resident 4 did not need to have a tuberculin skin test completed because the resident had had a chest x-ray prior to admission.

Based on record review and interview, the facility failed to ensure residents received a two step Tuberculin skin test upon

admission for 2 of 7 residents who were reviewed. (Residents 4 and 5)

Finding includes:

1. Resident 5's record review was completed on 7/1/205 at 2:55 P.M. Resident 5 was admitted on 6/6/2025. Diagnoses included, but were not limited to: dementia with visual hallucinations, hyperosmolality and hypernatremia.

Resident 5's record lacked the documentation to show Resident 5 had received a 1st and 2nd step Tuberculin skin test.

During an interview on 7/2/2025 at 11:05 A.M., the Administrator indicated Resident 5 had had a chest X-ray prior to admission and she did not think Resident 5 needed to have a two step Tuberculin skin test completed.

2. The record review for Resident 4 was completed on 7/1/2025 at 2:40 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, depression, polycythemia vera and glaucoma.

A Resident Face Sheet, undated, indicated Resident 4 had been admitted to the facility on 2/18/2025.

A chest x-ray had been completed for Resident 4 on 5/14/2024, nine months prior to the resident's admission. There were no further chest X-ray documentation or Tuberculin skin testing documentation completed for Resident 4.

During an interview, on 7/2/2025 at 1:40 P.M., the Executive Director (ED) indicated she thought Resident 4 did not need to have a tuberculin skin test completed because the resident had had a chest x-ray prior to admission.

Based on record review and interview, the facility failed to ensure residents received a two step Tuberculin skin test upon admission for 2 of 7 residents who were reviewed. (Residents 4 and 5)

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Resident 5's record lacked the documentation to show Resident 5 had received a 1st and 2nd step Tuberculin skin test.

During an interview on 7/2/2025 at 11:05 A.M., the Administrator indicated Resident 5 had had a chest X-ray prior to admission and she did not think Resident 5 needed to have a two step Tuberculin skin test completed.

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A Resident Face Sheet, undated, indicated Resident 4 had been admitted to the facility on 2/18/2025.

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During an interview, on 7/2/2025 at 1:40 P.M., the Executive Director (ED) indicated she thought Resident 4 did not need to have a tuberculin skin test completed because the resident had had a chest x-ray prior to admission.

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