STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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. Survey dates: January 22, 23, 24, 25, 26, and 29, 2024 Facility number: 011150 Provider number: 155760 AIM number: 20083120 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 25 Medicaid: 15 Other: 34 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/5/24.	F 0000	Preparation and execution of this plan of correction by The Residence at Waterford Crossing does not constitute admission or agreement of truth to the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey ending December 22, 2024. Please accept this plan of correction as the provider's credible statement of compliance. With this, we the provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Plantinga	Executive Director	02/12/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. During observation, interview, and record review,	F 0656	1. The comprehensive care	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	the facility failed to develop and implement a personalized care plan for 1 of 22 residents whose care plans were reviewed. (Resident 49) Finding includes: The record review for Resident 49 was completed on 1/23/2024 at 2:47 P.M. Diagnoses included, but were not limited to: Parkinson's Disease and obstructive sleep apnea. A Physician's Order, dated 9/18/2023, indicated oxygen- bilevel positive airway pressure (BiPap) at 10 cm water at 0 liters to wear during the night and as needed during the day. There was no care plan available for the resident's BiPap machine. During an interview on 1/24/2024 at 9:38 A.M., the MDS Support indicated that Resident 49 should have had a care plan for his BiPap. On 1/25/2024 at 9 A.M., the Clinical Support Nurse provided a policy titled, "Comprehensive Care Plan Guideline," dated 12/31/22, and indicated the policy was the one currently used by the facility. The policy indicated "... 6. Comprehensive care plans need to remain accurate and current. a. New interventions will be added and updated or directly following CCM meeting. b. Newly recognized problems will have a care plan developed and added after CCM meeting...." 3.1-35(a)		plan was updated on 01/24/24 to reflect the use of bi-pap/c-pap for resident 49. 2. All comprehensive care plans for like residents were audited to ensure the care plan reflected their specific needs. 3. The disciplinary team was educated on the care planning process and additional need for documentation for residents with bi-pap and c-pap use. 4. During Clinical meeting the DHS or designee will audit any new orders for bi-pap or c-pap to ensure comprehensive care plan compliance for like residents. Audits will be completed 3x a week for 3 months and reviewed monthly in QAPI to ensure compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, record review, and observation, the facility failed to provide treatment for a skin tear and dry skin for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident 43) Finding includes: During an interview on 1/23/2023 at 10:39 A.M., Resident 43 indicated he had sores on both shins. He was scratching and broke the skin open. A record review was conducted on 1/24/2023 at 10:25 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, Parkinson's disease, and Alzheimer's disease. An Annual Minimum Data Set (MDS) assessment, dated 11/25/2023, indicated Resident 43 had moderate cognitive impairment. Current Physician's Orders indicated a weekly skin assessment was to be completed. There were no orders for any treatment to the shins. A Shower Sheet, dated 1/22/2024, indicated no bruising or redness was observed. A weekly Skin Assessment, dated 1/22/2024, indicated no skin issue was observed. A Care Plan, dated 12/08/2022, indicated Resident	F 0684	1. Resident number #43 was affected, and assessment was completed immediately. Resident had No adverse reactions noted from deficient practice. 2. All residents with skin tears have the potential to be affected. All nurses educated on weekly skin assessments with documentation in the EMAR reviewed. 3. Like residents are monitored weekly and as needed. All education to nurses completed at skills fair. All residents currently in the facility with skin tears have appropriate orders in place currently. 4. Audits will be complete by DHS or designee of 3 residents per week to ensure accurate skin assessment and documentation. Audits will be brought to QAPI monthly x 6 months to ensure compliance or additional needs in system.	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	43 was at risk for skin breakdown related to incontinence and impaired mobility. The goal was for Resident 43's skin to remain intact. Interventions included, to conduct a weekly skin assessment. During an observation and interview on 1/25/2024 at 11:19 A.M., the Director of Nursing (DON) described the left shin as very discolored with dried scabs, and a skin tear that had not dried up. Dry skin was present. She indicated Resident 43 needed a treatment for the skin tear and lotion for the dry skin. As of 1/29/2024 at 9:07 A.M., the medical record had no new orders or documentation of the left shin. A policy was provided by the Regional Support Nurse on 1/29/2024 at 11:26 A.M. The policy titled, "Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines", indicated, " ...Utilized to describe and monitor bruises, rashes, lesions, skin tears, and laceration ...1. May complete Skin Tear/Laceration Event in the EMR [electronic medical record] by an RN/LPN [registered nurse/licensed practical nurse] if the Skin Tear/Laceration warrants documentation due to the extent and/or location. 2. Complete one event for each Skin Tear/Laceration. 3. One weekly follow-up assessment may be completed to ensure Skin Tear/Laceration are resolved or in the progress of healing. If further follow-up is needed, documentation may be placed in a progress note ...." 3.1-37(a)			
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
Bldg. 00	Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure respiratory equipment for oxygen and sleep apnea machines was stored and maintained according to professional standards for 3 of 3 residents reviewed for respiratory care. (Residents 37, 49 and 50) Findings include: 1. The record for Resident 37 was reviewed on 1/23/24 at 11:30 A.M. Diagnoses included, but were not limited to: status post pneumonia and sepsis, chronic respiratory failure and obstructive sleep apnea. The initial Minimum Data Set assessment, completed on 12/15/23, did not indicate oxygen therapy was in use for Resident 37. A Care Plan to address shortness of breath was initiated on 12/10/24, and included an intervention to utilize oxygen as needed per Physician's Orders. On 1/22/24 at 11:24 A.M., Resident 37 was observed in his room, seated in his recliner, holding his oxygen tubing. There was no date on the oxygen tubing, which was connected to a	F 0695	1. Residents #47 and #49 and #50 received new bags and dating was completed on the oxygen tubing, bi-pap masks, and distilled water. No adverse reactions noted from deficient practice. 2. All like residents with orders for oxygen, bi-pap/c-pap, and distilled water have the potential to be affected. All nurses and QMA's were educated on dating of tubing and storage of masks and the distilled water. 3. Like residents with oxygen, bi-pap/c-pap, and distilled water will be checked weekly and as needed to ensure dating and storage is completed correctly. 4. DHS or designee will audit 3 like residents weekly x 6months and brought to QAPI monthly x 6 months to ensure compliance or additional needs in system.	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	concentrator in his room. In addition, there was oxygen tubing draped over a wheelchair in the resident's room. There was no date on the tubing on the wheelchair. On 1/23/24 at 11:11 A.M., Resident 37 was observed resting in his recliner with oxygen via a nasal cannula. The oxygen tubing was connected to a humidifier on an oxygen concentrator in the resident's room. There was additional tubing with a nasal cannula, attached to a portable oxygen tank on the resident's wheelchair. There was no date on any of the oxygen tubing or humidifier water bottle. There was a plastic bag taped to the concentrator, but it was empty and not dated. On 1/24/24 at 9:26 A.M. Resident 37 was observed seated in his room in a recliner. He had oxygen via a nasal cannula in place, connected to a concentrator in his room. There was no humidified water bottle on the concentrator. There was a plastic bag taped to the concentrator with the portable oxygen tubing in the bag. There were no dates on the oxygen tubing or the plastic bag. On 1/25/24 at 8 45 A.M. Resident 37 was observed, seated in his recliner in his room. The resident had oxygen tubing in place via a nasal cannula. There was no date on the oxygen tubing. There was a bag taped to the oxygen concentrator in the room with portable oxygen tubing inside. There was no date on the portable oxygen tubing. During an interview with the Regional Nurse Consultant, on 1/24/24 at 11:20 A.M., she acknowledged there were no dates on the oxygen equipment and/or tubing for Resident 37. She indicated she would have to research his oxygen			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	use. A policy and procedure, titled, "Administration of Oxygen," provided as current by the Regional nurse Consultant on 1/25/24 at 10:59 A.M., indicated the following: "...14. Date the tubing for the date it was initiated. a. Tubing should be changed monthly and PRN...." 2. During an observation, on 1/22/2024 at 10:43 A.M., Resident 49's BiPap mask was behind the nightstand on the floor in a bag, and a partially filled gallon of distilled water was undated. During an observation, on 1/23/2024 at 10:29 A.M., the BiPap mask was laying on the nightstand, and the partially filled gallon of distilled water was undated. During an observation on 1/24/2024 at 9:10 A.M., the mask was hanging over the nightstand, and a partially filled gallon of distilled water was undated. The record review was completed for Resident 49 on 1/23/2023 at 2:47 P.M. Diagnoses included, but were not limited to: Parkinson's Disease, and obstructive sleep disorder. A Physician's Order, dated 9/18/2023, indicated oxygen- BiPap at 10 cm water at 0 liters to wear during the night and as needed during the day. During an interview, on 1/24/2024 at 9:15 A.M., RN 2 indicated when the BiPap was not in use, the tubing should be in a bag and the bottled water should have an opened date. 3. During observations on 1/22/204 at 9:38 A.M., 1/23/2024 at 10:44 A.M., and 1/24/2024 at 3:12 P.M., Resident 50's CPAP (continuous positive airway pressure) mask was observed lying on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	bedside table, and a gallon of distilled water was on the floor undated. A record review was completed on 1/25/2024 at 10:26 A.M. Diagnoses included, but were not limited to: pulmonary fibrosis, sleep apnea, and unspecified dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 12/13/2023, indicated Resident 50 had a non-invasive mechanical ventilation device. A Physician's Order, dated 5/11/2022, indicated to wear the CPAP at night and as need during the day. A Care Plan, dated 5/26/2022, indicated Resident 50 had the potential for complications of functional and cognitive status decline related to respiratory disease, due to pulmonary fibrosis and sleep apnea with the use of a CPAP. During an interview on 1/25/2024 at 1:04 P.M., the Director of Nursing (DON) indicated the CPAP mask should be stored in a respiratory bag when it was not in use, and the gallon of distilled water should be dated when opened. On 1/29/2024, the Regional Support Nurse indicated a policy was not available for the use of CPAP/BiPap machines. 3.1-47(6)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	Based on observation, interview, and record review, the facility failed to ensure a Physician reviewed a Medication Regimen Review (MRR) provided by the Pharmacist following a monthly MRR, for 1 out of 5 residants selected for unnecessary medication review. (Resident 225) Finding includes: A record review was completed for Resident 225 on 1/24/2024 at 2:43 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, neurocognitive disorder with Lewy body, and unspecified psychosis not due to a substance or known physiological condition. A Physician's Order, dated 12/9/2022, indicated doneprizil 10 mg (milligram) tablet, orally at bedtime. A Pharmacy Recommendation, dated 9/26/2023, indicated Resident 225 "has an order for DONEPEZIL TAB 10 MG daily. The most recent BIMS [Brief Interview for Mental Status] score on file is < 7 which indicated severe impairment [BIMS =3 on 6/27/23]. The American Geriatric Society has found that deprescribing acetylcholinesterase inhibitors is not associated with negative effects to the resident, and is likely to help reduce the risk of falls and fractures in older nursing home residents with dementia. Please consider tapering off of DONEPEZIL TAB 10 MG at this time [Donepezil 5 mg QD [every day] x 2 weeks then d/c [discontinue]" During an interview on 1/26/2024 at 10:15 A.M., the Regional Support Nurse indicated the Nurse	F 0756	1.The Director of Nursing and/or designee reviewed pharmacy recommendations for resident # 225. NP did put a note in for 12/12/23 to contraindicate the GDR, no ill effects noted from the September GDR. 2. All like residents were reviewed that have been accessed by pharmacy for drug reduction no other deficiencies noted, audits were completed by 02/07/2024. 3.Regional nurse in-serviced DHS and nursing admit team on ensuring that the physicians address all the GDR's in a timely manner. DHS and or nursing admit team will print off GDR from pharmacy to ensure physician has addressed and signed before closing out. 4.Audits will be completed by DHS and or nursing admit team. 5 like will be reviewed every other week for 3 months and then monthly x 3 months with results of audits to QAPI monthly to ensure compliance with system.	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	Practitioner (NP) did not address the pharmacy recommendation in September of 2023. During an interview on 1/26/2024 at 11:00 A.M., the Regional Support Nurse indicated, when they receive the recommendations, the nurse initiates an Event if there is a GDR (gradual dose reduction), then it is printed out and placed in the NP's folder. The NP then reviews it, signs, and puts in a note in her progress note if she agrees or disagrees with the recommendation. The Assistant Director of Nursing then attaches the note before closing the recommendation. She acknowledged that the September recommendation got missed. On 1/26/2024 at 11:00 A.M., the Regional Support Nurse provided a policy titled, "Consultant Pharmacist Reports," revised 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...E. Recommendations are acted upon and documented by the facility personnel and/or the prescriber. 10 Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing...." 3.1-25(i)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure 1 of 4 nursing staff (QMA 4) administering medications followed infection control policies regarding hand washing. Finding includes: During an observation of a medication administration pass, on 1/24/2024 at 11:01 A.M., QMA 4 administered a crushed oral medication to Resident 31. After he completed the medication administration for Resident 31, he then prepared medication for Resident 62. He assessed Resident 62's vital signs, and then crushed the medications and administered them to Resident 62. QMA 4 then pushed Resident 62 back to the dining table. Next, QMA 4 prepared a medication for Resident 63 and administered the oral medication. QMA 4	F 0880	1 .Resident #31, #62 and #63 were affected. The DHS and/or designee immediately educated all nurses and QMA's about hand hygiene during medication pass. No ill effects noted to these residents. 2. All residents have the potential to be affected. Nurses and QMAs were educated on infection practices including hand hygiene during medication pass 01/26/2024. 3. Education was provided at skills fair on 02/07/2024 by our state infection preventionist on hand hygiene during medication administration to all nurses and QMA's .	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	did not perform hand hygiene in between any of the three resident's medication preparations and administrations. During an interview with the Administrator, on 1/26/2024 at 2:31 P.M., she indicated the medication policy included instructions for handwashing during the medication administration process. The facility policy, titled, "Preparation and General Guidelines" provided as current by the Administrator on 1/26/2024 at 2:31 P.M., indicated the following: "...2. Handwashing and Hand Sanitation: The person administering medications adheres to good hand hygiene before beginning a medication pass, prior to handling any medications, after coming into direct contact with a resident...b. Hand sanitization is done with an approved sanitizer between handwashings, when returning to the medication cart or preparation area, at regular intervals during the mediation pass such as after each room, again assuming handwashing is not indicated..." 3.1-18(l)		4. DHS and or designee will observe 2 staff members passing medications per week x one month and then every other week x 2 months with results to QAPI monthly to ensure compliance with system.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 22, 23, 24, 25, 26, and 29, 2024 Facility number: 011150 Residential Census: 88	R 0000	Preparation and execution of this plan of correction by The Residence at Waterford Crossing does not constitute admission or agreement of truth to the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/5/24.		annual survey ending December 22, 2024. Please accept this plan of correction as the provider's credible statement of compliance. With this, we the provider request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review, and interview, the facility failed to ensure nursing staff administering medication to 1 of 5 residents observed, followed the facility policy and manufacturer's instructions regarding insulin injections from an insulin pen. (LPN 2, Resident 11) Finding includes: During an observation of a medication administration pass, on 1/29/2024 at 11:05 A.M., LPN 2 obtained supplies to check a blood glucose level and took a Novolog insulin pen from the medication cart. She then moved the dial on the insulin pen dose wheel to 8 units. After entering the resident's room, LPN 2 donned gloves and checked the resident's blood glucose level, then moved the dose wheel on the Novolog insulin pen from 8 to 14. She then rubbed the resident's right upper abdomen area with an alcohol swab, and injected the insulin into the resident's abdomen. She then immediately, in less than 2 seconds,	R 0296	1 The NP was notified of not priming the insulin pen and holding it down for 10 seconds per manufacturer recommendation. 2 All diabetic residents using insulin pens have the potential to be affected. All nurses and QMA's were educated immediately on the manufacturer recommendations for insulin pens. 3 All nurses and QMA's went through a skills training regarding insulin pens from the pharmacy. 4. DHS or designee will review two residents with insulin pens weekly x 4 weeks then two residents every other week x 2 months to ensure correct process. Audits will be brought to QAPI monthly to ensure ongoing compliance and discuss if changes are needed in the system to ensure 100% compliance.	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	removed the needle from the resident's skin. During an interview with LPN 2, on 1/29/2024 at 11:20 A.M., she indicated she had never heard of priming an insulin pen prior to dialing up the dose, and was not aware of the need to hold the needle in the resident's skin for any extended amount of time. She indicated she was a brand new nurse. A pharmacy policy, titled "Preparing an Insulin Pen for Use," was provided by the healthcare Director of Nursing as current, on 1/29/2024 at 1:00 P.M. The policy indicated the following: "...dial a 2- unit prime/test dose. Hold the pen upright, lightly tap the pen reservoir so any air bubbles will rise to the top. Press the injection button all the way in to make sure insulin comes out the end of the needle..." The following instructions were included regarding the technique for injecting the insulin: "...Clean injection site with an alcohol swab, Keep the pen straight, insert needle into the skin, using your thumb press the injection button all the way in until the dial returns to zero, once the dial reaches zero, slowly count to 10 before removing needle...." The manufacturer's instructions for the Basaglar insulin pen, provided by the Regional Nurse Consultant on 1/29/2024 at 1:00 P.M., included the following instructions: "...Priming your pen. Prime before each injection...Step 5c. To prime your Pen, turn the Dose Knob to reflect 2 units. 6c. Hold your pen with the needle pointed up. Tap the Cartridge holder gently to collect air bubbles at the top. Step 7c. Continue holding your pen with needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	needle....Step 10c. Insert the needle into your skin, Push the Dose Knob all the way in, Continue to hold the Dose Knob in and slowly count to 5 before removing the needle...."			
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, interview, and record review, the facility failed to ensure 1 of 2 licensed nursing staff administering medications following proper infection control procedures related to not disinfecting a glucometer in between resident use. (LPN 2) Finding includes: During an observation of a medication administration pass, on 1/29/2024 at 11:05 A.M., LPN 2 retrieved supplies and a glucometer to check Resident 11's blood glucose level. After obtaining Resident 11's blood glucose level and administering insulin, LPN 2 removed the test strip from the glucometer and wiped the glucometer off with a Super Sani wipe. She then placed the glucometer into the case and exited the room. The glucometer was observed in the case	R 0407	1. The nurse was immediately educated on the disinfecting of the glucometer to include dwelling time of one minute before next usage. 2.All residents who require glucometer checks have the potential to be affected. 3.All nurses and QMA's were in-serviced on cleaning and disinfecting of the glucometers on 01/29/2024 and on 02/07/2024 at skills fair. 4.DHS or designee will review two residents with insulin pens weekly x 4 weeks then two residents every other week x 2 months to ensure correct cleaning and disinfecting of the glucometers. Audits will be	02/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	and was dry with no visible wetness noted. During an interview with LPN 2 at that time, she indicated the glucometer was utilized for multiple residents. The directions on the Super Sani wipe packet were read and indicated, for disinfecting and sanitizing, the surface was to remain wet for 2 full minutes. The facility policy and procedure, titled, "Glucometer Cleaning and Control Test Guidelines" provided by the Director of Nursing as current on 1/29/2024 at 12:35 P.M., indicated the following: "1. If glucometers are used from one resident to another, they should be cleaned and disinfected after each use...3. See manufacture guidelines for cleaning and disinfection...." The manufacturer's instructions for cleaning and sanitizing the glucometer indicated the following: "... open the disinfectant package, wipe the entire surface of the meter using the towelette at least 3 times vertically and 3 times horizontally to clean blood and other body fluids form meter, dispose of the towelette, allow the exterior to remain wet for 1 minutes, then wipe meter dry using a dry cloth..." During an interview with the healthcare Director of Nursing, on 1/29/2024 at 1:30 P.M., she indicated there were no Assisted Living residents with a diagnosis of a blood borne disease.		brought to QAPI monthly to ensure ongoing compliance and discuss if changes are needed in the system to ensure 100% compliance.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD CROSSING	1332 WATERFORD CIR GOSHEN, IN 46526

(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
	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 have an annual health statement for 1 of 7 residents reviewed for health statements. (Resident 3) Finding includes: A record review was completed on 1/26/2024 at 1:22 P.M. Diagnoses included, but were not limited to: cerebral infarction, dementia, diabetes mellitus type 2, and obstructive sleep apnea. A signed Annual Health Statement could not be found in the medical record. During an interview, on 1/29/2024 at 12:46 P.M., the Executive Director of Healthcare and the Director of Nursing for Assisted Living indicated Resident 3 did not have documentation of an annual health assessment which indicated Resident 3 was free of communicable diseases in an infectious state. A policy, titled, "Physician Services Guidelines", was provided as current on 1/29/2024 at 1:36 P.M. The policy indicated, " ...4. A Physician, Physician Assistant or Nurse Practitioner shall complete a history and physical prior to or at time of admission. The health assessment shall include: ii. IN- a. Statement that the resident shows no evidence of tuberculosis in an infectious state ...."	R 0409	1. The record was reviewed, NP notified, and orders received for Free of communicable diseases. 2.All residents have the potential to be affected. 3.AL manager did an audit of all like residents to ensure the Annual health statement was in place. All nurses were educated on checking with physicians on admission/readmission for this order. 4.AL manager or designee will audit all new admissions/readmissions to ensure statement is completed and correct. Audits will be completed upon new admissions/readmissions and brought to QAPI monthly x 3 months to ensure ongoing compliance and discuss if changes are needed in the system to ensure 100% compliance.	02/07/2024