STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF NEWBURGH	5311 ROSEBUD LANE, 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 an Initial State Residential Licensure Survey. This visit included the Investigation of Residential Complaint IN00454973. Complaint IN00454973- State deficiencies related to the allegations are cited at R0026, R0033, R0095, R0119, R0121, R0144, R0217, R0273, R0298, R0409, Survey dates: March 11, 12, 13, 14, 2025. Facility number: 016891 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 20, 2025.	R 0000	The submission of this plan of correction does not indicate an admission by Celebration Villa of Newburgh that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Celebration Villa of Newburgh. The community hereby maintains it is in substantial compliance with the requirements of participation for Residential Care Facilities. Please accept this plan of correction as the credible allegation of compliance with all state and federal requirements governing the management of this facility.	
R 0026	Residents' Rights - Noncompliance	R 0026	Resident Rights. It is the policy of	04/14/2025

	410 IAC 16.2-5-1.2(a) (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to ensure a copy of resident rights were posted in a publicly accessible area for 2 of 4 days of the survey, failed to inform residents of their resident rights. Resident records contained no documentation that signified the residents received a list of resident rights, in writing, for 7 of 7 residents		Celebration Villa of Newburgh to have a copy of Resident rights Poster posted in the community in a publicly accessible area. A copy of the residents' rights poster typed in 12 font was ordered but was not able to be delivered in time during the timeframe of the initial certification of licensure. The Resident Rights poster has arrived and has been hung in the main entrance of the community satisfying the requirement to be available in a publicly accessible area. Resident rights are included in the newly updated Residential admissions agreement which was updated in March 2025. Residents prior to initial licensure certification had independent living agreements, which do not require resident rights notification. Admission agreement for all new move ins have been updated to residential Assisted living agreements which include notification of residents' rights. All residents had the potential to be affected. ensure that the deficient practice does not recur. A copy of the purchase receipt showing the residents' rights poster had been ordered was given to the survey team. The Resident Rights poster arrived after the initial certification survey and has been hung in the main entrance of the community satisfying the requirement to be available in a publicly accessible	

	reviewed for resident rights. (Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H) Findings include: 1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. Resident F's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. Resident H's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 5. During the survey on March 11 and 12 2025, the facility was observed to lack resident rights posted in 12-font in a publicly		area. Admission agreements for all new move ins have been updated to residential AL agreements which include resident rights. The ED or designee will monitor that the Resident Rights poster is located in the main entrance of the community twice a week for 4 weeks then monthly thereafter indefinitely. Resident rights poster that was ordered arrived after the initial certification survey and has been hung in the main entrance of the community satisfying the requirement to be available in a publicly accessible area. The ED or designee will audit each new move in admissions agreement to verify the notification of residents' rights are part of the admission agreement. The ED or designee will monitor that the resident rights poster is located at the main entrance of the community twice a week for 4 weeks then monthly thereafter indefinitely.	

accessible area.

On 3/12/25 at 2:02 P.M., the Interim Administrator indicated he noticed when he came to the facility that resident rights and advocacy agencies were not posted in the facility, he was working on it, but needed to find out who the Ombudsman was.

6. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no signed list of resident rights that indicated the resident had been informed of their rights.

7. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no signed list of resident rights that indicated the resident had been informed of their rights.

8. During record review on 3/12/25 at 10:15 A.M., Resident E's record contained no signed list of resident rights that indicated the resident had been informed of their rights.

During an interview on 3/13/25 at 9:15 A.M., the Interim Facility Administrator indicated that no resident rights acknowledgments had been signed by the residents.

On 3/14/25 at 2:20 P.M., Regional Nurse 3 supplied an undated facility policy titled, Protecting and Ensuring Resident Rights. The policy

	included, "Residents will be informed of resident rights in writing... The resident will sign a form acknowledging the receipt of these rights prior to admission..." On 3/14/25 at 3:20 P.M., the Regional Nurse 3 provided an undated procedure for protecting and ensuring resident rights. The procedure guide included but was not limited to: ...5. The list of resident rights will be available for residents to review at any time... No specific policy was provided related to posting of resident rights in a publicly accessible area. This citation relates to complaint IN00454973. Based on observation, interview, and record review, the facility failed to ensure a copy of resident rights were posted in a publicly accessible area for 2 of 4 days of the survey, failed to inform residents of their resident rights. Resident records contained no documentation that signified the residents received a list of resident rights, in writing, for 7 of 7 residents reviewed for resident rights. (Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H)			

Findings include:

1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. Resident F's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. Resident H's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

5. During the survey on March 11 and 12 2025, the facility was observed to lack resident rights posted in 12-font in a publicly accessible area.

On 3/12/25 at 2:02 P.M., the Interim Administrator indicated he noticed when he came to the facility that resident rights and

	advocacy agencies were not posted in the facility, he was working on it, but needed to find out who the Ombudsman was. 6. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no signed list of resident rights that indicated the resident had been informed of their rights. 7. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no signed list of resident rights that indicated the resident had been informed of their rights. 8. During record review on 3/12/25 at 10:15 A.M., Resident E's record contained no signed list of resident rights that indicated the resident had been informed of their rights. During an interview on 3/13/25 at 9:15 A.M., the Interim Facility Administrator indicated that no resident rights acknowledgments had been signed by the residents.			

	On 3/14/25 at 2:20 P.M., Regional Nurse 3 supplied an undated facility policy titled, Protecting and Ensuring Resident Rights. The policy included, "Residents will be informed of resident rights in writing... The resident will sign a form acknowledging the receipt of these rights prior to admission..." On 3/14/25 at 3:20 P.M., the Regional Nurse 3 provided an undated procedure for protecting and ensuring resident rights. The procedure guide included but was not limited to: ...5. The list of resident rights will be available for residents to review at any time... No specific policy was provided related to posting of resident rights in a publicly accessible area. This citation relates to complaint IN00454973. Based on observation, interview, and record review, the facility failed to ensure a copy of resident rights were posted in a publicly accessible area for 2 of 4 days of the survey, failed to inform residents of their resident rights. Resident records contained no documentation that signified the residents received a list of resident rights, in writing, for 7 of 7 residents reviewed for resident rights.			

	(Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, Resident H) Findings include: 1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. Resident F's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. Resident H's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights. 4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.			

	5. During the survey on March 11 and 12 2025, the facility was observed to lack resident rights posted in 12-font in a publicly accessible area. On 3/12/25 at 2:02 P.M., the Interim Administrator indicated he noticed when he came to the facility that resident rights and advocacy agencies were not posted in the facility, he was working on it, but needed to find out who the Ombudsman was. 6. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no signed list of resident rights that indicated the resident had been informed of their rights. 7. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no signed list of resident rights that indicated the resident had been informed of their rights. 8. During record review on 3/12/25 at 10:15 A.M., Resident E's record contained no signed list of resident rights that indicated the resident had been informed of their rights. During an interview on 3/13/25 at 9:15 A.M., the Interim Facility Administrator indicated that no resident rights acknowledgments had been signed by the residents. On 3/14/25 at 2:20 P.M.,			

	Regional Nurse 3 supplied an undated facility policy titled, Protecting and Ensuring Resident Rights. The policy included, "Residents will be informed of resident rights in writing... The resident will sign a form acknowledging the receipt of these rights prior to admission..." On 3/14/25 at 3:20 P.M., the Regional Nurse 3 provided an undated procedure for protecting and ensuring resident rights. The procedure guide included but was not limited to: ...5. The list of resident rights will be available for residents to review at any time... No specific policy was provided related to posting of resident rights in a publicly accessible area. This citation relates to complaint IN00454973. Based on observation, interview, and record review, the facility failed to ensure a copy of resident rights were posted in a publicly accessible area for 2 of 4 days of the survey, failed to inform residents of their resident rights. Resident records contained no documentation that signified the residents received a list of resident rights, in writing, for 7 of 7 residents reviewed for resident rights. (Resident B, Resident C,			

Resident D, Resident E, Resident F, Resident G, Resident H)

Findings include:

1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. Resident F's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. Resident H's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G's clinical record contained no signed list of resident rights that indicated the resident had been informed of their rights.

5. During the survey on March 11 and 12 2025, the facility was observed to lack resident rights posted in 12-font in a publicly accessible area.

	On 3/12/25 at 2:02 P.M., the Interim Administrator indicated he noticed when he came to the facility that resident rights and advocacy agencies were not posted in the facility, he was working on it, but needed to find out who the Ombudsman was. 6. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no signed list of resident rights that indicated the resident had been informed of their rights. 7. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no signed list of resident rights that indicated the resident had been informed of their rights. 8. During record review on 3/12/25 at 10:15 A.M., Resident E's record contained no signed list of resident rights that indicated the resident had been informed of their rights. During an interview on 3/13/25 at 9:15 A.M., the Interim Facility Administrator indicated that no resident rights acknowledgments had been signed by the residents. On 3/14/25 at 2:20 P.M., Regional Nurse 3 supplied an undated facility policy titled, Protecting and Ensuring Resident Rights. The policy included, "Residents will be informed of resident rights in			

	writing... The resident will sign a form acknowledging the receipt of these rights prior to admission..." On 3/14/25 at 3:20 P.M., the Regional Nurse 3 provided an undated procedure for protecting and ensuring resident rights. The procedure guide included but was not limited to: ...5. The list of resident rights will be available for residents to review at any time... No specific policy was provided related to posting of resident rights in a publicly accessible area. This citation relates to complaint IN00454973.			
R 0033	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(h)(1-2) (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of	R 0033	It is the policy of Celebration villa of Newburgh to have a posting (important contact information) with the names of advocating agencies and their respective phone numbers/ state agencies contact information, including the department, local ombudsman, APS, and other agencies. The important numbers posting was posted in the main entrance located in publicly accessible area during the initial certification of licensure and a copy given to the survey team. All residents had the potential to be	04/01/2025

	family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure information for contacting advocacy agencies was posted in an area accessible to residents for 2 of 4 days of the survey. Finding includes: During the survey on March 11 and 12 2025, the facility was observed to lack posting of advocacy agencies in an area accessible to residents. On 3/12/25 at 2:02 P.M., the Interim Administrator indicated he noticed when he came to the facility that resident rights and advocacy agencies were not posted in the facility, he was working on it, but needed to find out who the Ombudsman was. No specific policy was provided related to posting advocacy		affected. The important numbers to know posting was posted in the main entrance during the time of the survey. The ED or designee will monitor that the important contact information is located in the main entrance of the community twice a week for 4 weeks then monthly thereafter.	

	agencies in an area accessible to residents. This citation relates to complaint IN00454973. Based on observation and interview, the facility failed to ensure information for contacting advocacy agencies was posted in an area accessible to residents for 2 of 4 days of the survey. Finding includes: During the survey on March 11 and 12 2025, the facility was observed to lack posting of advocacy agencies in an area accessible to residents. On 3/12/25 at 2:02 P.M., the Interim Administrator indicated he noticed when he came to the facility that resident rights and advocacy agencies were not posted in the facility, he was working on it, but needed to find out who the Ombudsman was. No specific policy was provided related to posting advocacy agencies in an area accessible to residents. This citation relates to complaint IN00454973.			
R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2)	R 0095	As of 4/3/2025, Care Giver 2 has been removed from the position of Dementia Care Director.	04/14/2025

	(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. Based on interview and record review the facility failed to ensure a dementia director was provided with an earned degree for the 1 of 1 locked dementia care unit. The locked dementia		All residents had the potential to be affected. A licensed administrator is now assigned to the Demetia care Director role, to oversee the department. A qualified individual meeting the requirements of IC 12-10-5.5 has been identified and appointed as the Dementia Care Director as of 4/4/2025. A formal policy has been established outlining the qualifications and training requirements for the Dementia Care Director position. See attachment. Training logs and personnel files will be reviewed monthly to verify adherence to training requirements. All corrective actions will be fully implemented by 4/14/2025. The facility will remain in compliance through ongoing monitoring and oversight indefinitely.	

	care unit had a non degreed staff in charge. (Dementia Care Unit) Finding includes: On 3/12/25 at 11:14 A.M., the locked dementia care unit was observed. Care Giver 2 indicated she was in charge of the dementia care unit. Care Giver 2 was listed on the employee records roster under the title of Dementia Care Director. On 3/14/25 at 1:44 P.M., the Regional Nurse 3 indicated the Director Of Nursing Services (DON) was acting as the Dementia Care Director, Care Giver 2 was the coordinator not the director. The DON was a Licensed Practical Nurse. The Regional Director Of Clinical Services indicated the facility had no policy, they followed the state guidelines related to having a director over the dementia care unit. This citation relates to complaint IN00454973. Based on interview and record review the facility failed to ensure a dementia director was provided with an earned degree for the 1 of 1 locked dementia care unit. The locked dementia care unit had a non degreed staff in charge. (Dementia Care Unit)			

	Finding includes: On 3/12/25 at 11:14 A.M., the locked dementia care unit was observed. Care Giver 2 indicated she was in charge of the dementia care unit. Care Giver 2 was listed on the employee records roster under the title of Dementia Care Director. On 3/14/25 at 1:44 P.M., the Regional Nurse 3 indicated the Director Of Nursing Services (DON) was acting as the Dementia Care Director, Care Giver 2 was the coordinator not the director. The DON was a Licensed Practical Nurse. The Regional Director Of Clinical Services indicated the facility had no policy, they followed the state guidelines related to having a director over the dementia care unit. This citation relates to complaint IN00454973.			
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:	R 0119	An audit was conducted of all employee files to ensure that all staff were in compliance with the 2 step TB test requirements upon hire. The 2 step TB test method was initiated for all employees who were not in compliance with this requirement. All employees and all new employees will receive the 2 step TB test upon hire and prior to working in the facility.	04/14/2025

	(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; (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.		The DON or designee will create a binder to track all TB tests and to track when annual screenings are due. The DON or designee will audit this binder on a monthly basis indefinitely.	

Based on interview and record review, the facility failed to ensure staff received tuberculosis (TB) testing at the time of hire for 4 of 5 staff reviewed. No documentation of TB testing was included in employee files. (QMA 5, QMA 7, CNA 8, and Culinary Aide 3)

Findings include:

1. During a review of employee files on 3/14/25 at 11:15 A.M.,Qualified Medication Aide (QMA) 5's employee file indicated the employees hire date was 12/16/24. No TB testing documentation was included in the employee's file.

2. During a review of employee files on 3/14/25 at 11:15 A.M., QMA 7's employee file indicated the employees hire date was 1/24/25. No TB testing documentation was included in the employee's file.

3. During a review of employee files on 3/14/25 at 11:15 A.M., Certified Nursing Assistant (CNA) 8's employee file indicated the employees hire date was 1/20/25. No TB testing documentation was included in the employee's file.

4. During a review of employee files on 3/14/25 at 11:15 A.M., Culinary Aide 3's employee file indicated the employees hire

	date was 11/18/24. No TB testing documentation was included in the employee's file. During an interview on 3/14/25 at 11:25 A.M., Regional Nurse 3 indicated TB testing had not yet been completed for recently hired staff. On 3/14/25 at 2:20 P.M., Regional Nurse 3 supplied an undated facility policy, titled Mantoux Testing Policy. The policy indicated, "All new employees will have a two-step Mantoux test for tuberculosis." This citation relates to complaint IN00454973. Based on interview and record review, the facility failed to ensure staff received tuberculosis (TB) testing at the time of hire for 4 of 5 staff reviewed. No documentation of TB testing was included in employee files. (QMA 5, QMA 7, CNA 8, and Culinary Aide 3) Findings include: 1. During a review of employee files on 3/14/25 at 11:15 A.M.,Qualified Medication Aide (QMA) 5's employee file indicated the employees hire date was 12/16/24. No TB testing documentation was included in the employee's file. 2. During a review of employee files on 3/14/25 at 11:15 A.M.,			

	QMA 7's employee file indicated the employees hire date was 1/24/25. No TB testing documentation was included in the employee's file. 3. During a review of employee files on 3/14/25 at 11:15 A.M., Certified Nursing Assistant (CNA) 8's employee file indicated the employees hire date was 1/20/25. No TB testing documentation was included in the employee's file. 4. During a review of employee files on 3/14/25 at 11:15 A.M., Culinary Aide 3's employee file indicated the employees hire date was 11/18/24. No TB testing documentation was included in the employee's file. During an interview on 3/14/25 at 11:25 A.M., Regional Nurse 3 indicated TB testing had not yet been completed for recently hired staff. On 3/14/25 at 2:20 P.M., Regional Nurse 3 supplied an undated facility policy, titled Mantoux Testing Policy. The policy indicated, "All new employees will have a two-step Mantoux test for tuberculosis." This citation relates to complaint IN00454973.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4)	R 0121	An audit of employee files was conducted for all staff to identify	04/14/2025

	(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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health		that staff received documented job specific training. Current employees along with all new employees will receive job specific orientation/training as required. DON/designee will conduct job specific training for current employees twice weekly for one month to ensure completion and documentation of the required training. All new employees will receive job specific orientation/training upon hire. DON/designee will monitor employee files monthly indefinitely to ensure that all required orientation/training has been completed, and compliance is maintained. Any further monitoring will be discussed with the QA committee to determine further action as necessary.	

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 interview and record review, the facility failed to ensure new hired staff received job specific orientation for 4 of 5 staff reviewed. No documentation of job specific orientation was included in the employee files. (QMA 5, QMA 7, CNA 8, and Culinary Aide 3)

Findings include:

1. During a review of employee files on 3/14/25 at 11:15 A.M., QMA 5's employee file indicated the employees hire date was 12/16/24. QMA 5's file included no documentation of job specific orientation.

2. During a review of employee files on 3/14/25 at 11:16 A.M., Qualified Medication Aide (QMA) 7's employee file indicated the employees hire date was 1/24/25. QMA 7's file included no documentation of job specific orientation.

3. During a review of employee files on 3/14/25 at 11:17 A.M., Certified Nursing Assistant (CNA) 8's employee file indicated the employees hire

	date was 1/20/25. CNA 8's file included no documentation of job specific orientation. 4. During a review of employee files on 3/14/25 at 11:18 A.M., Culinary Aide 3's employee file indicated the employees hire date was 11/18/24. Culinary Aide 3's file included no documentation of job specific orientation. During an interview on 3/14/25 at 11:27 A.M., Regional Nurse 3 indicated the staff members did not have any documentation of job specific orientation following their hire date. On 3/14/25 at 1:40 P.M., Regional Nurse 3 supplied an undated facility policy, titled New-Hire Orientation Process. The policy indicated, "...All state mandatory training's must be completed within the required time outlined by law... New hires will be scheduled to attend a general orientation meeting within the first 30 days of employment..." This citation relates to complaint IN00454973. Based on interview and record review, the facility failed to ensure new hired staff received job specific orientation for 4 of 5 staff reviewed. No documentation of job specific orientation was included in the employee files. (QMA 5, QMA 7,			

CNA 8, and Culinary Aide 3)

Findings include:

1. During a review of employee files on 3/14/25 at 11:15 A.M., QMA 5's employee file indicated the employees hire date was 12/16/24. QMA 5's file included no documentation of job specific orientation.

2. During a review of employee files on 3/14/25 at 11:16 A.M., Qualified Medication Aide (QMA) 7's employee file indicated the employees hire date was 1/24/25. QMA 7's file included no documentation of job specific orientation.

3. During a review of employee files on 3/14/25 at 11:17 A.M., Certified Nursing Assistant (CNA) 8's employee file indicated the employees hire date was 1/20/25. CNA 8's file included no documentation of job specific orientation.

4. During a review of employee files on 3/14/25 at 11:18 A.M., Culinary Aide 3's employee file indicated the employees hire date was 11/18/24. Culinary Aide 3's file included no documentation of job specific orientation.

During an interview on 3/14/25 at 11:27 A.M., Regional Nurse 3 indicated the staff members did not have any documentation of job specific orientation following

	their hire date. On 3/14/25 at 1:40 P.M., Regional Nurse 3 supplied an undated facility policy, titled New-Hire Orientation Process. The policy indicated, "...All state mandatory training's must be completed within the required time outlined by law... New hires will be scheduled to attend a general orientation meeting within the first 30 days of employment..." This citation relates to complaint IN00454973.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. 3. During an observation on 3/11/25 at 10:44 A.M., windows in the stairwell between the second floor and third floor had dust and debris built up on the screen and a black/brown substance build up at the base of the window. Upon entering the third floor hall, the window at the end of the hall had a build up of a black/brown substance at the base of the window, the wall paper was peeling off under	R 0144	As of 3/17, all laundry rooms have been deep cleaned, including removal of debris from washers, dryers, and utility sinks. Windows, stairwells, and common areas have been thoroughly cleaned. Peeling wallpaper has been repaired, and the stained ceiling tile has been replaced. All residents had the potential to be affected, all common washers and dryers have been cleaned and sanitized and all areas have been cleaned and repairs made. A revised cleaning schedule has been implemented, ensuring that all hallways, stairwells, and	03/17/2025

	the window sill, and a ceiling tile at the end of the hall near a sprinkler head had a brown water stain. During an observation on 3/12/25 at 2:00 P.M., windows in the stairwell between the second floor and third floor had dust and debris built up on the screen and a black/brown substance build up at the base of the window. Upon entering the third floor hall, the window at the end of the hall had a build up of a black/brown substance at the base of the window, the wall paper was peeling off under the window sill, and a ceiling tile at the end of the hall near a sprinkler head had a brown water stain. 4. During an interview on 3/12/25 at 2:10 P.M., Resident J indicated the housekeeping staff did not often clean the third floor halls as there were only two residents living on the third floor. Staff indicated to the resident the day prior (3/11/25) that they would vacuum the resident's room, however they never returned to do so. Resident J indicated she had picked debris from the 300 hall herself. During an interview on 3/14/25 at 10:05 A.M., Housekeeper 11 indicated resident hall should be cleaned two times a week and that there were no outlets in the halls, so staff would vacuum		laundry rooms are cleaned. High-traffic and low-occupancy areas will receive equal attention to maintain facility-wide cleanliness. Cleaning schedules have been posted in housekeeping areas for staff reference and accountability. The Administrator and Maintenance Director will conduct weekly inspections of all common areas indefinitely to ensure compliance. Housekeeping supervisors will perform daily rounds and document the condition of the facility indefinitely. By what date the systematic changes will be completed. Immediately.	

	parts of the hallways as they vacuumed the resident rooms. Housekeeper 11 indicated she was the only housekeeper on duty on the main part of the building and that another housekeeping staff member was on duty on the locked dementia unit. During an interview on 3/14/25 at 10:10 A.M., the Maintenance Director indicated that he observed the peeling wall paper and stained ceiling tile on the third floor but had not been aware of them prior to the survey. On 3/14/25 at 2:20 P.M., the Regional Nurse 3 provided an undated procedure guide for cleaning of common areas. The procedure guide included, but was not limited to: 1. All staff and residents are responsible for seeing that the common areas are cleaned and neat. 2. The following schedule will be maintained: ...Hallways 2 times per week, ...Laundry 3 times per week...3. Any area will be cleaned if found dirty, even if it is not the specific day for cleaning that area... A piece of paper provided on the same date and time had typed " LAUNDRY ROOM CLEANING SCHEDULE EVERY MONDAY, WEDNESDAY AND FRIDAY"			

This citation relates to complaint IN00454973.

Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment for 4 of 4 days observed. Laundry rooms had debris build up on washers and dryers, utility sink, stairwells and halls had debris built up on windows, wall paper peeling on walls, stained ceiling tile. (Resident J, 300 Unit, 200 and 300 Stairwell, 100 Unit Laundry Room, 200 Unit Laundry Room)

Findings include:

1. On 3/11/25 at 10:31 A.M., the 200 unit laundry room was observed to have debris built up under the lid, around the rim under the lid, the top of two washers. The dryer on the left side of washers had debris built up around the control panel. The utility sink had debris built up around the faucets.

2. On 3/11/25 at 10:45 A.M., the 100 unit laundry room two washers were observed to have debris built up under the lid, around the rim under the lid, the top of washers. The dryer on the right side of the washers had debris built up around the control panel. The utility sink had debris built up around the faucets.

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On 3/14/25 at 2:20 P.M., the Regional Nurse 3 provided an undated procedure guide for cleaning of common areas. The procedure guide included, but was not limited to: 1. All staff and residents are responsible for seeing that the common areas are cleaned and neat. 2. The following schedule will be maintained: ...Hallways 2 times per week, ...Laundry 3 times per week...3. Any area will be cleaned if found dirty, even if it is not the specific day for cleaning that area...

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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	R 0217	An audit was conducted to ensure that physician orders were current and accurate. All nursing staff were inserviced on following physician orders including proper documentation practices regarding obtaining and documenting monthly weights timely and as ordered by the physician. The DON/designee will conduct monthly audits indefinitely to ensure completion and to ensure that compliance is maintained.	04/14/2025

	or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 3. During record review on 3/11/25 at 2:00 P.M., Resident B's record included physician orders of monthly weights and monthly vital signs (started 10/1/24). Resident B's Medication Administration Record (MAR) for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained. Resident B's last documented weight was dated 11/4/24. 4. During record review on 3/12/25 at 9:45 A.M., Resident D's record included physician			

orders of monthly weights and monthly vital signs (started 10/2/24).

Resident D's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights were obtained, and no vital signs were obtained January and February, 2025.

Resident D's last documented weight was dated 7/10/24.

5. During record review on 3/12/25 at 10:15 A.M., Resident E's record included physician orders of monthly weights and monthly vital signs (started 10/2/24).

Resident E's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained.

Resident E's last documented weight was dated 9/19/24.

No policy was provided related to following physicians orders.

This citation relates to complaint IN00454973.

Based on interview and record review, the facility failed to ensure orders were followed for 5 of 7 residents reviewed for physicians orders. (Resident B, Resident C, Resident D,

Resident E, Resident G)

Findings include:

1. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C admitted to the facility on 4/11/24. Current physicians orders were reviewed and included but were not limited to:

Monthly weights every evening shift starting on the 4th and ending on the 4th every month, order date 9/19/24.

Resident C's Electronic Medication Administration Record (EMAR) was reviewed for January, February, and March 2025. The weights were not recorded on the 4th of each month, the space was blank. No weights were found in the clinical record for those months.

2. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G admitted to the facility on 5/24/24 and discharged on 1/31/25. Current physicians orders were reviewed and included but were not limited to:

Monthly weights very day shift on the 1st and ending on the 1st every month, order date 9/19/24. The EMAR was reviewed for January 2025, no weights were recorded on the 1st of the month. No weights were found in the clinical record

	for January 2025. On 3/14/25 at at 10:12 A.M., Regional Nurse 3 indicated Resident C and Resident G did not have the monthly weights recorded in the clinical record. 3. During record review on 3/11/25 at 2:00 P.M., Resident B's record included physician orders of monthly weights and monthly vital signs (started 10/1/24). Resident B's Medication Administration Record (MAR) for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained. Resident B's last documented weight was dated 11/4/24. 4. During record review on 3/12/25 at 9:45 A.M., Resident D's record included physician orders of monthly weights and monthly vital signs (started 10/2/24). Resident D's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights were obtained, and no vital signs were obtained January and February, 2025.			

	Resident D's last documented weight was dated 7/10/24. 5. During record review on 3/12/25 at 10:15 A.M., Resident E's record included physician orders of monthly weights and monthly vital signs (started 10/2/24). Resident E's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained. Resident E's last documented weight was dated 9/19/24. No policy was provided related to following physicians orders. This citation relates to complaint IN00454973. Based on interview and record review, the facility failed to ensure orders were followed for 5 of 7 residents reviewed for physicians orders. (Resident B, Resident C, Resident D, Resident E, Resident G) Findings include: 1. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C admitted to the facility on 4/11/24. Current physicians orders were reviewed and included but were not limited to:			

Monthly weights every evening shift starting on the 4th and ending on the 4th every month, order date 9/19/24.

Resident C's Electronic Medication Administration Record (EMAR) was reviewed for January, February, and March 2025. The weights were not recorded on the 4th of each month, the space was blank. No weights were found in the clinical record for those months.

2. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G admitted to the facility on 5/24/24 and discharged on 1/31/25. Current physicians orders were reviewed and included but were not limited to:

Monthly weights very day shift on the 1st and ending on the 1st every month, order date 9/19/24. The EMAR was reviewed for January 2025, no weights were recorded on the 1st of the month. No weights were found in the clinical record for January 2025.

On 3/14/25 at at 10:12 A.M., Regional Nurse 3 indicated

Resident C and Resident G did not have the monthly weights recorded in the clinical record.

3. During record review on 3/11/25 at 2:00 P.M., Resident B's record included physician

	orders of monthly weights and monthly vital signs (started 10/1/24). Resident B's Medication Administration Record (MAR) for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained. Resident B's last documented weight was dated 11/4/24. 4. During record review on 3/12/25 at 9:45 A.M., Resident D's record included physician orders of monthly weights and monthly vital signs (started 10/2/24). Resident D's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights were obtained, and no vital signs were obtained January and February, 2025. Resident D's last documented weight was dated 7/10/24. 5. During record review on 3/12/25 at 10:15 A.M., Resident E's record included physician orders of monthly weights and monthly vital signs (started 10/2/24). Resident E's MAR for the months of January, February, and March, 2025 contained no documentation that monthly			

	weights or vital signs were obtained. Resident E's last documented weight was dated 9/19/24. No policy was provided related to following physicians orders. This citation relates to complaint IN00454973. Based on interview and record review, the facility failed to ensure orders were followed for 5 of 7 residents reviewed for physicians orders. (Resident B, Resident C, Resident D, Resident E, Resident G) Findings include: 1. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C admitted to the facility on 4/11/24. Current physicians orders were reviewed and included but were not limited to: Monthly weights every evening shift starting on the 4th and ending on the 4th every month, order date 9/19/24.			

Resident C's Electronic Medication Administration Record (EMAR) was reviewed for January, February, and March 2025. The weights were not recorded on the 4th of each month, the space was blank. No weights were found in the clinical record for those months.

2. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. Resident G admitted to the facility on 5/24/24 and discharged on 1/31/25. Current physicians orders were reviewed and included but were not limited to:

Monthly weights very day shift on the 1st and ending on the 1st every month, order date 9/19/24. The EMAR was reviewed for January 2025, no weights were recorded on the 1st of the month. No weights were found in the clinical record for January 2025.

On 3/14/25 at at 10:12 A.M., Regional Nurse 3 indicated

Resident C and Resident G did not have the monthly weights recorded in the clinical record.

3. During record review on 3/11/25 at 2:00 P.M., Resident B's record included physician orders of monthly weights and monthly vital signs (started 10/1/24).

Resident B's Medication

	Administration Record (MAR) for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained. Resident B's last documented weight was dated 11/4/24. 4. During record review on 3/12/25 at 9:45 A.M., Resident D's record included physician orders of monthly weights and monthly vital signs (started 10/2/24). Resident D's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights were obtained, and no vital signs were obtained January and February, 2025. Resident D's last documented weight was dated 7/10/24. 5. During record review on 3/12/25 at 10:15 A.M., Resident E's record included physician orders of monthly weights and monthly vital signs (started 10/2/24). Resident E's MAR for the months of January, February, and March, 2025 contained no documentation that monthly weights or vital signs were obtained.			

Resident E's last documented weight was dated 9/19/24.

No policy was provided related to following physicians orders.

This citation relates to complaint IN00454973.

Based on interview and record review, the facility failed to ensure orders were followed for 5 of 7 residents reviewed for physicians orders. (Resident B, Resident C, Resident D, Resident E, Resident G)

Findings include:

1. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. Resident C admitted to the facility on 4/11/24. Current physicians orders were reviewed and included but were not limited to:

Monthly weights every evening shift starting on the 4th and ending on the 4th every month, order date 9/19/24.

Resident C's Electronic Medication Administration Record (EMAR) was reviewed for January, February, and March 2025. The weights were not recorded on the 4th of each month, the space was blank. No weights were found in the clinical record for those months.

2. The clinical record for Resident G was reviewed on

	3/12/25 at 11:20 A.M. Resident G admitted to the facility on 5/24/24 and discharged on 1/31/25. Current physicians orders were reviewed and included but were not limited to: Monthly weights very day shift on the 1st and ending on the 1st every month, order date 9/19/24. The EMAR was reviewed for January 2025, no weights were recorded on the 1st of the month. No weights were found in the clinical record for January 2025. On 3/14/25 at at 10:12 A.M., Regional Nurse 3 indicated Resident C and Resident G did not have the monthly weights recorded in the clinical record.			
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 ensure food was stored and distributed in accordance with professional standards for food service safety during 2 of 2 kitchen	R 0273	During state visit, all food items have been removed from the floor and properly stored on designated shelving. Open food packages in the walk-in freezer have been discarded or appropriately sealed in airtight containers. The kitchen, including vents, ceiling tiles, and base of walls, has been deep cleaned and sanitized. All residents had the potential to be affected.	04/01/2025

	observations. Food packages were stored on the dry food storage room floor, food was open to air in the walk in freezer, dust and debris build up was observed on ceiling tiles and vents near food preparation areas and along the base of walls and floor corners, and hand hygiene was not completed during food service. Finding includes: During an observation on 3/11/25 at 8:45 A.M., a box of canned refried beans, a box of canned corn, a box of packaged pastries, a flat of canned applesauce, 2 flats of bottled juice, 6 cans of tomato soup, a box of yellow cake mix, and a box of non-dairy creamer were stored on the dry food storage floor. During an interview on 3/11/25 at 8:50 A.M., the dietary manager (DM) indicated food should not be stored on the floor. During an observation on 3/11/25 at 9:00 A.M., a box of ground beef patties and a box of sausage was open to air in the walk in freezer. During an observation on 3/11/25 at 9:05 A.M., the kitchen vents and ceiling tiles near a 3 compartment sink and above the food preparation areas and cook stove contained		The dietary manager will conduct weekly inspections to ensure compliance. All dietary staff received retraining on April 1, 2025 regarding proper food storage, sanitation, and hygiene practices, emphasizing state and local regulations. Specific training on hand hygiene compliance was conducted, and staff were required to demonstrate proper technique. Paper towel dispensers are now checked and refilled at the beginning of each shift to prevent hygiene lapses. The Administrator and Dietary Manager will perform random kitchen inspections twice weekly for the next 60 days to ensure continued compliance. Any violations will be addressed immediately with additional staff training or disciplinary action. Any further monitoring will be discussed with the QA committee monthly to determine further action as necessary.	

	a build up of dust and debris. Areas along the wall base and under the stove and oven also contained a build up of dust and debris. During an observation on 3/12/25 at 11:20 A.M., a box of ground beef patties and a box of sausage was open to air in the walk in freezer. The kitchen vents and ceiling tiles near a 3 compartment sink and above the food preparation areas and cook stove contained a build up of dust and debris. Areas along the wall base and under the stove and oven also contained a build up of dust and debris. During an observation of meal service on 3/12/25 at 11:27 A.M., Dietary Aide (DA) 15 entered the kitchen from the dining room door with a crumbled paper tissue and placed it in a trash can. Without performing hand hygiene, DA 15 approached the food preparation area, wiped his face with his hand, then poured a beverage into a Styrofoam cup and placed a lid on the cup. DA 15 then walked to an ice cream freezer and scooped ice cream into a Styrofoam container. DA 13 entered the kitchen and performed hand hygiene but could not dry hands due to the paper towel dispenser being empty. With wet hands, DA 13 approached the food service area and took a food tray to be			

	delivered. During an interview on 3/12/25 at 2:20 P.M., the DM indicated staff should clean daily and fill out a cleaning schedule. A copy of the cleaning schedule for the week of 3/3/25 was provided. Daily cleaning tasks were not completed according to the schedule, including sweeping and mopping the entire kitchen (not completed 3/8/25). On 3/14/25 at 10:15 A.M., Regional Nurse 3 supplied an undated facility policy titled, Food Safety and an undated policy titled Storage of Refrigerated and Dry Foods. The policies included, "...All food service staff will wash their hands upon entering the kitchen and when moving from one food prep area to another" and, "...Food being returned to storage... must be covered." This citation relates to complaint IN00454973. Based on observation, interview, and record review, the facility failed to ensure food was stored and distributed in accordance with professional standards for food service safety during 2 of 2 kitchen observations. Food packages were stored on the dry food storage room floor, food was open to air in the walk in freezer, dust and debris build up			

	was observed on ceiling tiles and vents near food preparation areas and along the base of walls and floor corners, and hand hygiene was not completed during food service. Finding includes: During an observation on 3/11/25 at 8:45 A.M., a box of canned refried beans, a box of canned corn, a box of packaged pastries, a flat of canned applesauce, 2 flats of bottled juice, 6 cans of tomato soup, a box of yellow cake mix, and a box of non-dairy creamer were stored on the dry food storage floor. During an interview on 3/11/25 at 8:50 A.M., the dietary manager (DM) indicated food should not be stored on the floor. During an observation on 3/11/25 at 9:00 A.M., a box of ground beef patties and a box of sausage was open to air in the walk in freezer.			

	During an observation on 3/11/25 at 9:05 A.M., the kitchen vents and ceiling tiles near a 3 compartment sink and above the food preparation areas and cook stove contained a build up of dust and debris. Areas along the wall base and under the stove and oven also contained a build up of dust and debris. During an observation on 3/12/25 at 11:20 A.M., a box of ground beef patties and a box of sausage was open to air in the walk in freezer. The kitchen vents and ceiling tiles near a 3 compartment sink and above the food preparation areas and cook stove contained a build up of dust and debris. Areas along the wall base and under the stove and oven also contained a build up of dust and debris. During an observation of meal service on 3/12/25 at 11:27 A.M., Dietary Aide (DA) 15 entered the kitchen from the dining room door with a crumbled paper tissue and placed it in a trash can. Without performing hand hygiene, DA 15 approached the food preparation area, wiped his face with his hand, then poured a beverage into a Styrofoam cup and placed a lid on the cup. DA 15 then walked to an ice cream freezer and scooped ice cream into a Styrofoam container. DA 13 entered the kitchen and			

	performed hand hygiene but could not dry hands due to the paper towel dispenser being empty. With wet hands, DA 13 approached the food service area and took a food tray to be delivered. During an interview on 3/12/25 at 2:20 P.M., the DM indicated staff should clean daily and fill out a cleaning schedule. A copy of the cleaning schedule for the week of 3/3/25 was provided. Daily cleaning tasks were not completed according to the schedule, including sweeping and mopping the entire kitchen (not completed 3/8/25). On 3/14/25 at 10:15 A.M., Regional Nurse 3 supplied an undated facility policy titled, Food Safety and an undated policy titled Storage of Refrigerated and Dry Foods. The policies included, "...All food service staff will wash their hands upon entering the kitchen and when moving from one food prep area to another" and, "...Food being returned to storage... must be covered." This citation relates to complaint IN00454973.			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall	R 0298	Education regarding pharmacy reviews was provided to all nursing staff.	04/14/2025

	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, interview, and record review, the facility failed to ensure a contracted pharmacist reviewed resident's medications every 60 days for 2 of 7 residents reviewed for pharmacy services. Residents who's medications were stored and administered by the facility did not have a pharmacy review every 60 days. (Resident C, Resident H) Findings include: 1. During an observation on 3/11/25 at 4:05 P.M., Resident C received medications administered by Qualified		All pharmacy reviews were submitted to the proper physicians for review and signatures obtained. Pharmacy reviews will be completed every 60 days as required and placed in a binder upon completion. The DON/designee will conduct an audit of pharmacy reviews on a monthly basis indefinitely to ensure completion and accuracy of orders.	

	Medication Assistant (QMA) 2. During record review on on 3/12/25 at 9:15 A.M., Resident C's physician orders did not include an order for the resident to administer medications per self. Resident C's admission date was 4/11/24. Resident C's records did not contain documentation of a pharmacy review during a review period that dated back to December, 2024. 2. During record review on 3/12/25 at 9:30 A.M., Resident H's physician orders did not include an order for the resident to administer medications per self. Resident H's admission date was 10/24/24. Resident H's records did not contain documentation of a pharmacy review during a review period that dated back to December, 2024. During an interview on 3/14/25 at 1:10 P.M., Regional Nurse 3 indicated the facility followed state rules and regulations regarding pharmacy services. During an interview on 3/14/25 at 2:30 P.M., Regional Nurse 3 indicated no pharmacy reviews had been completed due to the facility's pharmacy service not starting until January, 2025. This citation relates to complaint			

	IN00454973. Based on observation, interview, and record review, the facility failed to ensure a contracted pharmacist reviewed resident's medications every 60 days for 2 of 7 residents reviewed for pharmacy services. Residents who's medications were stored and administered by the facility did not have a pharmacy review every 60 days. (Resident C, Resident H) Findings include: 1. During an observation on 3/11/25 at 4:05 P.M., Resident C received medications administered by Qualified Medication Assistant (QMA) 2. During record review on on 3/12/25 at 9:15 A.M., Resident C's physician orders did not include an order for the resident to administer medications per self. Resident C's admission date was 4/11/24. Resident C's records did not contain documentation of a pharmacy review during a review period that dated back to December, 2024.			

	2. During record review on 3/12/25 at 9:30 A.M., Resident H's physician orders did not include an order for the resident to administer medications per self. Resident H's admission date was 10/24/24. Resident H's records did not contain documentation of a pharmacy review during a review period that dated back to December, 2024. During an interview on 3/14/25 at 1:10 P.M., Regional Nurse 3 indicated the facility followed state rules and regulations regarding pharmacy services. During an interview on 3/14/25 at 2:30 P.M., Regional Nurse 3 indicated no pharmacy reviews had been completed due to the facility's pharmacy service not starting until January, 2025. This citation relates to complaint IN00454973.			

R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview, and record review, the facility failed to ensure resident's had an annual health statement for 6 of 7 residents reviewed for annual health statements. (Resident C, Resident F, Resident G, Resident H, Resident B, Resident D) Findings include: 1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. The resident admitted to the facility on 11/6/24. The resident's record did not contain an annual health statement. 2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. The resident admitted to the facility on 10/14/25. The resident's record did not contain an annual health statement. 3. The clinical record for Resident C was reviewed on	R 0409	An audit was conducted to determine each resident requiring an annual health statement stating that the resident is free of communicable diseases. The annual health statements will be uploaded to the EHR. The DON/designee will ensure the receipt of the signed annual health statements for each new and existing residents indicating that they are free of communicable diseases upon admission and annually as required per regulations and will monitor monthly indefinitely to ensure compliance.	04/14/2025

3/12/25 at 9:25 A.M. The resident admitted to the facility on 4/11/24. The resident's record did not contain an annual health statement.

4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. The resident admitted to the facility on 5/24/24. The resident's record did not contain an annual health statement.

On 3/14/25 at 10:12 A.M., Regional Nurse 3 indicated Resident C and Resident F did not have an annual health statement in the clinical record.

On 3/14/25 at 1:32 P.M., the Regional Director Of Clinical Services indicated Resident G and Resident H did not have annual health statements in the clinical record.

5. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no declaration from the physician that the resident was free from communicable diseases.

6. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no declaration from the physician that the resident was free from communicable diseases.

On 3/14/25 at 1:44 P.M., the Regional Director Of Clinical Services indicated the facility

follows state guidelines for annual health statements.

This citation relates to complaint IN00454973.

Based on interview, and record review, the facility failed to ensure resident's had an annual health statement for 6 of 7 residents reviewed for annual health statements. (Resident C, Resident F, Resident G, Resident H, Resident B, Resident D)

Findings include:

1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. The resident admitted to the facility on 11/6/24. The resident's record did not contain an annual health statement.

2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. The resident admitted to the facility on 10/14/25. The resident's record did not contain an annual health statement.

3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. The resident admitted to the facility on 4/11/24. The resident's record did not contain an annual health statement.

4. The clinical record for Resident G was reviewed on

3/12/25 at 11:20 A.M. The resident admitted to the facility on 5/24/24. The resident's record did not contain an annual health statement.

On 3/14/25 at 10:12 A.M., Regional Nurse 3 indicated Resident C and Resident F did not have an annual health statement in the clinical record.

On 3/14/25 at 1:32 P.M., the Regional Director Of Clinical Services indicated Resident G and Resident H did not have annual health statements in the clinical record.

5. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no declaration from the physician that the resident was free from communicable diseases.

6. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no declaration from the physician that the resident was free from communicable diseases.

On 3/14/25 at 1:44 P.M., the Regional Director Of Clinical Services indicated the facility follows state guidelines for annual health statements.

This citation relates to complaint IN00454973.

Based on interview, and record review, the facility failed to

ensure resident's had an annual health statement for 6 of 7 residents reviewed for annual health statements. (Resident C, Resident F, Resident G, Resident H, Resident B, Resident D)

Findings include:

1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. The resident admitted to the facility on 11/6/24. The resident's record did not contain an annual health statement.

2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. The resident admitted to the facility on 10/14/25. The resident's record did not contain an annual health statement.

3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. The resident admitted to the facility on 4/11/24. The resident's record did not contain an annual health statement.

4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. The resident admitted to the facility on 5/24/24. The resident's record did not contain an annual health statement.

On 3/14/25 at 10:12 A.M., Regional Nurse 3 indicated

Resident C and Resident F did not have an annual health statement in the clinical record.

On 3/14/25 at 1:32 P.M., the Regional Director Of Clinical Services indicated Resident G and Resident H did not have annual health statements in the clinical record.

5. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no declaration from the physician that the resident was free from communicable diseases.

6. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no declaration from the physician that the resident was free from communicable diseases.

On 3/14/25 at 1:44 P.M., the Regional Director Of Clinical Services indicated the facility follows state guidelines for annual health statements.

This citation relates to complaint IN00454973.

Based on interview, and record review, the facility failed to ensure resident's had an annual health statement for 6 of 7 residents reviewed for annual health statements. (Resident C, Resident F, Resident G, Resident H, Resident B, Resident D)

Findings include:

1. The clinical record for Resident F was reviewed on 3/11/25 at 2:13 P.M. The resident admitted to the facility on 11/6/24. The resident's record did not contain an annual health statement.

2. The clinical record for Resident H was reviewed on 3/11/25 at 2:35 P.M. The resident admitted to the facility on 10/14/25. The resident's record did not contain an annual health statement.

3. The clinical record for Resident C was reviewed on 3/12/25 at 9:25 A.M. The resident admitted to the facility on 4/11/24. The resident's record did not contain an annual health statement.

4. The clinical record for Resident G was reviewed on 3/12/25 at 11:20 A.M. The resident admitted to the facility on 5/24/24. The resident's record did not contain an annual health statement.

On 3/14/25 at 10:12 A.M., Regional Nurse 3 indicated Resident C and Resident F did not have an annual health statement in the clinical record.

On 3/14/25 at 1:32 P.M., the Regional Director Of Clinical Services indicated Resident G and Resident H did not have

	annual health statements in the clinical record. 5. During record review on 3/11/25 at 2:00 P.M., Resident B's record contained no declaration from the physician that the resident was free from communicable diseases. 6. During record review on 3/12/25 at 9:45 A.M., Resident D's record contained no declaration from the physician that the resident was free from communicable diseases. On 3/14/25 at 1:44 P.M., the Regional Director Of Clinical Services indicated the facility follows state guidelines for annual health statements. This citation relates to complaint IN00454973.			

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