

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2026	
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF NEWBURGH		STREET ADDRESS, CITY, STATE, ZIP CODE 10144 WARRICK TRAIL, NEWBURGH, , 47630					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...		(X5) COMPLETION DATE		
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intakes 466947 and 470437. Intake 466947 - State deficiencies related to the allegations are cited at R95, R120, R121, and R411. Intake 470437 - No deficiencies related to the allegations are cited. Survey dates: August 7 and 10, 2026 Facility number: 016276 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 13, 2026.	R 0000					

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R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia.	R 0095	R 095 Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 9/10/26. The facility will ensure this requirement is met through the following corrective measures: 1. On 8/20/26, Director of Nursing (DON) dementia training courses were reviewed. No residents were harmed during this	08/17/2026
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	Based on record review and interview, the facility failed to provide documentation that the Dementia Care Director completed a minimum of twelve hours of dementia-specific training during the first three months of employment for 1 of 1 employee files reviewed for Dementia Care Director. (Director of Nursing) Finding includes: Confidential interviews were conducted during the course of the survey. An interview indicated that staff were not completing in-services as required by state guidelines. Interview on 8/7/26 at 8:50 A.M., the Director of Nursing (DON) indicated she was the Dementia Care Director. On 8/10/26 at 9:38 A.M., the Dementia Disclosure State Form 48896 was reviewed. The document listed the DON as the program director. On 8/10/26 at 10:48 A.M., the DON's employee file was reviewed. She was hired on 11/17/25. The record lacked 12 hours of dementia-specific training completed by 2/17/26. Interview on 8/10/26 at 10:52 A.M., the DON indicated she did not complete 12 hours of dementia-specific training in the		finding. 2. On 8/20/26, ED conducted an audit to determine number of dementia hours needed. Dementia courses assigned to be completed. 3. By 8/27/25, DON will be in-serviced on completing dementia specific courses for requirements of Dementia Care Director. 4. The Executive Director is responsible for sustained compliance. The ED, or designee, will review DON dementia specific courses; weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. 9/10/26.	
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	first three months of employment. On 8/10/26 at 12:01 P.M., the Administrator indicated the facility did not have a policy related to dementia in-service requirements for staff but referred to state guidelines. This citation related to Intake 466947.			
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 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	R 0120	R 120	08/17/2026
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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. Based on record review and interview, the facility failed to provide documentation of staff completing a minimum of six hours of dementia-specific training during the first six months of employment for 2 of 5 employee files reviewed. (Certified Nurse Aide 7 and Certified Nurse Aide 4) Finding includes: Confidential interviews were conducted during the course of	survey review on or after 9/10/26. The facility will ensure this requirement is met through the following corrective measures: 1. On 8/20/26, CNA 4 & 7 dementia training courses were reviewed. No residents were harmed during this finding. 2. On 8/20/26, ED conducted an audit to determine number of dementia hours needed. Dementia courses assigned to be completed. 3. By 8/27/25, CNA 4 & 7 will be in-serviced on completing dementia specific courses for requirements of new hire dementia training. 4. The Executive Director is responsible for sustained compliance. The DON, or designee, will review CNA 4 & 7 dementia specific courses; weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary	
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the survey. An interview indicated that staff were not completing in-services as required by state guidelines.

On 8/10/26 at 9:04 A.M., employee files were reviewed. Records from Certified Nurse Aide (CNA) 7 and CNA 4 lacked the six hours of dementia-specific training in six months.

CNA 7 was hired on 11/4/25 and lacked 5.5 hours of dementia-specific training prior to 5/4/26.

CNA 4 was hired on 10/21/25 and lacked 5.5 hours of dementia-specific training prior to 4/21/26.

Interview on 8/10/26 at 10:42 A.M., the Director of Nursing (DON) indicated that she could not find any record of dementia-specific in-services completed by CNA 7 and CNA 4 in the first six months of their employment.

On 8/10/26 at 12:01 P.M., the Administrator indicated the facility did not have a policy related to dementia in-service requirements for staff but referred to state guidelines.

This citation related to Intake 466947.

based on three consecutive months of compliance. Monitoring will be ongoing.
5. 9/10/26.

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R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.	R 0121	R 121 Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 9/10/26. The facility will ensure this requirement is met through the following corrective measures: 1. On 8/19/26, CNA 4 & 9, QMA 2 TB results were reviewed. No residents were harmed during this finding. 2. On 8/19/26, ED conducted an audit to	08/17/2026
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	(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to screen employees upon hire for tuberculosis (TB) according to standard practice for 3 of 5 employee files reviewed. (Certified Nurse Aide 9, Qualified Medication Aide 2, and Certified Nurse Aide 4) Finding includes: Confidential interviews were conducted during the course of the survey. An interview indicated employees were not being screened as per state regulation for TB upon hire to the facility. On 8/10/26 at 9:04 A.M., employee records were reviewed. The following staff members did not have valid second step TB results: Certified Nurse Aide (CNA) 9 was hired on 5/12/25. Her second step TB test was		determine TB testing for new hires. All hires will have 1st and 2nd step TB tests within required regulations. 3. By 8/27/25, DON and BOM will be in-serviced on TB testing requirements for new hires. 4. The Executive Director is responsible for sustained compliance. The DON, or designee, will review new hire TB testing results; weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. 9/10/26.	
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	administered on 5/15/26 and read on 5/28/25, more than 72 hours after the test was administered making the test invalid. Qualified Medication Aide (QMA) 2 was hired on 5/28/25. Her second step TB test was administered on 5/14/25 and read on 5/26/25, more than 72 hours after the test was administered making the test invalid. CNA 4 was hired on 10/21/25. Her first step TB test was read on 10/17/25. The documentation lacked a second step TB test. Interview on 8/10/26 at 10:18 A.M., the Director of Nursing (DON) indicated nurses administering and reading the TB tests were not certified to do so. On 8/10/26 at 12:01 P.M., the Administrator provided a current Tuberculosis policy, dated 12/1/22, that indicated "The Community will conduct TB testing and screenings for all its employees and residents according to State regulations ... Visit #3 ...place the second TST (two-step test) ... Visit #4 48 to 72 hours later read the second TST". The article, "Clinical Testing Guidance for Tuberculosis:			
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	Tuberculin Skin Test," dated 1/31/25, was retrieved on 8/10/26 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html. The guidance included: "The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TB skin results ... A patient who does not return within 72 hours will need to be rescheduled for another skin test". This citation relates to Intake 466947.			
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 ensure that hair covering was worn during food preparation and serving, food containers were appropriately labeled with open and expiration dates, temperature logs were maintained for refrigerators and	R 0273	R 273	08/17/2026
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dishwashers, preparation and storage areas were clean, and cooking utensils were clean in 1 of 1 kitchen observations.
(Kitchen)

Finding includes:

Observation on 8/7/26 at 8:40 A.M., the following was observed during the initial kitchen tour:

Dietary Manager had no hair net or beard protector on.

Dietary Manager had on the same pair of gloves while making food and touched multiple surfaces without changing gloves.

Reach-in refrigerator:

1 bottle of lemon juice with no open date

1 bottle of mayonnaise with no open date and dried matter on the neck and bottle

3 bottles of yellow mustard with no open date

1 container of sour cream with no open date

1 container of Italian dressing with no prep or open date

1 container of relish with no open date

1 container of cherries with no

any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 9/10/26.

The facility will ensure this requirement is met through the following corrective measures:

1. On 8/17/26, ED and DSD discarded identified opened unlabeled and/or undated food. Storage bins were closed and sealed appropriately. On 8/10/26 the spice shelf was cleaned, utensils removed and cleaned, floor swept near flour bin. No residents were harmed during this finding.
2. On 8/21/26, ED conducted an audit unlabeled/undated food items, properly sealed storage bins, hair nets and cleanliness of kitchen areas and temperature logs.
3. By 8/27/26, DSD will be in-serviced for hair net and beard net policy. All dining staff will be in-serviced for hair net

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	open date 1 container of pepper corn dressing with no open date and drippings on the side 1 container of salsa with no open date 1 container of Caesar dressing with no open date 2 containers of tea with no prep date Spice rack shelf: 1 container of celery seed with no open or expiration date 1 container of white pepper with no open date 1 package of red powder with no label or open date 1 package of red flakes with no label or open date 1 container of Spanish paprika with no open date 1 container of baking soda with no open date 1 bag of croutons with open no open date The shelf was covered with different colored powders and had areas of sticky spots On the shelf under the spice rack the following was		and beard net policy, labeling/dating, cleanliness, temperature logs by 9/10/26. 4. The Executive Director is responsible for sustained compliance. The DSD, or designee, will review hair and beard net proper usage, storage bins, cleanliness of the kitchen and temperature logs; weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. 9/10/26.	
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observed:

2 large containers of soy sauce
with no open date

The shelf was covered with
large areas of sticky spots.

Scoop with red debris on it
amongst clean utensils in a
container

Walk-in refrigerator:

1 large container of macaroni
and cheese with no preparation
date

1 bag of open spinach with no
open date

1 open bag of cilantro with no
open date

Dry storage:

White powder was all over the
floor near a flour container and
on the baker's rack

1 box of potato pearls with no
open date

1 bag of potato pearls with no
open date

1 wrapped bag of potato pearls
with no open date

1 box of instant pudding with no
open date

1 bag of cheesecake mix with a use by date of 7/15/26

1 box of biscuit mix that was open to air

1 bag of rice cereal with a use by date of 4/9/26

1 bag of tortilla chips with a use by date of 8/3/26

The following temperature logs were not completed:

Reach-in refrigerator was lacking the following days:

8/1, 8/2, 8/5, 8/6, and 8/7/2026

Walk-in refrigerator and freezers were lacking the following days:

8/1, 8/2, 8/3, 8/5, 8/6, and 8/7/2026

Dishwasher temperatures were lacking the following dates:

7/7 PM, 7/8 PM, 7/9 PM, 7/10, 7/13, PM, 7/14 PM, 7/15 PM, 7/16, 7/17, 7/18 PM, 7/19, 7/20, 7/21, 7/22, 7/23, and 7/26/2026

Interview on 8/7/26 at 10:15 A.M., the Dietary Manager indicated that there should be no undated or expired food or spices, the temperature logs should have been kept up, and the shelves should be clean and without debris.

Interview on 8/7/26 at 1:00

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	P.M., the Regional Dietary Manager indicated that all staff needed hair nets and beard protectors when preparing food and gloves should be changed. On 8/10/26 at 12:01 P.M., the Administrator provided a current, undated "Sanitizing Equipment and Food Contact Areas" policy that indicated "...employees shall follow the sanitizing recommendations and procedures for each piece of equipment or food contact surface as discussed in the cleaning guideline and procedure for the specific piece of equipment, or per manufacturer's recommendations..." On 8/10/26 at 12:01 P.M., the Administrator provided a current, undated "Hair Nets" policy that indicated "...Hair restraints shall be worn by all Dining Services staff. Staff should wear hair restraints in all food preparation and serving areas. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food." On 8/10/26 at 12:01 P.M., the Administrator provided a current, undated "Refrigerator/Freezer Temperatures" policy that indicated "...Dining Services will be responsible for taking			
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temperatures on all kitchen and nourishment room refrigerators and freezers, and recording temperatures on temperature report logs daily, during each shift..."

On 8/10/26 at 12:01 P.M., the Administrator provided a current, undated "Glove and Handwashing" policy that indicated "...Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break or going to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment. Staff should be reminded that gloves become contaminated just as hands do and should be changed often. When in doubt, remove gloves and wash hands again. When gloves must be changed, they are removed, hand washing procedure is followed, and a new pair of gloves is applied. Gloves are never placed on dirty hands; the procedure is always wash, glove, remove, rewash, and re-glove..."

R 0298	Pharmaceutical Services - Deficiency	R 0298	R 298 Submission of this response	08/17/2026
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	410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, record review, and interview, the facility failed to ensure proper storage of unlabeled medications and expired medications in 2 of 2 medication carts observed. (Memory Care and Assisted Living Medication Carts) Findings include:		and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 9/10/26. The facility will ensure this requirement is met through the following corrective measures: 1. On 8/10/26, QMA discarded expired medications. Aspirin, calcium, clearlax were discarded. Fish oil, purelax and collagen were labeled and dated on 8/10/26. No residents were harmed during this	
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1. Observation on 8/7/26 at 9:35 A.M., the following expired and unlabeled medications were observed in the Memory Care Medication Cart: 1 container of Purelax (a laxative) expired 4/2026 1 container of Clearlax with no label 1 container of Clearlax with no open date 1 bottle of collagen with no label or open date 2. Observation on 8/7/26 at 9:50 A.M., the following expired and unlabeled medications were observed in the Assisted Living Medication Cart: 1 bottle of aspirin with no label and an expiration date of 2/2024 1 bottle of calcium with no label 1 bottle of fish oil with no label Interview on 8/7/26 at 9:40 A.M., Qualified Medication Aide (QMA) 2 indicated that the containers should be labelled with a name and an open date, and expired medications should be thrown away. On 8/10/26 at 12:01 P.M., the Administrator provided a current "Medication Storage" policy, dated 8/30/24, that indicated		finding. 2. On 8/20/26, ED conducted an audit of medication carts for unlabeled/expired medications. None were found at this time. 3. By 8/27/26, Nurse's and QMA's will be in-serviced for labeling and dating and proper discarding of medications. 4. The Executive Director is responsible for sustained compliance. The DON, or designee, will review labeling and dating and proper discarding of medications; weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. 5. 9/10/26.	
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	"...each prescription medication container stored in original packaging is to be labeled with the resident's full name...Any deteriorated, contaminated, expired, or discontinued medication... should be disposed of..."			
R 0411	Infection Control - Noncompliance 410 IAC 16.2-5-12(h) (h) All skin testing for tuberculosis shall be done using the Mantoux method (5TU, PPD) administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording. Based on record review and interview, the facility failed to ensure nurses who administered skin testing for tuberculosis (TB) had training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording for 4 of 5 employee files reviewed. (Certified Nurse Aide 7, Certified Nurse Aide 9, Qualified Medication Aide 2, Certified Nurse Aide 4, Registered Nurse 11, Director of Nursing, and Registered Nurse 15)	R 0411	R 411 Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and request a desk review for paper compliance in lieu of post survey review on or after 9/10/26. The facility will ensure this	08/17/2026

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FORM APPROVED

OMB NO. 0938-0391

Finding includes:

Confidential interviews were conducted during the course of the survey. An interview indicated the staff that were administering skin testing for TB were not certified to do so.

On 8/10/26 at 9:04 A.M., employee records were reviewed. The following staff members had skin testing administered and read by an uncertified nurse:

Certified Nurse Aide (CNA) 7 was hired on 11/4/25. Her first step TB test was read by Registered Nurse (RN) 11. Her second step TB test was administered on 11/18/25 by the Director of Nursing (DON) and was read on 11/20/25 by the DON.

CNA 9 was hired on 5/12/25. Her first step TB test was administered on 5/8/25 by RN 15 and was read on 5/11/25 by RN 15. Her second step TB test was administered on 5/15/25 by RN 15 and read on 5/28/15 by RN 15.

Qualified Mediation Aide (QMA) 2 was hired on 5/28/25. Her first step TB test was administered on 4/29/25 by RN 15 and was read on 5/1/25 by RN 15. Her second step TB test was administered on 5/14/25 by RN 15 and read on 5/26/25 by RN

requirement is met through the following corrective measures:

1. On 8/12/26, reviewed employee records for TB testing of the 5 employee files. The 4 employees noted will receive TB testing within required administration guidelines. No residents were harmed during this finding.
2. On 8/20/26, DON acquired TB certification. All new hires will received TB testing by DON within required guidelines.
3. By 8/27/26, DON will be in-serviced for proper TB testing guidelines.
4. The Executive Director is responsible for sustained compliance. The ED, or designee, will review TB testing timelines for all new hires; weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.
5. 9/10/26.

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15.

CNA 4 was hired on 10/21/25.
Her first step TB test was
administered on 10/15/26 by RN
11 and read on 10/17/25 by RN
11.

Employee files for RN 11, RN
15, and the DON lacked TB
administration certification.

Interview on 8/10/26 at 10:18
A.M., the Director of Nursing
(DON) indicated nurses
administering and reading the
TB tests were not certified to do
so and the facility was unaware
they were required to be
certified.

On 8/10/26 at 12:01 P.M., the
Administrator provided a current
Tuberculosis policy, dated
12/1/22, that indicated "The
Community will conduct TB
testing and screenings for all its
employees and residents
according to State regulations".

The article, "Clinical Testing
Guidance for Tuberculosis:
Tuberculin Skin Test," dated
1/31/25, was retrieved on
8/10/26 from the Centers of
Disease Control (CDC) website
at
[https://www.cdc.gov/tb/hcp/testi
ng-diagnosis/tuberculin-skin-test
.html](https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html). The guidance included:
"The TB skin test should be
placed (administered) and read
by a designated, trained health

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

FORM APPROVED

OMB NO. 0938-0391

care provider. Consult with your state and local public health authorities to determine who is authorized to place and read TB skin tests in your state".

This citation related to Intake 466947.

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
SIGNATURET.J. Bates

TITLEExecutive Director

(X6) DATE08/24/2026