STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155290	A. BUILDING 00 B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaints IN00452258, IN00452657 and IN00458127. Complaint IN00452258 - No deficiencies related to the allegations are cited. Complaint IN00452657 - Federal/State deficiencies related to the allegations are cited at F565. Complaint IN00458127 - No deficiencies related to the allegations are cited. Survey dates: April 30, May 1, 2, 5, 6 and 7, 2025 Facility number: 000187 Provider number: 155290 AIM number: 100267300 Census Bed Type: SNF/NF: 47 SNF: 5 Residential: 22 Total: 74 Census Payor Type: Medicare: 6 Medicaid: 39 Other: 30 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 12, 2025.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lashonda Lapsley-Martin	BSN, RN Clinical Support Nurse	05/24/2025

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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F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on interview and record review, the facility failed to ensure resident council concerns and grievances were resolved for 3 of 5 residents reviewed for resident council concerns. (Resident 28, 37 and B) Findings include: A meeting with the resident council was conducted on 5/5/25 at 10:01 a.m. The residents in attendance indicated call light wait times had been an ongoing concern. The resident council meeting minutes were reviewed and indicated: a. On 2/24/25, the residents indicated the call light waiting time was long. b. On 3/19/25, the residents indicated the call light response time remained untimely. The call light concerns from 2/24/25 were included with no resolution. c. On 4/21/25, the residents indicated there were concerns with the call lights being answered in a timely manner. The call light concerns from 3/19/25 were included with no resolution. 1. During an interview, on 4/30/25 at 10:34 a.m., Resident B indicated she had laid in her feces and urine before and there had been times when Resident B waited over an hour before someone cleaned her up. It could take anywhere from 30 minutes to over an hour for someone to answer the call light and provide care. The call lights continued to be an ongoing issue. 2. During an interview, on 5/5/25 at 10:01 a.m., Resident 28 indicated call lights could take up to	F 0565	**F-565 Resident/Family Group and Response** ="" span="">
="" span="">
span=""> **1 Immediate actions taken for those residents identified: Resident counsel minutes were reviewed for the past 90 days to determine resolution had occurred. Areas of concern were forwarded to the department head responsible for the resolution. Those residents identified in 2567 were interviewed to determine their concerns had been addressed and resolution had occurred. 2 How the facility identified other residents: Any residents that reside in the facility have the potential to be affected, however no adverse effects identified. 3 Measures put into place/ System changes: Responsible department heads educated on the expectations for timely resolution of concerns brought forth in resident counsel. Education provided to nursing staff related to call light response expectations. 4 How the corrective actions will be monitored: The party**	05/30/2025

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	30 minutes before being answered and had been an issue for a while now. 3. During an interview, on 5/5/25 at 10:02 a.m., Resident 37 indicated call light wait times were an ongoing problem. During an interview, on 5/1/25 at 3:00 p.m., the Clinical Support Nurse provided a general form which indicated the names of the residents who had filled out a grievance, but no evidence of specific concerns or resolution. The Clinical Support Nurse indicated the grievances/concerns forms were filled out in a program on the computer and she could not print an individual form from the program with the information. During an interview, on 5/5/25 at 10:05 a.m., the Activity Director indicated she helped the residents fill out grievances/concerns forms. Management reviewed the concerns. Management has been invited to resident council meetings to address the concerns.During an interview, on 5/8/25 at 3:03 p.m., the Director of Nursing (DON) indicated the facility had completed call light audits. Call light audits from 4/1/25 to 4/29/25 were the only audits the facility could provide. A current facility policy, titled "Resident Council," dated 6/2/16 and received from Director of Nursing (DON) 5/7/25 at 4:30 p.m., indicated "...The Resident Council structure and process including staff liaison designation will be established with the residents...Residents are informed of council meetings and are encouraged to utilize the complaint resolution process...Minutes of the meeting will be recorded and maintained for a least 2 years. Minutes will not disclose specific individuals who voice		**responsible for this plan of correction is the Executive Director, Activity Director, or designee. Identified areas of concern will immediately be reviewed after resident counsel and addressed within 72 hours of post resident council meeting for resolution. Call light response audits will be reviewed during scheduled morning IDT meetings and monthly during Quality Assurance. The Executive Director will attend scheduled Resident Council Meetings per invitation from Resident Council President for 6 months.** **Audits will continue for 6 months and or until 100% compliance is achieved for 3 consecutive months at which time the QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.5. Date of Compliance: 5-30-2025**	

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	concerns about the Campus. The group facilitator will determine the prevalence of the concerns/recommendations voiced to determine appropriate follow-up. The group's grievances and recommendations will be brought to the attention of the Executive Director who will forward the concerns to the appropriate department leader for attention and response. Responses regarding resolutions will be documented, reviewed by the Executive Director and kept with Resident Council minutes...Actions taken and/or considerations given to issues will be reported back to the Resident Council at the next meeting...." A current facility policy, titled "Resident Concern Process," dated 11/13/19 and received from DON on 5/7/25 at 4:30 p.m., indicated "...To provide a process of handling, tracking and resolving customer concerns to provide excellence in customer service...The facility staff will follow these basic steps in responding to a complaint: Listen to the concern without interruption...Take steps to correct the problem. Make the problem their own by following up to make sure it is resolved and stays resolved...Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution...The Executive Director will review and manage the follow up of the concerns...The QAPI team will review the trends of the concerns and the action plans to resolve concerns on a monthly basis...." A current policy, titled "Your Rights and Protections as a Nursing Home Resident," not dated and received from the Executive Director at entrance indicated "...Make Complaints: You have the right to make a complaint to the staff of the nursing home, or any other person, without fear of			

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	punishment. The nursing home must address the issue promptly...." This citation relates to Complaint IN00452657. 3.1-3(l)			
F 0628 SS=E Bldg. 00	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48 Discharge Process Based on interview and record review, the facility failed to ensure the written reason for discharge and the bed hold policy with cost information was provided to the resident and resident's representative for 4 of 4 residents reviewed for hospitalization. (Resident 2, F, 23 and 27) Findings include: 1. The clinical record for Resident 2 was reviewed on 5/1/25 at 11:49 a.m. The diagnoses included, but were not limited to, cervical spina bifida, pressure ulcer, type 2 diabetes mellitus, paraplegia, hydrocephalus, cerebral palsy, major depressive disorder, anxiety disorder, neuromuscular dysfunction of the bladder, and mood affective disorder. A notice of transfer discharge, dated 4/30/25, indicated the reason for the discharge and the bed hold policy was included. The notice did not include any indication of the charges for holding the bed while the resident was discharged. The notice did not indicate Resident 2 was provided with a written copy of the notice or the bed hold policy information. A nursing progress note, dated 4/30/25 at 3:47 p.m., indicated the resident was taken to the hospital by emergency medical service (EMS) at	F 0628	**F 628E Discharge Process** **The facility respectively requests a desk review for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1)Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** ·Residents R2, R23, and R27, RF, **2.) Identification of other residents having the potential**	06/07/2025

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	3:40 p.m., for suicidal ideation. The nursing note did not indicate any transfer or bed hold information given to Resident 2 by the facility. A nursing progress note, dated 4/30/25 at 3:23 p.m., indicated the resident notified staff of thoughts of suicide. The staff verbally notified the resident and resident's family of the plan to discharge to the hospital. During an interview, on 5/5/25 at 2:44 p.m., Resident 2 indicated he did not remember receiving a copy of the discharge information or bed hold policy.2. The clinical record for Resident F was reviewed on 5/1/25 at 11:46 a.m. The diagnoses included, but were not limited to, congestive heart failure, pulmonary edema, hypertension, diabetes mellitus, chronic kidney disease, dementia, depression, atrial fibrillation, and fibromyalgia. Resident F was transferred from the facility to the hospital on 1/2/25, 1/10/25 and 1/22/25. The documentation did not indicate a bed hold policy was given to the resident or responsible party. 3. The clinical record for Resident 23 was reviewed on 5/1/25 at 1:54 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, diabetes mellitus, chronic obstructive pulmonary disorder, hypertension, depression, epilepsy, major depressive disorder, cardiomegaly, congestive heart failure, and dementia. Resident 23 was transferred from the facility to the hospital on 10/22/25, 3/25/25 and 4/22/25. The documentation did not indicate a bed hold policy was given to the resident or responsible party.4. The clinical record for Resident 27 was reviewed on 5/6/25 at 11:03 a.m. The diagnoses included,		**to be affected by the same alleged deficient practice and corrective actions taken**: ·Those residents identified to have been discharged home within the last 30 days were reviewed. ·No residents were affected by the alleged practice. ·Based on that review, contact of resident/responsible party was completed to determine understanding of discharge instructions were provided and Discharge/Transfer and Bed Hold Policy were issued. **3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** ·Licensed nursing staff and Social Services will be re-educated regarding completing the Notice of Transfer/Discharge and Bed Hold Policy upon transfer to the hospital and instructed to keep a copy for facility records. ·Social Services will mail a copy of the notices to the Resident Representative by the next business day after the transfer. ·All transfers to the hospital will be reviewed on the next business day to ensure a copy of the Notice of Transfer/Discharge and Bed Hold with cost information were issued at the time of discharge. ·The Social Services Director of designee shall be responsible for oversight of these audits. **4)How the corrective measures**	

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	but were not limited to, displaced intertrochanteric fracture of left femur, pneumonitis due to inhalation of food and vomit, diabetes type 2, hypertension, depression, anxiety, dysphagia, pain, heart attack, stroke, and myalgia. A progress note, dated 4/29/25 at 11:35 a.m., indicated Resident 27 was sent to the emergency room for symptoms of a stroke. The record did not contain documentation to indicate Resident 27 or the resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital or the facility's bed hold policy, including the facility's charge to hold a bed. During an interview, on 5/5/25 at 1:42 p.m., the Director of Nursing (DON) indicated the discharge paperwork was usually printed and sent to the hospital with the resident, but there was no specific indication in the chart the transfer form and the bed hold policy with charges were given to the residents and the residents' representative. During an interview, on 5/5/25 at 2:46 p.m., the Clinical Support Nurse indicated there was no documentation in the electronic health record to indicate the residents or the residents' representatives were given the bed hold policy. A current facility policy, titled "Discharge/Transfer Notification Process Communicating Unplanned Discharges," dated 2/8/22 and received from the DON on 5/5/25 at 2:56 p.m., indicated "...This communication must occur within 24 hours of receiving a 30-day notice, and/or PRIOR to conversation with families regarding internal service line transfers...If the campus is requesting a move out or choosing to		**will be monitored to ensure the alleged deficient practice does not recur:** Audits will be conducted during daily stand-up meeting,5 days weekly to determine accuracy of discharge instructions and bed hold policy with cost information was provided and documentation of said provision. Identification of issues will result in notification of resident/responsible party for review. 1-1 education will be provided to nursing staff related to any identified issues. Discharge /Transfer/Bed Hold audits results will be reviewed in monthly Quality Assurance/Performance Improvement meetings for a minimum of 6 months and until 100% compliance is met for 3 months and the IDT determines substantial compliance has been achieved. **5. Date of Correction 6-7-2025**	

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	change a resident's service level, communication must be sought...." A current facility policy, titled "Bed Hold Policy," dated 2/1/11 and received from Director of Nursing on 5/5/25 at 11:00 a.m., indicated "...the campus will properly inform residents in advance of their option to make bed-hold payments as well as the amount of the facility's charge to hold a bed ..." 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(26)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview and record review, the facility failed to ensure staff obtained a follow-up weight to determine if a significant weight loss or gain had occurred and to document if a resident refused for 1 of 3 residents reviewed for nutrition. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/1/25 at 1:44 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, diabetes mellitus, morbid obesity, hypertension, major depressive disorder, post-traumatic stress disorder, major depressive disorder, panic disorder, bipolar disorder, anxiety disorder, and chronic pain. Resident B had the following weights: 1. On 11/2/24, the weight was 322.6 pounds. 2. On 12/16/24, the weight was 246.3 pounds. Resident B had a 23.65 % weight loss in 1 month.	F 0692	**F 692 D Nutrition/Hydration Status Maintenance** **The facility respectively requests a Desk Review for this Plan of Correction**Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the	05/30/2025

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	3. On 1/1/25, the weight was 314.0 pounds. Resident B had a 27.49 % weight gain in 1 month. There was no documentation, between 11/1/24 to 5/7/25, of the significant gain or loss, no indication the resident was re-weighed, and no indication the physician, dietician, or family representative were notified. During an interview, on 5/6/25 at 2:39 p.m., the Clinical Support Nurse indicated the resident had refused some weights. The staff should attempt multiple times to obtain a resident's weight. During an interview, on 5/7/25 at 2:40 p.m., Licensed Practical Nurse (LPN) 11 indicated any staff member could weigh a resident. When a resident refused to be weighed, staff would attempt 1 or 2 more times to obtain the weight. Resident B was a mechanical lift weight. If the resident refused 3 times, management would be told. During an interview, on 5/7/25 at 2:41 p.m., Certified Nursing Assistant (CNA) 12 indicated when a resident refused to be weighed, she would inform the nurse, and the nurse would let management know. The nurse would normally get the resident to agree to be weighed, Resident B liked to be weighed before breakfast and CNA 12 did not know of anytime the resident refused. During an interview, on 5/7/25 at 2:46 p.m., Qualified Medical Assistant (QMA) 13 indicated Resident B did not normally refuse to be weighed. Resident B had never refused care when she asked. If a resident refused to be weighed, she would attempt multiple times and then inform management.		alleged facts occurred as presented in the statements. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Identified resident B was assessed and a current weight was obtained and documented. The resident was reviewed by registered dietician and her care plan was updated to reflect nutritional requirements.**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Facility residents will be reweighed with a licensed nurse oversight and that weight compared to the last weight obtained and any resident with a weight loss will be placed in the Clinically at Risk (CAR) program. Current care plan interventions will be evaluated and physician and Dietitian notified for additional weight loss interventions if needed. The POA/Responsible party will be notified of any abnormal findings of weight loss and the plan of care reviewed. (weight variance of 5% in 30 days, 7.5% in 90 days and 10% in 180 days (unless on a planned weight loss or gain program) This will be conducted on 5-19-2025 through	

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	During an interview, on 5/7/25 at 2:48 p.m., QMA 14 indicated she would attempt 2 or 3 times to obtain a weight. If a resident refused, she would tell management. During an interview, on 5/7/25 at 2:55 p.m., the Clinical Support Nurse indicated the facility did not have a documentation policy and they followed the state guidelines. A current facility policy, titled "Guidelines for Weight Tracking," dated 12/17/24 and received from the Clinical Support Nurse on 5/6/25 at 2:39 p.m., indicated "...Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. (Unless on a planned weight loss or gain program) ...." A current facility policy, titled "Clinical Services-Weight Management," dated 12/20/24 and received from the Clinical Support Nurse on 5/6/25 at 2:39 p.m., indicated "...Review of error weights, daily, in CCM...Re-weights as needed...Correct weights as needed...Invalidate weights as needed ...." 3.1-46(a)(1)		5-23-2025 by the DON, Unit Managers and or designee. The physicians and responsible parties will be notified if a resident refuses to be weighed. Care Plans will reflect refusal.**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Dietitian will attend weekly CAR and monthly QA committee meetings. The DON, Unit managers and Dietitian were re-educated on the NAR Program. The DON and Dietitian will be responsible to ensure that the CAR meetings are conducted weekly, and all residents' weights are obtained as indicated. Any residents with weight loss will be monitored in the CAR program, to include meal percentages. The physician will be notified weekly of any weight variance of 5% in 30 days, 7.5% in 90 days and 10% in 180 days (unless on a planned weight loss or gain program) by the DON and/or Unit managers. The residents are observed throughout the day by the Unit managers Monday through Friday and the charge nurses on Saturday and Sunday during meals to ensure they are eating appropriately and there is immediate intervention offered if the meal is refused. If the resident refuses to be weighed, the physician and family	

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			will be notified.**4. How will the corrective actions be monitored.** The DON and Dietitian will be responsible for ensuring that the CAR meetings are conducted weekly, and all residents weighed as indicated and that all weight loss is appropriately evaluated with physician notification and interventions added as needed. Weight (loss/refusal) concerns will be reviewed daily during morning /clinical meetings per the IDT team Monday through Fridays for 6 months and until compliance has reached 90% or greater for 3 months, at which time the IDT/QA committee recommends changes to the plan of care. Audits will be reviewed during the monthly QA meeting to ensure compliance continues.**5. Date of Correction: 5-30-2025**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on interview and record review, the facility failed to ensure staff had documented training prior to administering 2 step Mantoux skin tests for tuberculosis (TB) and all parts of the procedure were documented to ensure accuracy for 1 of 5 employees and 3 of 7 residents reviewed for infection control. (CNA 16, Resident 2, 20, and 50) Findings include:	F 0880	**F880 E Infection Prevention and Control.** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	06/07/2025

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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
	1. A facility tuberculin testing for employees' form indicated CNA 16 was given a second step Mantoux test on 4/10/24 and read on 4/12/24. There was no documentation to indicate the time the second step test was given or read to ensure there was a 48-hour lapse before reading the test. 2. The clinical record for Resident 2 was reviewed on 5/1/25 at 11:49 a.m. The diagnoses included, but were not limited to, spina bifida with hydrocephalus, type 2 diabetes mellitus, paraplegia, cerebral palsy, major depressive disorder with psychotic symptoms, anxiety disorder, and neuromuscular dysfunction of bladder. A TB skin test record, dated 2/2/24, indicated LPN 3 administered the skin test. There was no documentation to indicate LPN 3 was trained to administer TB tests. 3. The clinical record for Resident 20 was reviewed for 5/2/25 at 9:47 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, chronic diastolic congestive heart failure, dementia, and schizoaffective disorder bipolar type. A first step TB skin test record indicated the skin test was administered on 2/20/25 at 8:23 p.m., by RN 8. The skin test was read on 2/22/25 with no time recorded to indicate the time the second step test was read to ensure there was a 48-hour lapse before reading the test. There was no documentation to indicate RN 8 was trained to administer TB tests.		conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1)Immediate actions taken for those residents identified:** TB testing was completed on C.N.A #16, Residents #2, 20, and 50 by a certified nurse and documentation completed. **2)How the facility identified other residents:** Any resident residing in the facility has the potential to be affected. Audits were conducted on TB administration and documentation for residents and employees to ensure testing was documented and accurate. Areas of concern were immediately addressed. Physician was notified for areas of identified concern. **3)Measures put into place/ System changes:** Scheduled Training for licensed nurses on Mantoux administration and documentation per Synchrony Pharmacy Education on federal regulation F800 related to Mantoux administration and documentation. TB audits/documentation weekly to determine tests are administered as ordered, per certified licensed staff, and	

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	155290	A. BUILDING 00 B. WING	05/07/2025

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	A second step TB skin test record indicated the skin test was administered on 3/7/25 at 11:54 p.m., by RN 9. The skin test was read on 3/8/25 with no time recorded. The test was read before the 48 hours. There was no documentation to indicate RN 9 was trained to administer TB tests. 4. The clinical record for Resident 50 was reviewed on 5/1/25 at 2:26 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy, Parkinson's disease, dementia, delirium, delusional disorders, major depressive disorder, anxiety disorder, depression, visual hallucinations, and hydrocephalus. A physician's order, dated 4/16/25, indicated to administer Aplisol (TB) solution intradermally (into the skin) on 4/16/25. The Medication Administration Record (MAR) indicated the skin test was administered late on 4/17/25 at 2:41 a.m., by RN 9. The skin test was read on 4/18/25. 48 hours had not passed before the test was read. There was no documentation to indicate RN 9 was trained to administer TB tests. During an interview, on 5/7/25 at 1:54 p.m., the Infection Prevention Nurse indicated 2 step TB tests should be completed upon admission for all residents. The test should be read between 48 and 72 hours after administration. The clinical record should have included the time the test was administered. The nurses who administer and read the tests must be trained.		documented accurately. **4)How the corrective actions will be monitored:** The person responsible for this plan of correction is the DON/IP with Executive Director oversight. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 6-7-2025**	

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	During an interview, on 5/7/25 at 1:54 p.m., the Director of Nursing (DON) indicated 2 step TB tests were required upon admission and should have been read within the 48-to-72-hour window to be considered valid. She indicated LPN 2, LPN 3, RN 5, LPN 6, RN 7, RN 8, and RN 9 did not have the required training to give or read TB tests. The facility could not verify if LPN 4 was certified because she was no longer in their system. A current facility policy, titled "Mantoux Test Procedure," dated 12/16/24 and provided by the Clinical Support Nurse on 5/6/25 at 10:02 a.m., indicated "...Record administration of Mantoux Test (date, time...) ... Read the Mantoux Test results in 48-72 hours...." A current facility policy, titled "Guidelines for TB Control Plan for Residents-Indiana," dated 4/2/24 and provided by the DON on 5/5/25 at 2:56 p.m., indicated "...tuberculin skin test...administered by persons having documentation of training from a department approved program...Upon admission a baseline two-step TST shall be completed...." 3.1-18(e) 3.1-18(h)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00452258, IN00452657 and IN00458127. Complaint IN00452258 - No deficiencies related to the allegations are cited.	R 0000		

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	Complaint IN00452657 - Federal/State deficiencies related to the allegations are cited at F565. Complaint IN00458127 - No deficiencies related to the allegations are cited. Survey dates: April 30, May 1, 2, 5, 6 and 7, 2025 Facility number: 000187 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 12, 2025.			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure staff had documented training prior to administering 2 step Mantoux skin tests for tuberculosis (TB) and all parts of the procedure were documented to ensure accuracy for 4 of 7 residents reviewed for tuberculin testing. (Residents 9, 14 and 18) Findings include: 1. The clinical record for Resident 9 was reviewed on 5/6/25 at 2:15 p.m. The diagnoses included, but were not limited to, pulmonary edema, respiratory failure with hypoxia, muscle weakness, kidney failure, and hypertensive chronic kidney disease. A preventative health care note indicated a first step Mantoux skin test was administered by LPN 4 on 11/27/24 at 3:03 a.m. and was read by LPN 6 less than 48 hours later, on 11/28/24, with no time	R 0410	**R410 Infection Control-Noncompliance.** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1)Immediate actions taken for those residents identified:** TB testing was completed on	06/07/2025

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	documented. A second step Mantoux skin test was administered on 12/10/24 with no time documented, and was read by RN 5 at 4:07 p.m. There was no documentation to indicate LPN 4, LPN 6 and RN 5 were trained to administer or read TB tests.2. The clinical record for Resident 14 was reviewed on 5/6/25 at 10:15 a.m. The diagnoses included, but were not limited to, anxiety disorder, paroxysmal atrial fibrillation, chronic kidney disease stage 3, and mild cognitive impairment. A tuberculosis record indicated a first step Mantoux skin test was administered on 3/23/24 at 9:48 p.m., and read on 3/23/24 at 10:48 p.m., by LPN 2. 48 hours had not passed before the test was read. A second step test was not found in the medical record. There was no documentation to indicate LPN 2 was trained to administer or read TB tests. 3. The clinical record for Resident 18 was reviewed on 5/2/25 at 10:30 a.m. The diagnoses included, but were not limited to, atrial fibrillation, edema, anxiety, and depression. A tuberculosis record indicated a first step Mantoux skin test was administered by LPN 4 on 9/27/24 at 2:28 p.m. and read on 9/28/24 at 8:06 p.m. 48 hours had not passed before the test was read. There was no documentation to indicate LPN 4 was trained to administer or read TB tests. A tuberculosis record indicated a second step Mantoux skin test was administered by LPN 4 on 10/10/24 at 9:05 p.m., and read on 10/12/24 at 8:04 p.m., by RN 7. 48 hours had not passed before the		Residents #9, 14, and 18 by a certified nurse and documentation completed. **2)How the facility identified other residents:** Any resident residing in the facility has the potential to be affected. Audits were conducted on TB administration and documentation for residents and employees to ensure testing was documented and accurate. Areas of concern were immediately addressed. Physicians were notified for areas of identified concern. **3)Measures put into place/ System changes:** Scheduled Training for licensed nurses on Mantoux administration and documentation per Synchrony Pharmacy TB audits/documentation weekly to determine tests are administered as ordered, per certified licensed staff, and documented accurately. **4)How the corrective actions will be monitored:** The person responsible for this plan of correction is the DON/IP with Executive Director oversight. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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	test was read. There was no documentation to indicate LPN 4 and RN 7 were trained to administer or read TB tests. During an interview, on 5/7/25 at 1:54 p.m., the Infection Prevention Nurse indicated 2 step TB tests should be completed upon admission for all residents. The test should be read between 48 and 72 hours after administration. The nurses who administer and read the tests must be trained. During an interview, on 5/7/25 at 1:54 p.m., the Director of Nursing (DON) indicated 2 step TB tests were required upon admission and should have been read within the 48 and 72-hour window to be considered valid. She indicated LPN 2, LPN 3, RN 5, LPN 6, RN 7, RN 8, and RN 9 did not have the required training to give or read TB tests. The facility could not verify if LPN 4 was certified because she was no longer in their system. A current facility policy, titled "Mantoux Test Procedure," dated 12/16/24 and provided by the Clinical Support Nurse on 5/6/25 at 10:02 a.m., indicated "...Record administration of Mantoux Test (date, time...) ... Read the Mantoux Test results in 48-72 hours...." A current facility policy, titled "Guidelines for TB Control Plan for Residents-Indiana," dated 4/2/24 and provided by the DON on 5/5/25 at 2:56 p.m., indicated "...tuberculin skin test...administered by persons having documentation of training from a department approved program...Upon admission a baseline two-step TST shall be completed...."		The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 6-7-2025**	