STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155818	A. BUILDING 00 B. WING	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEARTHSTONE HEALTH CAMPUS	3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This included the Investigation of Complaints IN00429061, IN00428485, and IN00428342. This visit was in conjunction with the Investigation of Complaints IN00429626 and IN00429701. Complaint IN00429061 - No deficiencies related to the allegations are cited. Complaint IN00428485 - No deficiencies related to the allegations are cited. Complaint IN00428342 - No deficiencies related to the allegations are cited. Complaint IN00429626 - No deficiencies related to the allegations are cited. Complaint IN00429701 - No deficiencies related to the allegations are cited. Survey dates: February 27, 28, 29, March, 1, 4, 5 and 6, 2024 Facility number: 012974 Provider number: 155818 AIM number: 201247830 Census Bed Type: SNF/NF: 23 SNF: 30 Residential: 41 Total: 94	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted March 6, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 28, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Nowacki	Executive Director	03/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Payor Type: Medicare: 17 Medicaid: 17 Other: 19 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 8, 2024.			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as			

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	practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy			

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	of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 3 of 4 residents reviewed for hospitalization and discharge. (Resident 39, Resident 63, Resident 64)	F 0623	F623 Notice of Transfer/DC 1. Residents 39, 63 and 64 were affected by this alleged deficient practice. Resident #39 was provided a copy from the previous discharge. Residents #63 and #64	03/28/2024

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	Findings include: 1. On 2/29/24 at 12:00 p.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis and acute respiratory failure. Resident 39's progress notes indicated the resident was sent to the hospital on 2/2/24, 1/7/24, 11/4/23 and 12/5/23. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 2. On 2/29/24 at 12:15 p.m., Resident 63's clinical record was reviewed. The diagnosis included, but was not limited to, acquired absence of right leg below knee. Resident 63's progress notes indicated the resident was sent to the hospital on 12/8/23. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 3. On 2/29/24 at 12:45 p.m., Resident 64's clinical record was reviewed. The diagnoses included, but were not limited to, dislocation of left shoulder joint and respiratory failure. Resident 64's progress notes indicated the resident was sent to the hospital on 12/13/23. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. During an interview on 3/4/24 at 1:59 p.m.,		are no longer residents at Hearthstone. 2. All like residents have the potential to be affected. Nurses and Interdisciplinary team were educated on providing the notice of transfer/discharge to the resident and resident representative. 3. As a measure of ongoing compliance, the DHS or designee will audit discharges for notice of transfer/discharge during clinical care meeting 3x a week x4 weeks, then weekly x2 months, then every other week x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Administrator 2 indicated there had been no documentation of the Notice of Transfer or Discharge forms having been provided to the resident and the resident representative for Resident 39, Resident 63, and Resident 64. On 3/5/24 at 1:28 p.m., Administrator 2 provided the facility policy, "Bed Hold Notification," with an approval date of 9/24/18, and indicated this was the policy currently being used by the facility. A review of the policy did not indicate sending a Notice of Transfer and Discharge form with the resident and resident representative when the resident was transferred to the hospital. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and			

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	(iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 2 of 4 residents reviewed for hospitalization. (Resident 39, Resident 64) Findings include: 1. On 2/29/24 at 12:00 p.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis and acute respiratory failure. Resident 39's progress notes indicated the resident was sent to the hospital on 2/2/24, 1/7/24, 11/4/23 and 12/5/23. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. 2. On 2/29/24 at 12:45 p.m., Resident 64's clinical record was reviewed. The diagnoses included, but were not limited to, dislocation of left shoulder joint and respiratory failure. Resident 64's progress notes indicated the resident was sent to the hospital on 12/13/23. The	F 0625	F625 Bed hold policy 1 1. Residents 39 and 64 were affected by this alleged deficient practice. Resident #39 was provided a copy from previous discharge. Resident #64 is no longer a resident at Hearthstone. 2 2. Like residents have the potential to be affected. Nurses were educated on providing the bed hold policy to the resident and resident representative. 3 3. As a measure of ongoing compliance, the DHS or designee will audit bed hold policies during clinical care meeting 3x a week x 4 weeks, then weekly x 2 months then every other week x3 months. 4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/28/2024

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	clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. During an interview on 3/4/24 at 1:59 p.m., Administrator 2 indicated there had been no documentation of the facility's bed-hold policy having been provided to the resident or the resident representative for Resident 39 and Resident 64. On 3/5/24 at 1:28 p.m., Administrator 2 provided the facility policy, "Bed Hold Notification," with an approved date of 9/24/18, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "... OVERVIEW: ... Before a nursing facility transfers a resident or a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration of the state bed hold policy ..." 3.1-12(a)(25) 3.1-12(a)(26)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to include the participation of the resident and the resident's representative in the development of a resident's care plan for 1 of 1 resident reviewed for care planning conferences. (Resident 8) Findings include: During a family interview on 2/28/24 at 12:31 p.m., Resident 8's family representative indicated they had not been invited to participate in any care planning conferences. On 3/4/24 at 10:36 a.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, toxic encephalopathy (a disturbance of brain function. It causes confusion, memory loss and coma in severe cases), atrial fibrillation (an irregular and fast heart beat), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce	F 0657	F657 Quarterly RFM's 1 1. Resident 8 was affected by alleged deficient practice. A resident first care plan meeting was held with resident #8 and her family. 2 2. All residents have the potential to be affected. A housewide audit was conducted for outdated resident care plan meetings; any outstanding meetings were scheduled and/or conducted per preference. The Director of Social Services was educated on the ~~resident the~~ resident first care plan meeting process. 3 3. As a measure ongoing compliance, the Director of Social Services will monitor the completion of quarterly resident first care conference meetings	03/28/2024

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	blood flow to the limbs), mild cognitive impairment, and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 12/22/23 indicated the resident had moderately impaired cognition. An Admission Resident First Meeting (care plan meeting), dated 9/26/23, indicated the resident's representative was not involved in the care plan conference. A review of the resident's clinical record indicated no other care plan meetings took place between 9/26/23 and 3/6/24. During an interview on 3/6/24 at 2:45 p.m. the Clinical Nurse Consultant indicated the resident did not have a quarterly care plan conference after admission because the facility did not have a Social Services Director when her care plan conference would have been due. On 3/6/24 at 3:25 p.m., the Administrator provided the facility policy, "Resident First Meeting Guidelines," revised 4/25/22, and indicated the policy was currently being used by the facility. A review of the policy indicated, "PURPOSE To facilitate communication and participation regarding the resident's plan of care, medical condition and care need between the resident, family, and family representative and care givers ... 3. Subsequent meetings ... should be conducted minimally quarterly ... 6. Director of Social Services or designee should send invitations to the resident and/or representative notifying them of the date and time of the conference as far in advance as possible ... 18. Resident/ Resident Representative to e-sign completed Resident First Observation if present ... 19. If the resident or		weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	representative is unable to attend ... a copy of the Meeting discussion may be communicated with them ..." 3.1-35(c)(2)(C)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident admitted to the facility without pressure-related skin impairment did not develop a pressure injury for 1 of 2 residents reviewed for pressure injuries. This deficient practice resulted in Resident 5 developing a facility acquired Stage 3 pressure ulcer on the left buttock. Findings include: During a continuous observation on 2/28/24 at 10:27 a.m. through 11:36 a.m., Resident 5 was observed sitting in wheelchair in her room. Resident 5's room was observed to have a urine odor.	F 0686	F686 Pressure Ulcers – G tag 1 1. Resident #5 was affected by alleged deficient practice. Resident #5 wound care plan was reviewed and updated, treatment plan updated and toileting patterns established. 2 2. Like residents have the potential to be affected. Nursing staff was educated on ~~the importance of~~ pressure ulcer prevention, assisting residents to the bathroom as needed, and pressure ulcer interventions. 3 3. As a measure of ongoing	03/28/2024

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	On 2/28/24 at 11:36 a.m., Certified Nursing Assistant (CNA) 1 was observed to enter Resident 5's room. CNA 1 placed Resident 5's sock on her foot; covered Resident 5's lap with a blanket; and assisted Resident 5 to the dining room for lunch. CNA 1 did not offer to assist Resident 5 to the bathroom or to reposition her prior to going to the dining room. During a continuous observation on 2/28/24 from 11:44 a.m. through 12:36 p.m., Resident 5 was observed to be in the dining room eating lunch. On 2/28/24 at 12:36 p.m., Resident 5's family member was observed to assist Resident 5 back to her room. On 2/28/24 from 12:42 p.m. until 12:57 p.m., Resident 5's family member was with Resident 5 in her room. At that time, Resident 5's family member indicated Resident 5 had a decline since receiving a left arm fracture after a fall. The family member indicated Resident 5 had developed a pressure ulcer to her "buttock". When she or other family members visit Resident 5, the resident would be incontinent of urine and her room had an urine odor. On 2/28/24 at 12:57 p.m., Resident 5 was observed to be assisted to bed by CNA 1. During a continuous observation on 3/1/24 from 9:44 a.m. through 11:44 a.m., Resident 5 was observed sitting in a wheelchair in her room. Resident 5's room was observed to have a urine odor. On 3/1/24 at 10:49 a.m., CNA 2 was observed to offer Resident 5 a baby doll. CNA 2 did not offer		compliance, the Director of Nursing or designee will conduct random pressure ulcer prevention audits on 3 residents weekly x 4 weeks, then on 3 residents every other week x 2 months, then on 3 residents monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to assist Resident 5 to the bathroom or to assist in repositioning her. On 3/1/24 at 11:00 a.m., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, Stage 3 (full thickness tissue loss) pressure ulcer to left hip, weakness, left humerus (a bone in the upper arm) fracture, pain, and congested heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/17/23, indicated Resident 5 had severe cognitive impairment; no upper and lower extremity impairment; required maximal assistance with toileting, sit to stand; required moderate assistance with rolling left and right in bed, sitting to lying position; was always incontinent of urine and bowel movements; and was at risk for skin breakdown. The Significant Change MDS assessment, dated 1/29/24, indicated Resident 5 had severe cognitive impairment; no upper and lower extremity impairment; required maximal assistance with toileting, roll left and right in bed, sit to stand, and sitting to lying position; was always incontinent of urine and bowel movements; and was at risk for skin breakdown. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 was at risk for skin breakdown. The interventions were to avoid shearing skin during positioning, turning, and transferring; encourage and assist to turn and reposition for comfort as needed; keep linens clean and dry; keep resident clean and dry as possible. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 had the potential for			

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	155818	A. BUILDING 00 B. WING	03/06/2024

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	decline in activities of daily living (ADLs). Her interventions were to provide incontinent care after each incontinence episode. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 had impairment with bed mobility, transfers, and toileting. She required extensive assistance with transfers, bed mobility, and toileting. The care plan, dated 2/22/19 and current through 6/12/24, indicated Resident 5 had episodes of incontinence. Her interventions were to offer and to assist with toileting as needed and/or per request and to provide incontinence care as needed. The care plan, dated 2/9/24 and current through 6/12/24, indicated Resident 5 had a pressure ulcer. The care plan lacked interventions to assist with repositioning or toileting resident. The care plan lacked any new interventions after Resident 5's decline in mobility from the left humerus fracture. The Quarterly Observation and Data Collection, dated 11/6/23 at 3:01 a.m., indicated Resident 5 was incontinent and the Braden Scale indicated she was at a moderate risk for skin breakdown. The clinical record lacked documentation of a Braden Scale Assessment after her fall with a left humerus fracture and her Significant Change MDS assessment. The Hospital Discharge Instructions, dated 1/21/24, indicated the diagnoses during Resident 5's Emergency Room visit were a fall and a left			

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	humeral fracture. The Progress Notes indicated the following: - On 1/22/24 at 2:16 a.m., Resident 5 returned the from emergency room. She had a left humeral fracture. - On 1/22/24 at 6:42 a.m., Resident 5 had a fall and was diagnosed with a left humerus fracture. The plan was for staff to assist with ADLs and mobility as needed. - On 1/22/24 at 11:09 a.m., the Interdisciplinary Team (IDT) note indicated Resident 5 had pain related to shoulder fracture. The note lacked any documentation of interventions for requiring more assistance since recent fall. - On 2/8/24 at 6:21 p.m., Resident 5 had a chronic wound on her left ischium. The wound was closed and had reopened. - On 2/16/24 at 12:22 p.m., Resident 5 had a pressure ulcer to left buttock. The care plan was reviewed and updated as needed. The Treatment Administration History indicated the following: - On 1/25/24, the weekly skin assessment indicated an old impairment. - On 2/1/24, the weekly skin assessment indicated unchanged. - On 2/8/24, the weekly skin assessment indicated an old impairment. The Wound Management Report dated 7/27/23 at 12:10 p.m., indicated Resident 5 had a Stage 2 pressure ulcer healed to left hip on 9/25/23 at 10:34 a.m., .			

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	The Wound Management Detail Report indicated the following: - On 2/8/24 at 10:24 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 3.5 centimeters (cm) length (l) by (X) 2.5 cm width (w) with granulation tissue. - On 2/9/24 at 10:26 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 3.5 cm l X 2.5 cm w with granulation tissue. - On 2/16/24 at 10:26 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 3.5 cm l X 2.5 cm w with granulation tissue. - On 2/21/24 at 11:17 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 4 cm l X 3 cm w with granulation tissue. - On 2/28/24 at 9:10 a.m., Resident 5 had a facility acquired Stage 3 pressure ulcer to her left buttock that measured 4cm l X 3 w with granulation tissue. On 3/1/24 at 11:44 a.m., Licensed Practical Nurse (LPN) 1 offered to take Resident 5 to the dining room. LPN 5 did not offer to assist Resident 5 to the bathroom or to reposition her prior to going to the dining room. On 3/1/24 11:44 a.m. through 12:40 p.m., Resident was in the dining room eating lunch. On 3/1/24 at 12:40 p.m., Resident 5 was assisted back to her room from lunch. At that time LPN 1, administered Resident 5 her medication. LPN 1 did not assist Resident 5 to the bathroom or assist in			

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	repositioning her. During a continuous observation on 3/1/24 from 12:40 p.m. through 12:55 p.m., Resident 5 was observed sitting in a wheelchair in her room. During this observation, no staff offered to assist Resident 5 to the bathroom or to assist with repositioning her. During a continuous observation from 3/1/24 from 1:00 p.m. through 1:51 p.m., Resident 5 was observed sitting in a wheelchair in her room. During this observation, no staff offered to assist Resident 5 to the bathroom or to assist with repositioning her. On 3/1/24 at 1:55 p.m., the Corporate Nurse Consultant indicated the clinical record lacked any Braden Scale Assessment completed since 11/6/23. On 3/4/24 at 10:30 a.m., Resident 5 was observed to be lying in bed. The Corporate Nurse was observed to remove the dressing on Resident 5's left buttock. The pressure ulcer was the size of a half dollar with a red center and white tissue surrounding the area. The Corporate Nurse indicated Resident 5's pressure ulcer was observed on her left buttock. She indicated Resident 5 had a history of pressure ulcer to her left buttock. On 3/4/24 at 10:33 a.m., LPN 2 indicated Resident 5 had a fall with a left arm fracture. Resident 5 required extensive assistance of 2 staff members with ADLs. She had a pressure ulcer to her left buttock. Her pressure ulcer interventions were a pressure relieving wheelchair cushion, a low-loss air mattress to her bed, and to turn and reposition every 2 hours while she is in the bed or chair. The			

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	facility had been working short-staffed. Some days it was difficult to get Resident 5 toileted and turned and repositioned. Some days it would be 4 hours before they could turn and reposition and toilet the residents. On 3/4/24 at 11:23 a.m., CNA 1 indicated Resident 5 had a fall with a fractured left arm and had a pressure ulcer to her left buttock. Resident 5's interventions were check and change and reposition every 2 hours and pressure relieving cushion in her wheelchair and bed. It had been challenging getting the residents checked, changed, and repositioned every 2 hours because they had been working short-staffed. On 3/5/24 at 10:18 a.m., the Corporate Nurse indicated the old impairments on the weekly skin assessments were not documented in the clinical record. On 3/5/24 at 2:04 p.m., Corporate Nurse Consultant indicated the last time Resident 5 had a pressure ulcer on left buttock was 7/27/23 and it was healed on 9/13/23. The pressure ulcer which healed on 9/25/23 at 10:34 a.m., was the same as left buttock. On 3/5/24 at 1:21 p.m., The Administrator provided the facility's policy, "Guidelines for Pressure Prevention," dated 12/31/23, and indicated it was the policy being used by the facility. A review of the policy indicated, "...Clean skin with premoistened wipes or periwash, rinse and dry thoroughly after incontinent episodes ...Keep skin clean, dry and free of body wastes, perspiration, and wound drainage ...Establish an individualized turning schedule if resident is immobile or compromised. Frequency of position change is individualized. Notify the nurse to document if the			

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	resident refuses turning intervention..." On 3/5/24 at 1:21 p.m., The Administrator provided the facility's policy, "Guidelines for General Wound and Skin Care," dated 12/31/23, and indicated it was the policy being used by the facility. A review of the policy indicated, "...2. Turn/reposition residents who are immobile according to their care plan requirements...8. Provide incontinence care promptly..." 3.1-40(a)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a sanitary environment for 4 of 7 days during the survey. Sit to stand lift foot platforms were not clean and resident rooms were not free from urine odor. (Room 212, Room 219, Room 219) Findings include: 1. On the following dates and times, a sit to stand lift was observed between rooms 108 and 110 with the foot platform containing food crumbs and debris: - On 2/28/24 at 11:37 a.m.; - On 3/1/24 at 1:21 p.m.; - On 3/4/24 at 10:45 a.m.; - On 3/5/24 at 9:15 a.m. On the following dates and times, a sit to stand lift was observed by Room 313 with the foot platform	F 0921	F921 Safe/comfortable environment crumbs on platform of sit/stand and urine odor in rooms 1 1 Residents #212, #219 and #220 were affected by alleged deficient practice. The platform of all sit to stand lifts were immediately cleaned. The carpets in rooms #212, #219 and #220 were shampooed. 2 2. All residents have the potential to be affected. A 100% audit of all of the stand up lifts was conducted to ensure they were free of debris. A 100% audit of all rooms was conducted to inspect for odor and corrections were made as needed. Staff was in-serviced on cleaning medical	03/28/2024

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	containing food crumbs and debris: - On 2/28/24 at 11:55 a.m.; - On 3/1/24 at 1:28 p.m.; - On 3/4/24 at 10:55 a.m.; - On 3/5/24 at 9:20 a.m. On the following dates and times, a sit to stand lift between Rooms 200 and 212 was observed with the foot platform contain food crumbs and debris: - On 2/28/24 at 2:49 p.m.; - On 3/1/24 at 1:25 p.m.; - On 3/4/24 at 10:50 a.m.; - On 3/5/24 at 9:25 a.m. On the following dates and times, a sit to stand lift by Room 207 was observed with the foot platform containing food crumbs and debris: - On 2/28/24 at 2:52 p.m.; - On 3/1/24 at 1:24 p.m.; - On 3/4/24 at 10:52 a.m.; - On 3/5/24 at 9:27 a.m. 2. On the following dates and times a strong urine odor was observed in Room 212: - On 2/28/24 at 2:50 p.m.; - On 3/1/24 at 1:26 p.m.; - On 3/4/24 at 10:51 a.m.; - On 3/5/24 at 9:26 a.m. On the following dates and times a strong urine odor was observed in Room 219: - On 2/28/24 at 2:53 p.m.; - On 3/1/24 at 1:25 p.m.; - On 3/4/24 at 10:53 a.m.; - On 3/5/24 at 9:28 a.m. On the following dates and times a strong urine odor was observed in Room 220: - On 2/28/24 at 2:53 p.m.; - On 3/1/24 at 1:25 p.m.;		equipment to avoid debris. Environmental services employees were inserviced proper cleaning of carpets and scheduled cleaning practices. 3 3. As a measure of ongoing compliance, the ED or designee will monitor for room odor weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months. As a measure of ongoing compliance, the ED or designee will monitor for debris on medical equipment weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	- On 3/4/24 at 10:53 a.m.; - On 3/5/24 at 9:28 a.m. During an interview on 3/5/24 at 10:17 a.m., the Executive Director indicated the sit to stand lift foot platforms were in need of cleaning, and Rooms 212, 219, and 220 each had an odor of urine. On 2/28/24 at 11:50 AM, the facility Executive Director provided the Resident Rights, dated 11/1/23 and indicated these were the resident rights currently used by the facility. A review of the Resident Rights indicated, "...the resident has the right to a safe, clean, comfortable and homelike environment..." 3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This included a Recertification and State Licensure Survey and the Investigation of Complaints IN00429061, IN00428342, and IN00428485. This visit was in conjunction with Investigation of Complaints IN00429626 and IN00429701. Complaint IN00429061 - No deficiencies related to the allegations are cited. Complaint IN00428342 - No deficiencies related to the allegations are cited. Complaint IN00428485 - No deficiencies related to the allegations are cited.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted March 6, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 28, 2024. The provider	

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	Complaint IN00429626 - No deficiencies related to the allegations are cited. Complaint IN00429701 - No deficiencies related to the allegations are cited. Survey dates: February 27, 28, 29, March, 1, 4, 5 and 6, 2024 Facility number: 012974 Residential Census: 41 These State Residential Finding are cited in accordance with 410 IAC 16.2-5.		respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (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.			

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	Based on observation and interview, the facility failed to ensure a copy of the residents' rights was available in a publicly accessible area, potentially affecting 15 of 15 residents who resided on the Legacy Neighborhood Unit. Findings include: On 3/5/24 at 3:15 p.m., no posting of the residents' rights was observed in the Legacy Neighborhood Unit. On 3/6/24 at 2:45 p.m., no posting of the residents' rights was observed in the Legacy Neighborhood Unit. During an interview on 3/6/24 at 2:55 p.m., the Director of the Legacy Neighborhood Unit indicated no copy of the residents' rights was posted in an area immediately accessible to residents on the Legacy Neighborhood Unit.	R 0026	R026 Resident Rights being posted 1 1.There were no adverse reactions to any residents. A residents right poster was posted in the assisted living and legacy neighborhood. 2 2. All residents have the potential to be affected. Staff education was provided on the location of resident rights. 3 3. As a measure of ongoing compliance, the ED or designee will monitor that poster remain in place. This will be conducted weekly x 4 weeks, then every other week x 2 months then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/28/2024
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (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			

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	telephone numbers of the following: (A) The department. (B) The office of the secretary of 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 the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service were posted in an area accessible to residents. This had the potential to affect 15 of 15 residents residing on the Legacy Neighborhood Unit. Findings include: On 3/5/24 at 3:15 p.m., no posting of the addresses or telephone numbers were observed in the Legacy Neighborhood Unit. On 3/6/24 at 2:45 p.m., no posting of the addresses or telephone numbers were observed in the Legacy Neighborhood Unit. During an interview on 3/6/24 at 2:55 p.m., the Director of the Legacy Neighborhood Unit indicated the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social	R 0033	R033 Advocacy numbers being posted 1 1. There were no adverse reactions to any residents. The advocacy numbers were posted in the assisted living and legacy neighborhood. 2 2.All residents have the potential to be affected. Staff education was provided on the location of the advocacy numbers. 3 3. As a measure of ongoing compliance, the ED or designee will monitor that poster remain in place. This will be conducted weekly x 4 weeks, then every other week x 2 months then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	03/28/2024

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	Services, the area agency on aging, the local mental health center, and adult protective service were not posted in an area immediately accessible to residents on the Legacy Neighborhood Unit. During an interview on 3/6/24 at 3:00 p.m., the Executive Director indicated the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service were not posted in an area immediately accessible to residents who resided on the Legacy Neighborhood Unit.		Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be			

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	155818	A. BUILDING 00 B. WING	03/06/2024

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HEARTHSTONE HEALTH CAMPUS	3043 NORTH LINTEL DRIVE BLOOMINGTON, IN 47404

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	documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to conduct a fire and disaster drill in conjunction with the local fire department at least every 6 months for 12 of 12 months of reviewed fire drills. Findings include: On 3/5/24 at 3:45 p.m., the Executive Director and the Director of Plant Operations (DPO) provided the last 12 months of fire drills which were conducted at the facility. They indicated they did not know the facility was to attempt to conduct a fire and disaster drill with the local fire department every 6 months. On 3/6/24 a review of the facility fire drills indicated no drills were conducted in conjunction with the local fire department. An undated "Fire Dept Tour," note indicated on 1/27/24 the fire department was invited to tour the Legacy building open house and breakfast. While the fire department was there, the ED took them on a tour of the riser rooms, the fire panels, and walked throughout both buildings. The note did not specify a fire and disaster drill was conducted during this visit. An undated, "Fire Department Response," note indicated on 4/27/23 the DPO was conducting his first fire drill on the campus. He was given codes which were for the Legacy building while he was conducting a drill on the separate health center building. The fire department showed up and they were unsure why they were called. While the fire department was there, they did a "sweep through" the building just for training purposes. The DPO	R 0092	R092 Inviting fire department to attend fire/disaster drills 2x a year 1 1.The local fire department was invited to the campus disaster drill. 2 2. The Director of plan operations was educated on inviting the local fire department to campus disaster drills twice a year. 3 3. As a measure of ongoing compliance, the ED or designee will monitor fire department invitations to disaster drills twice a year. This will be monitored monthly x 6 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/28/2024

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	later met with the Fire Chief to discuss previous responses before his tenure began at the facility. The note did not specify a fire and disaster drill was conducted during this visit. No additional fire drills nor notes indicated any fire and disaster drills were performed in conjunction with the local fire department. On 3/6/25 at 3:25 p.m., the Executive Director provided the facility policy, "Fire Drills," revised 9/13/18, and indicated it was the policy currently being used by the facility. A review of the policy did not include instruction for the facility to conduct a fire and disaster drill with the local fire department every 6 months.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of 1 employee with a current Cardiopulmonary Resuscitation (CPR) certification and First Aid (FA) certification was on each shift for 5 of 7 days reviewed. Findings include: On 3/6/24 at 11:45 a.m., the Executive Director (ED) provided the schedule for the week 2/28/24 through 3/5/24 and copies of CPR and FA certifications for the employees on the schedule for the week reviewed. A review of the nurses and certified nursing assistant's schedule, dated 2/28/24 through 3/5/24 indicated the following: - On 2/28/24, there were no staff members on third shift that were CPR certified. - On 2/29/24, there were no staff members on third shift that were CPR or FA certified. - On 3/1/24, there were no staff members on first shift that were CPR certified. - On 3/4/24, there were no staff members on first and third shift that were CPR certified. - On 3/4/24, there were no staff members on third shift that were FA certified. - On 3/5/24, there were no staff members on first, second, and third shift that were CPR certified. - On 3/5/24, there were no staff members on second and third shift that were FA certified. During an interview on 3/6/24 at 2:24 p.m., the ED indicated shifts on 2/28/24, 2/29/24, 3/1/24, 3/4/24, and 3/5/24 lacked staff with CPR or FA certifications.	R 0117	R117 CPR/First Aide 1 1. Nursing staff received CPR and first aid training and classes will occur on an as needed basis. 2 2. AP Payroll and Director of Nursing educated on the importance of maintaining and up to date list of employees with CPR and first aid training and scheduling a minimum one trained employee per shift. 3 3. As a measure of ongoing compliance, the ED or designee will monitor for daily coverage of CPR and first aid trained employees per shift weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/28/2024

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	On 3/6/24 at 3:30 p.m., the Administrator indicated the facility did not a FA or CPR certification policy.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure staff completed an evaluation for 2 of 7 residents reviewed for semiannual evaluations. (Residents 3, Resident 8) Findings include: 1. On 3/6/24 at 10:20 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and chronic kidney disease. A review of the resident's record indicated no semiannual evaluation was completed for the resident after 2/15/23. 2. On 3/6/24 at 10:27 a.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and hypothyroidism (an under active thyroid disorder). A review of the resident's record indicated no semiannual	R 0216	R216 Semi annual evals 1 1. Residents #3 and #8 were affected with no adverse reaction. Semi annual evaluations were completed as indicated. 2 2. All like residents were reviewed and semi annual evaluations were completed as indicated. Nurses were educated on semi annual evaluations. 3 3. As a measure of ongoing compliance, the DHS or designee will monitor completion of semi annual evaluations weekly x 4 weeks, then every other week x 2 months then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any	03/28/2024

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	evaluation was completed for the resident after 8/31/23. During an interview on 3/6/24 at 2:30 p.m. the Clinical Nurse Consultant indicated the Residents 3 and Resident 8 did not have any additional semiannual evaluations. During an interview on 3/6/25 at 3:25 p.m. the Administrator indicated the facility did not have a policy in regard to completing the semiannual evaluations.		findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.			

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	(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. Based on interview and record review, the facility failed to ensure service plans were singed and dated by the resident for 3 of 7 residents reviewed for service plans. (Residents 6, Resident 8) Findings include: 1. On 3/6/24 at 10:20 a.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, UTI (urinary tract infection), malaise (discomfort), and sepsis (severe infection). An 11/30/23 service plan was not signed or dated by the resident or resident representative. 2. On 3/6/24 at 10:27 a.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and hypothyroidism (underactive thyroid disorder). An 8/31/23 service plan was not signed or dated by the resident or resident representative. During an interview on 3/6/24 at 2:30 p.m., the Clinical Nurse Consultant indicated the Resident 6 and Resident 8 did not have a service plan which was signed and dated by the resident or their representative. On 3/6/24 at 3:25 p.m., the Administrator provided the facility policy, "Assisted Living Evaluation and Service Plan Guidelines," revised 12/11/17, and indicated it was the current policy being used. A review of the policy did not indicate for staff to obtain a resident's dated signature upon completion of their service plan.	R 0217	R217 Signed service plans 1 1. Resident #6 and #8 were affected. Resident #6 no longer resides in the campus. Resident #8 had their service plans signed by themselves or their representative. 2 2. All like residents have the potential to be affected. Nurses were educated on residents or their representative signing the service plans. 3 3. As a measure of ongoing compliance, the DHS or designee will monitor that service plans are signed weekly x 4 weeks, then every other week x 2 months then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	03/28/2024

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a tuberculin (TB) skin test was completed upon admission for 1 of 7 residents reviewed for TB skin testing. (Resident 6) Findings include: On 3/6/24 at 10:34 a.m., Resident 6's clinical record was reviewed. The resident was admitted on 11/30/23. A review of the Resident's record indicated he did not have a TB skin test completed. During an interview on 3/6/24 at 2:30 p.m., the Clinical Nurse Consultant indicated the resident	R 0410	R410 TB skin tests 1 1 Resident #6 was affected with no adverse effects. Resident #6 no longer resides at the campus. 2 2. All like residents have the potential to be affected. Nurses were educated on administering and documenting TB skin tests upon admission. 3 3. As a measure of ongoing compliance, the DHS or designee will monitor the administration and documentation of TB skin tests on new residents during clinical care	03/28/2024

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	did not have a TB skin test completed. On 3/7/24 at 3:25 p.m., the Administrator provided the facility policy, "Mantoux Test Procedure," revised 5/11/16, and indicated it was the policy currently being used. A review of the policy did not indicate the need to obtain a TB skin test upon admission.		meeting ~~C~~weekly x 4 weeks, then every other week x 2 months then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	