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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KEYSTONE WOODS	2335 N MADISON AVE ANDERSON, IN 46011

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 15 and 16, 2025 Facility number: 010409 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 21, 2025.	R 0000	This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission by Keystone Woods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity cited are correctly applied. Any changes made to the community's policies or procedures should be considered subsequent remedial measures as defined under Rule 407 of the Federal Rules of Evidence and corresponding state rules of civil procedure, and should be deemed inadmissible in any proceeding. This Plan of Correction is submitted with the intent that it be inadmissible by any third party in any civil or criminal action against the Community, its employees, agents, officers, directors, attorneys, shareholders, or affiliated companies.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility failed to ensure a minimum of one awake staff	R 0117	1.The Community reviewed each resident's record to determine	07/15/2025

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

Kristin Johnson | Executive Director | 05/02/2025

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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	member certified in CPR (cardiopulmonary resuscitation) with a hands-on training component was on site for 11 of 21 shifts reviewed for staffing sufficiency. This deficiency had the potential to affect 55 of 55 residents residing in the facility. Finding includes: Review of the facility's worked employee schedule, provided by the Administrator on 4/16/25 at 11:40 a.m., indicated 11 of 21 shifts for the week of 4/8/25 through 4/14/24 lacked a staff member certified in CPR with a hands-on training component. During an interview, on 4/16/25 at 11:34 a.m., the Administrator indicated the CPR certifications acquired through the National CPR Foundation (online training company) did not require a hands-on training component. During an interview, on 4/16/25 at 12:02 p.m., the Business Director , indicated she tracked the employee certifications and did not know a hands-on training component with CPR certification was required. Guidance from the National CPR Foundation website, accessed on 4/17/25 at 2:49 p.m., at https://nationalcprfoundation.com/support/, indicated the following: " ...Do I need hands-on training? ... if your employer or licensing board requires a hands-on component or a skills check, please visit CPRNearMe.com [an online company that provides a range of life-saving skills training providers, including hands-on and skills-check training for assessments] ...." A current facility policy, dated 8/2023, titled		which residents, if any, were affected by the alleged deficient practice. 2.The Wellness Director or designee will complete a CPR/First Aid certification audit for all care staff. 3.The Wellness Director or designee will schedule in-person CPR/First Aid classes for all care staff currently employed by the Community as 5/4/2025. All currently employed care staff as of 5/4/2025 will obtain First Aid & CPR certification by 7/15/2025 or will be removed from the schedule until the First Aid & CPR certification is obtained. 4.The Wellness Director or designee will maintain a CPR/First Aid binder containing all certifications and expiration dates. 5.The Wellness Director or designee will ensure new nursing hires complete CPR/First Aid certification within 60 days of hire if needed, and annually thereafter.	

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	"GENERAL SAFETY," provided by the Administrator on 4/17/25 at 8:36 a.m., indicated the following: " ...All Community Team Members should be CPR certified, if required by state licensing regulations ...."			
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance Based on record review and interview, the facility failed to ensure a pet residing within the facility had received the required vaccinations for 1 of 4 pets reviewed for vaccinations. Finding includes: A facility document, titled "Pets in the Building," provided by the Business Director on 4/16/25 at 1:30 p.m., indicated the facility had four pets in the facility. Resident 4's pet's clinical health record from the veterinarian, provided on 4/16/25 at 1:30 p.m. by the Business Director, indicated the pet had an examination on 8/21/24. The pet had just been adopted from a pet store. The vaccinations were undetermined, and the pet owner was to provide the veterinarian with the vaccination records. During an interview, on 4/16/25 at 1:44 p.m., the Business Director indicated she would look into the vaccination of the pet to verify if the required vaccinations had been given. During an interview, on 4/16/25 at 2:27 p.m., the Business Director indicated she had checked with the veterinarian's office. The pet had not been vaccinated by the veterinarian. She had checked with the pet store from which the pet had been adopted and was told they no longer had the pet's	R 0151	1.The Community reviewed each resident's record to determine which residents, if any, were affected by the alleged deficient practice. The pet belonging to Resident #4 received updated vaccinations on April 18, 2025. 2.A full audit of all residents with pets was completed to ensure vaccination records are current. No additional non-compliant pets were identified. 3.A pet vaccination tracking log will be maintained and audited monthly by the Activities Director or designee. 4.If a resident fails to comply with pet care requirements, a written notice will be issued stating the need for rehoming the pet due to non-compliance.	04/18/2025

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	vaccination records. Resident 4 had lost the pet's vaccination records. During an interview, on 4/16/25 at 4:10 p.m., the Administrator indicated she was responsible for ensuring resident's pets had the required vaccinations upon admission. Once she obtained the information, she gave it to the Activities Director to place in a binder. An undated, current facility policy, titled "PET POLICY," provided by the Administrator on 4/15/25 at 2:55 p.m., indicated the following: " ...All cats and dogs must have current vaccinations as recommended by Your [the resident's] veterinarian and any other requirements required by applicable law or regulation. You [the resident] shall be required to show proof of current vaccinations and annually submit the Resident Pet Health Statement, and shall provide, upon request, any additional information about Your [the resident's] pet's health status ...."			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance Based on interview and record review, the facility failed to ensure the dietary manager was trained or enrolled in a division-approved program for dietary supervision. This deficiency has the potential to affect 55 of 55 residents who received meals from the facility kitchen. Finding includes: Review of employee licenses, certifications, and records provided by the Business Director on 4/16/25 at 9:05 a.m., indicated the Dietary Manager was hired 8/29/22 and lacked certification in food handing and dietary supervision.	R 0274	1. The Community reviewed each resident's record to determine which residents, if any, were affected by the alleged deficient practice. 2.An audit of current dietary department staff certifications was completed. 3.The Dietary Services Manager will be enrolled in an accredited food safety course by June 30, 2025. 4.The Executive Director or designee will ensure dietary staff	06/30/2025

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	During an interview, on 4/16/25 at 11:34 a.m., the Administrator indicated the Dietary Manager did not have any current certifications in food handling or dietary supervision. During an interview, on 4/16/25 at 1:52 p.m., the Dietary Manager indicated he had been the supervisor of the kitchen since he was hired in 2022. He had worked previously at other assisted living facilities and skilled nursing facilities as the supervisor. He had started the dietary manager certification course several times, but he had not completed the courses due to his long work hours. He was not currently certified in dietary supervision or food handling. During an interview, on 4/16/25 at 5:05 p.m., the Administrator indicated she was unable to provide a policy on the dietary manager requirement. The Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective 11/13/04, indicated the following: " ... Sec. 118. (a) ... the person-in-charge shall demonstrate to the regulatory authority knowledge of foodborne disease prevention, application of the HACCP principles, and the requirements of this rule. The person-in-charge shall demonstrate this knowledge by ... (1) Having a certified food employee who has shown proficiency of required information through passing a test that is part of an accredited program, as per 410 IAC 7-22.		certifications are reviewed and kept up to date annually.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to verify by statement, on admission and	R 0409	1.The Community reviewed each resident's record to determine	07/15/2025

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	annually, that residents were free from infectious tuberculosis for 2 of 7 residents reviewed for annual health statements. (Resident 2 and 58) Findings include: Resident 2's clinical record was reviewed on 4/15/25 at 11:10 a.m., and lacked an annual health statement. Resident 58's clinical record was reviewed on 4/16/25 at 11:02 a.m., and lacked an annual health statement. During an interview, on 4/16/25 at 5:15 p.m., the DON indicated she could not locate current annual health statements for residents. She was uncertain regarding a facility policy about annual health statements and unable to provide a policy.		which residents, if any, were affected by the alleged deficient practice. 2.Prior to admission and annually thereafter, the Wellness Director or designee will verify that each resident has the required health statement, including a statement that the resident is free from infectious tuberculosis. 3.The Wellness Director or designee will conduct quarterly reviews of resident charts to ensure annual health assessments are completed. 4.The Wellness Director or designee will assist residents in scheduling appointments for annual health screenings as needed. 1.Documentation of completed health assessments will be maintained in each resident's chart and reviewed during internal audits conducted quarterly by the Wellness Director or designee.	