STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF DYER	1763 CALUMET AVENUE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: September 21 and 22, 2021 Facility number: 014415 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/24/21.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the Physician was notified related to a fall for 1 of 7 residents reviewed for notification. (Resident 6) Finding includes: The closed record for Resident 6 was reviewed on 9/21/21 at 1:00 p.m. Diagnoses included, but were not limited to seizures and high blood pressure.	R 0036	Immediate: Nursing staff was in-serviced on 9/22/21 to re-educate on notification of physician and legal representative upon any noted resident change of condition and/or incident occurrence. Present: Audit spreadsheet created to identify any previous occurrences with residents an immediately	11/07/2021

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

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	A Communication Log Note, dated 7/12/21 at 1:04 a.m., indicated "Around 10:30 p.m., [resident name] fell out of his chair while sleeping. The QMA and myself checked his vital signs and asked him if he was ok. He stated that he felt ok, except for some slight right hip pain. I did a safety check on him around 11:00 p.m., he was up watching tv. Did another safety check at 12:00 a.m., still sitting up watching tv. 1:00 a.m., another safety check and assisted him getting in bed." (sic) The above entry was made by a CNA. There was no documentation the Physician was notified of the fall and the complaints of pain to the right hip. Interview with the Director of Wellness (DOW) on 9/22/21 at 12:45 p.m., indicated there was no documentation the Physician was notified of the fall and right hip pain. The current and undated "Fall Risk" policy, provided by the DOW on 9/22/21 at 12:40 p.m., indicated when a resident falls notify the physician and family.		correct area of non communication. Ongoing: For ongoing compliance spreadsheet audit tool created with weekly audit to be completed by DOW or ADOW to identify and verify correct communication is on on-going. Compliance to be met by 11/7/21.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, record review and interview, the facility failed to ensure residents were free from medication errors related to administering medication at the correct time and	R 0247	Immediate: Notification made to family and physician about med error. Staff member was given	11/07/2021

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	not priming an insulin pen for 2 of 5 residents observed for medication pass. (Residents 1 and 11) Findings include: 1. On 9/22/21 at 8:06 a.m., LPN 1 was preparing to obtain Resident 1's blood to determine his blood sugar. The LPN gathered her supplies and entered the resident's room. The LPN obtained the blood by pricking his finger and placing the strip into the machine. The resident's blood sugar was 136. The LPN indicated the resident would not be covered by the insulin sliding scale, but does have a standing order for 3 units of insulin before meals. The LPN walked out of the room and back to the medication cart and removed a multi dose vial of insulin, however, there were no syringes to administer the insulin. She then poured the resident's oral medications, administered them and pushed the resident down to the dining room to eat breakfast. The LPN asked the Director of Wellness to get her some insulin syringes so she could inject the insulin into the resident. At 8:30 a.m., the resident was observed eating his breakfast. At 9:00 a.m., the LPN asked CNA 1 to push the resident to his room, so she could administer the insulin. At 9:02 a.m., the LPN was given an insulin kwik pen (which was in the medication room refrigerator) to administer the daily dose of 3 units. The LPN dialed the pen to 3 units and placed the needle on the pen. She used an alcohol pad to wipe the resident's abdomen and administered the 3 units. She did not prime the insulin pen prior to use. The record for Resident 1 was reviewed on 9/21/21 at 2:35 p.m. Diagnoses included, but were not limited to, diabetes.		documented disciplinary about both areas of med administration error. Inservice completed 9/22/21 to nurses and any insulin certified QMA's to re-educate on insulin kwik pen being primed prior to administration. Present: Continued education in-servicing provided for any new hired nurse and/or insulin certified QMA on priming of insulin kwik pen. Ongoing: Audit tool created for daily observation by DOW and/or ADOW to observe one insulin administration via kwik pen and at random resident selection check on medications prior to pass to ensure correct meds administration time frame. Compliance to be met by 11/7/21	

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	Physician's Orders, dated 9/17/21 indicated Humalog Insulin inject 3 units before meals. The Humalog kwik pen insert indicated to prime before each injection. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen was working correctly. If the pen was not primed before each injection, too much or too little insulin may be result. Interview with LPN 1 on 9/22/21 at 9:10 a.m., indicated she was unaware the insulin kwik pen needed to be primed prior to each use. 2. On 9/21/21 at 9:00 a.m., LPN 1 was observed preparing medications for Resident 11. The LPN removed a bottle of Donepezil 10 milligrams (mg) give 1 at bedtime and poured 1 tablet into the medication cup. She walked over to the resident and administered the medication. The record for Resident 11 was reviewed on 9/22/21 at 10:20 a.m. Physician's Orders, dated 8/26/21, indicated Donepezil 10 milligrams (mg) give 1 at bedtime (8:00 p.m.) Interview with LPN 1 on 9/22/21 at 12:15 p.m., indicated she was unaware she gave the Donepezil too early. She had thought she administered the resident's Aspirin.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and			

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	personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview, the facility failed to ensure pureed food was prepared according to the recipe for 1 of 1 pureed food preparation observed. This had the potential to affect 1 resident who received a pureed diet. Finding includes: On 9/21/21 at 11:30 a.m., a pureed meal was observed. At that time, the Dietary Food Manager (DFM) placed a moderate size serving of plain spaghetti noodles on a plate and put them into the blender. He turned on the food processor and blended the noodles together. The DFM removed the spaghetti noodles from the machine and placed them on a plate. The noodles were dense and sticky to touch and in the shape of a ball. They were not puree texture. The DFM then placed a scoop of ground beef marinara sauce over the noodles. The ground beef was not puree texture, it was a regular texture and what the other residents were going to eat. He then placed a piece of saran wrap over the plate and was going to serve the spaghetti until he was stopped and asked to review the recipe. The recipe for pureed spaghetti was as follows: For 6 servings: add plain noodles to the food processor and combine with 1/2 cup and 2 tablespoons of milk and 1/4 cup and 2/3 tablespoons of food thickener. Blend until smooth and scrape sides and place in pan. Add ground beef marinara sauce to the blender and if needed add food thickener. Blend until smooth and place on top of noodles.	R 0270	Immediate: Dining Services Director and all dietary service staff were in-serviced on proper puree food preparations in accordance with the recipes on 9/22/21. Present: Audit tool created for daily observation of one pureed meal to ensure compliance of pureed meal standards. Ongoing: On -going audits using audit tool created for daily observation of one pureed meal to ensure compliance of pureed meal standards. Compliance to be met by 11/7/21	11/07/2021

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	Interview with the DFM on 9/22/21 at that time, indicated he did not know how to prepare the pureed spaghetti and did not follow the recipe.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to store and serve food under sanitary conditions related to the lack of hair and beard covers and expired left over food in the walk in cooler for 1 of 1 kitchens. (The Main Kitchen) Findings include: 1. During the full kitchen sanitation tour on 9/21/21 at 9:10 a.m. with the Dietary Food Manager (DFM) the following was observed: a. The DFM was observed wearing a regular face mask, however a moderate amount of facial hair on his cheeks and neck area were exposed. b. Inside the walk in cooler, there was a container of cooked green beans with an open date of 9/15/21, a container of pudding with an open date of 9/13/21, a container of coleslaw with an open date of 9/16/21 and a container of potato salad with an open date of 9/16/21. Interview with the DFM at that time, indicated he thought leftovers were good for 5 days, but was not sure of the facility's policy. The current and undated "Cleaning instructions	R 0273	Immediate: Dining services staff were in-serviced on wearing hair and beard covers upon entry of the kitchen area on 9/22/21. An immediate check for left over food was conducted to ensure that nothing was greater then three days old per community policy. Present: Station for hair and beard covers is located at the entrance of the kitchen area. Ongoing: Audit tool created for daily checks at end of day to ensure any left over food is not greater then three days old per community policy. Dining services Director and/or designee will daily audit compliance of staff wearing proper hair and beard coverings upon entering the kitchen area. Compliance to be met by 11/7/21	11/07/2021

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	for the walk-in refrigerator and freezer" policy provided by the DFM on 9/21/21 at 2:27 p.m., indicated check for outdated items (3 days after the date written) and discard. 2. On 9/21/21 at 11:10 a.m., Dietary Cook 1 was observed with a hat on her head and the rest of her hair was braided and down her back. The braided hair was not contained or covered. Interview with Dietary Cook 1 at that time, indicated today was her first day of work. 3. On 9/22/21 at 7:25 a.m., Dietary Aide 1 was observed in the Main Dining Room wrapping silverware. At that time, she was not wearing a face mask and was asked to place one over her mouth and nose. She walked into the kitchen where the breakfast meal was being served without wearing a hair restraint. Interview with Dietary Aide 1 at that time, indicated she was unaware she needed to wear a hair restraint while serving food to the residents. Interview with the DFM on 9/22/21 at 9:15 a.m., indicated the aide should have been wearing a hair restraint while serving the food, as they received the food to serve from the tray line in the kitchen.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.			

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	Based on observation, record review and interview, the facility failed to ensure over the counter medications were properly labeled for 2 of 5 residents observed during medication pass. (Residents 13 and 12) Findings includes: 1. During medication pass on 9/22/21 at 8:30 a.m., LPN 1 was observed pouring and preparing medication for Resident 13. She removed a bottle of the over counter medication of Vitamin D3 5000 units and placed 1 tablet into the medication cup. There was no label on the bottle. The LPN removed a bottle of Bayer Aspirin low dose and poured 1 tablet into the medication cup. The resident's name was the only information on the bottle. The record for Resident 13 was reviewed on 9/22/21 at 10:25 a.m. Physician's Orders, dated 7/30/21, indicated Vitamin D3 5000 units give 1 daily and Aspirin 81 milligrams (mg) give 1 daily. Interview with LPN 1 on 9/22/21 at 9:10 a.m., indicated she was aware all over the counter medications needed to be tabled with the resident's name, physician, dose and directions for use. 2. During medication pass on 9/22/21 at 8:55 a.m., LPN 1 was observed pouring and preparing medication for Resident 12. She removed a bottle of the over counter medication of Vitamin D3 1000 units and poured 1 tablet into the medication cup. The bottle of medication only had the resident's name on it.	R 0302	Immediate: Nursing staff was provided in-service about properly labeling OTC meds brought in for residents on 9/22/21. Present: All current OTC meds in the medication carts for residents are properly labeled. Ongoing: Audit tool created for weekly medication cart audit to ensure compliance of any new OTC medications labeling. Compliance to be met by 11/7/21	11/07/2021

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	The record for Resident 12 was reviewed on 9/22/21 at 10:18 a.m. Physician's Orders, dated 7/2/21, indicated Vitamin D3 1000 units give 1 daily. Interview with LPN 1 on 9/22/21 at 9:10 a.m., indicated she was aware all over the counter medications needed to be tabled with the resident's name, physician, dose and directions for use. Interview with the Director of Wellness on 9/22/21 at 12:45 p.m., indicated she was aware all over the counter medications needed to be labeled with the resident's name, physician, dose, and directions for use.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff, residents and visitors not wearing the appropriate personal protective equipment (PPE) while in the facility	R 0407	Immediate: All staff, residents, and visitors were instructed and provided face masks to be worn properly. Staff were in-serviced on the requirement to were facemasks, as well as ensuring residents and	11/07/2021

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		A. BUILDING 00 B. WING	09/22/2021

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	and the lack of daily COVID-19 monitoring for 3 of 3 residents reviewed for infection control. (Residents 3, 4, and 5) Findings include: 1. On 9/21/21 at 8:30 a.m., there were 2 employees observed behind the front desk, both were not wearing a face mask. When asked if they wore a face mask, the Human Resource Director indicated they socially distance, but did not wear face masks. At that time, there was a visitor pushing a resident in his wheelchair towards the front desk in the lobby. Neither the visitor nor the resident had a face mask over their nose and mouth. The receptionist at the front desk answered the visitor's question but did not direct either one to put on a face mask. 2. On 9/21/21 at 8:40 a.m., Dietary Aide 2 was observed in the dining room wearing a N95 face mask over his mouth and nose. He was serving the resident's food and was within 6 feet of them. He had no face shield over his face. Interview with Dietary Aide 2 at that time, indicated he was not vaccinated for COVID-19. 3. On 9/21/21 at 10:20 a.m., the Activity Director was observed wearing a N95 face mask over her mouth and nose. She was observed within 6 feet of a circle of memory care residents, participating in an activity with them and was in close contact. She was not wearing a face shield over her face. Interview with the Director of Wellness on 9/21/21 at 1:15 p.m., indicated the Activity		visitors on 9/22/21. Nursing staff was in-serviced on requirements for daily O2 sat. and temp. checks for all current residents on 9/22/21. Present: Sign at the front desk for all visitors to wear facemasks properly. Order was placed for face shields to be worn in addition to a face mask for all non vaccinated employees when within six feet of any residents. Ongoing: Audit tool created for daily COVID symptom checks on residents whereby DOW and/or ADOW ensure daily compliance. Compliance to be met by 11/7/21	

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	Director was not vaccinated for COVID-19. 4. On 9/21/21 at 10:30 a.m., the Director of Wellness was observed in the memory care unit assisting a resident. She was wearing a N95 face mask and a surgical face mask. She was not wearing a face shield. Interview with the Director of Wellness on 9/21/21 at 1:15 p.m., indicated she was not vaccinated for COVID-19 5. On 9/21/21 at 12:10 p.m., a family member was walking into the main dining room and was not wearing a face mask. She was escorting her loved ones to a dining room table. She walked by numerous residents without a face mask on. No staff stopped the visitor and informed her about the face mask. Interview with the Director of Wellness on 9/22/21 at 12:45 p.m., indicated she was aware all visitors were required to wear a face covering while in the facility. 6. On 9/22/21 at 7:25 a.m., Dietary Aide 1 was observed in the Main Dining Room wrapping silverware. At that time, there were 6 residents seated at tables for breakfast. The aide was not wearing a face mask and was asked to place one over her mouth and nose. At 9:15 a.m., the dietary aide was observed wearing a pink cloth face mask. At that time, she was asked to remove the face mask and place a medical grade face mask over nose and mouth. Interview with the Dietary Aide 1 on 9/22/21 at 9:15 a.m., indicated she was unaware she could not wear a cloth face mask.			

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	7. On 9/22/21 at 7:30 a.m., CNA 1 was observed helping and assisting residents on the memory care unit. She was within 6 feet of the residents and she was not wearing a face shield. Interview with CNA 1 at that time, indicated she was not vaccinated for COVID-19. 8. On 9/22/21 at 8:15 a.m., a lab technician entered the memory care unit, he was wearing a cloth face mask. No staff stopped him and told him he needed to be wearing a medical grade face mask. He indicated he was there to collect a resident's blood for labs ordered by the physician. Interview with the lab technician on 9/22/21 at 8:45 a.m., indicated he was unaware he needed to be wearing a medical grade face mask. 9. On 9/22/21 at 8:40 a.m., a family member was walking with her loved one out of a memory care apartment and to a table in the dining room for her to eat breakfast. There were other residents seated at the tables in the dining area. The family member was holding her face mask in her hand. The staff in the dining area and the nurse by the medication cart did not tell the family member to put the face mask back over her mouth and nose. The current 9/7/21, "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy indicated "Direct and indirect care HCP (Healthcare Professional) should wear a medical procedure mask for the duration of their shifts. HCP should not wear cloth masks. Residents should wear a mask (cloth is acceptable) when they leave their rooms, and when HCP are delivering care within 6 feet. Fully vaccinated			

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		A. BUILDING 00 B. WING	09/22/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	residents must continue to wear a mask while indoors. Face mask and Eye Protection Based on Vaccination Status: Unvaccinated HCP must wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission. Fully vaccinated HCP may choose to not wear eye protection in green zones and in yellow zones when residents are being monitored for new admission quarantine - irrespective of county positivity rates." The current 9/7/21 "COVID-19 Regulatory Visitation and Activities Guidance for Long-term Care" policy indicated Unless noted otherwise, this guidance is to be followed by all long-term care facilities (nursing homes and licensed residential facilities). All resident visits should be conducted following the core principles of infection prevention. The Core Principles of COVID-19 Infection Prevention: · Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status) · Hand hygiene (use of alcohol-based hand rub is preferred) · Face covering or mask (covering mouth and nose) and social distancing at least six feet between persons." 10. During the Infection Control task on 9/22/21 at 10:50 a.m., the following was noted:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/22/2021

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	Resident 3 was admitted to the facility on 8/31/21. He was only screened for COVID-19 symptoms on 9/15, 9/17, and 9/18/21 for the month of 9/2021. Resident 4 was admitted to the facility on 8/25/21. He was only screened for COVID-19 symptoms on 9/7, 9/8, and 9/9/21 for the month of 9/2021 Resident 5 was admitted to the facility on 7/12/21. She was only screened for COVID-19 symptoms on 9/7, 9/8, 9/10, 9/12 and 9/18/21 for the month of 9/2021. Interview with the Director of Wellness on 9/22/21 at 12:45 p.m., indicated the facility policy for screening residents for COVID-19 was two times a day. She was aware the screening was lacking every day. The current 9/7/21 "Long-term Care COVID-19 Clinical Guidance" policy, indicated "Screen all residents daily for COVID-19 symptoms."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (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 record review and interview, the facility failed to ensure a health statement was obtained which indicated the residents showed no evidence of tuberculosis in an infectious stage for 6 of 7 records reviewed in the sample of 13.	R 0409	Immediate: Request to update admission/annual physician H&P form to include area to indicate this submitted to home office on	11/07/2021

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	(Residents 1, 2, 3, 4, 5, and 6) Findings include: 1. The record for Resident 1 was reviewed on 9/21/21 at 2:35 p.m. Diagnoses included, but were not limited to, dementia, depression, high blood pressure, and diabetes. The resident was admitted on 7/26/21. There was no health statement in the record indicating the resident was free from tuberculosis in an infectious stage. Interview with the Director of Wellness on 8/22/21 at 12:45 p.m., indicated she was aware a health statement from the Physician was required for each resident. 2. The record for Resident 2 was reviewed on 9/21/21 at 2:45 p.m. Diagnoses included, but were not limited to, dementia with hallucinations. The resident was admitted on 6/28/21. There was no health statement in the record indicating the resident was free from tuberculosis in an infectious stage. 3. The record for Resident 3 was reviewed on 9/21/21 at 3:00 p.m. Diagnoses included, but were not limited to, Parkinson's disease and osteoarthritis. The resident was admitted on 8/31/21. There was no health statement in the record indicating the resident was free from tuberculosis in an infectious stage. 4. The record for Resident 4 was reviewed on		9/22/21 Present: New form has been created and in use. Compliance to be met by 11/1/21	

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	9/21/21 at 3:10 p.m. Diagnoses included, but were not limited to, high blood pressure, sleep apnea, and osteoarthritis. The resident was admitted on 8/25/21. There was no health statement in the record indicating the resident was free from tuberculosis in an infectious stage. 5. The record for Resident 5 was reviewed on 9/21/21 at 2:55 p.m. Diagnoses included, but were not limited to, dementia. The resident was admitted on 7/12/21. There was no health statement in the record indicating the resident was free from tuberculosis in an infectious stage. 6. The closed record for Resident 6 was reviewed on 9/21/21 at 1:00 p.m. Diagnoses included, but were not limited to, seizures and high blood pressure. The resident was admitted on 6/23/21. There was no health statement in the record indicating the resident was free from tuberculosis in an infectious stage. Interview with the Director of Wellness on 8/22/21 at 12:45 p.m., indicated she was aware a health statement from the Physician was required for each resident.			