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	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FIVE STAR RESIDENCES OF NOBLESVILLE	7235 RIVERWALK WAY N NOBLESVILLE, IN 46062

(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. This visit included the Investigation of Complaint IN00455923. Complaint IN00455923- No deficiencies related to the allegations are cited. Survey dates: April 21 and 22, 2025 Facility number: 004417 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 28, 2025.	R 0000	The submission of this Plan of Correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulations. This provider respectfully requests that the 2567 Plan of Correction be considered for desk review in lieu of Post Survey Review.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure newly hired employees completed six (6) hours of dementia training within six (6) months of hire for 2 of 2 new employees, who had worked over 6 months. (QMA 8, and CNA 9). Findings include: Employee Records were reviewed on 4/22/25. The following concerns regarding new employees completing 6 hours of dementia training upon hire were identified: QMA 8, who had an employment start date of 7/6/24 (over 6 months), had a record of completing .50 hours of dementia training.	R 0120	1. The facility will ensure that the deficient practice be corrected by conducting an audit of team members, recently hired and those that have been employed over a period of one year, to ensure that they have the required dementia-specific training hours. Any team members out of compliance will be assigned the required dementia-specific training to ensure that compliance measures are met. The Business Office Manager (BOM) will be In-serviced regarding the six (6) hours of dementia-specific training	06/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janice A Pegues	Executive Director	05/09/2025

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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	CNA 9, who had an employment start date of 9/10/24 (over 6 months), had a record of completing 1.25 hours of dementia training. During an interview on 4/22/25 at 4:30 p.m., Business Office Manger 11, indicated she had no additional documentation of dementia training for QMA 8 and CNA 9. She indicated she was new to her position and a system of maintaining total hours of dementia training was not in place. A current, 4/1/19, facility policy titled, "Team Member Orientation Requirements (Indiana)," provided by the DON on 4/22/25 at 3:40 p.m., indicated: "...guidelines for providing orientation and in-service education to team members... team members receive orientation and annual in-service education on the following subjects: ...Alzheimer's disease and other types of dementia."		within six (6) months of hire and the additional three (3) hours of dementia-specific training annually thereafter, to ensure regulatory compliance. 2. The facility will monitor and insure that all newly hired team members receive the required six (6) hours of dementia-specific training within six (6) months of hire and an additional three (3) hours of dementia training annually thereafter. 3. The Business Office Manager (BOM) and/or designee, in the absence of the BOM, will be responsible for overseeing and monitoring the training compliance, ensuring that the facility is meeting regulation requirements. The BOM and/or designee will ensure that team members are assigned the required amount of dementia-specific training at hire and annually. 4. Dementia-specific training will be reviewed and monitored to ensure that compliance is met for a thirty (30) day period, with each new hire and to ensure that all team members are in compliance with the dementia-specific training requirements. 5. The systematic changes will be completed by June 10, 2025.	

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance A. Based on interview and record review, the facility failed to ensure employees had 2-step tuberculin skin testing upon hire and an annual TB tests and/or screening thereafter as indicated for 5 of 5 newly hired employees reviewed (Receptionist 4, CNA 5, QMA 8, CNA 9, and Receptionist 7) and 2 of 3 long term employees reviewed (LPN 6 and LPN 10). B. Based on interview and record review, the facility failed to ensure newly hired employees had a health screen prior to resident contact for 5 of 5 newly hired employees reviewed (Receptionist 4, CNA 5, QMA 8, CNA 9, and Receptionist 7) Findings include: A. Employee Records were reviewed on 4/22/25. The following concerns regarding employee tuberculin testing were identified: New employee Receptionist 4, who had an employment start date of 3/5/25, did not have a record of a 2 step tuberculin skin test completed upon hire. New employee CNA 5, who had an employment start date of 11/27/24, did not have a record of a 2 step tuberculin skin test completed upon hire. New employee QMA 8, who had an employment start date of 7/6/24, did not have a record of a 2 step tuberculin skin test completed upon hire. New employee CNA 9, who had an employment start date of 9/10/24, did not have a record of a 2 step tuberculin skin test completed upon hire. New employee Receptionist 7, who had an employment date of 3/9/25, did not have a record	R 0121	1. The facility will ensure that the deficient practice will be corrected by ensuring that all team members, at hire, receive the two-step PPD Tuberculin skin test and annually thereafter. The facility will conduct an audit of both new team members that that have been employed over a period of one (1) year, to ensure that they have the required annual PPD Tuberculin skin test. The community will ensure that all newly hired team members are administered the two-step PPD Tuberculin skin test, with results screened prior to the start of employment and prior to contact with residents. A health screening will be required for all team members at the start of employment and prior any resident contact. Any team member with a known reaction to the skin test will be required to have and submit a chest x-ray prior to the start of employment and or contact with any resident. 2. The facility will monitor and ensure that newly hired team members, complete the required health screening and receive the two-step PPD Tuberculin skin test upon hire with results screened prior to the start of employment and prior to contact with residents.	06/10/2025

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	of a 2 step tuberculin skin test completed upon hire. Long term employee LPN 6, who had an employment date of 7/19/18, did not have a record of an annual TB and/or risk assessment completed for the 2024-2025 year. Long term employee LPN 10, who had an employment date of 3/4/13, did not have a record of an annual TB and/or risk assessment completed for the 2024-2025 year. During an interview on 4/22/25 at 4:30 p.m., Business Office Manger 11, indicated she had no additional information regarding 2 step tuberculin testing upon hire or annual TB testing and/or an assessment for long term employees. A current, 8/2/23, facility policy titled, "Tuberculosis Control Plan", which was provided by the DON on 4/22/25 at 5:35 p.m., indicated: "...Testing and Results...Administer the two- step PPD [Tuberculin skin test] to those without documented evidence of a negative PPD in the past 12 months." B. Employee Records were reviewed on 4/22/25. The following concerns regarding health screening completed prior to having resident contact were identified: New employee Receptionist 4, who had an employment start date of 3/5/25, did not have a record a health screen being completed since hire. New employee CNA 5, who had an employment start date of 11/27/24, did not have a record of a health screen being completed since hire. New employee QMA 8, who had an employment start date of 7/6/24, did not have a record of a health screen being completed since hire. New employee CNA 9, who had an employment		The second step of the two-step PPD Tuberculin skin test will be administered within three (3) weeks of hire and annually thereafter, with the annual questionnaire. 3. The Business Office Manager (BOM) and/or designee, in the absence of the BOM will ensure that the deficient practice be corrected by ensuring that all team members, at hire, complete the required health screening questionnaire and receive the two-step PPD Tuberculin skin test. The BOM will ensure that all team members annually, complete the required health screening questionnaire. 4. The two-step PPD Tuberculin skin test and annual questionnaire will be monitored and observed for compliance for a thirty (30) day period to ensure compliance. 5. The systematic changes will be completed by June 10, 2025.	

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	start date of 9/10/24, did not have a record of a health screen being completed since hire. New employee Receptionist 7, who had an employment date of 3/9/25, did not have a record of a health screen being completed since hire. During an interview on 4/22/25 at 4:30 p.m., Business Office Manger 11, indicated the facility had no record of health screens completed for newly hired employees. The facility had new hires complete a statements about their own health but did not have a health screen completed by any medical professional.			
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on interview and record review, the facility failed to ensure newly hired employees had signed job descriptions and job specific orientation for 5 of 5 newly hired employee records reviewed. (Receptionist 4. CNA 5, QMA 8, CNA 9 and Receptionist 7). Findings include: Employee Records were reviewed on 4/22/25. The following concerns regarding signed job descriptions and job specific orientation were identified: New employee Receptionist 4, who had an employment start date of 3/5/25, did not have a signed job description nor documentation of job specific orientations. New employee CNA 5, who had an employment start date of 11/27/24,did not have a signed job description nor documentation of job specific orientations. New employee QMA 8, who had an employment	R 0123	1. The facility will ensure that the deficient practice be corrected by conducting an audit of all team members, included those newly hired, to ensure that they have the required job-specific job description in the team member employment file. Any team members out of compliance will be required to review and sign the job specific job descriptions to ensure that compliance measures are met. 2. The facility will ensure that all new hires complete the job-specific job description at hire. The facility will complete an audit of all team members to ensure that signed job-specific job descriptions are included in all team member employment files. Team members found to be out of	06/10/2025

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	start date of 7/6/24, did not have a signed job description nor documentation of job specific orientations. New employee CNA 9, who had an employment start date of 9/10/24, did not have a signed job description nor documentation of job specific orientations. New employee Receptionist 7, who had an employment date of 3/9/25, did not have a signed job description nor documentation of job specific orientations. During an interview on 4/22/25 at 4:30 p.m., Business Office Manger 11, indicated she did not have signed job descriptions for Receptionist 4. CNA 5, QMA 8, CNA 9 and Receptionist 7. She indicated she was new to her position and had not been trained regarding the need for job specific orientation. A current, 3/13/19, facility policy titled, "Personnel File Checklist", which was provided by the DON on 4/22/25 at 3:40 p.m., indicated: " Job Description Signed... Orientation-Department Specific Skills Training Checklist..."		compliance will be required to sign the job specific job descriptions to ensure that compliance measures are met. 3. The Business Office Manager (BOM) and/or designee, in the absence of the BOM, will be responsible for overseeing and monitoring compliance, ensuring that newly hired team members sign job-specific job descriptions at new hire and that all team members have job-specific job descriptions in their employment file. 4. Monitoring of newly hired team members and reviewing and signing job-specific job descriptions will be monitored for thirty (30) days to ensure compliance. An audit of current team members, ensuring that job-specific job descriptions are with employee files will be corrected with thirty (30) days to ensure compliance. 5. The systematic changes will be completed by June 10, 2025.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, record review, and interview, the facility failed to ensure medications were administered safely and appropriately for 2 of 5 residents reviewed for medication administration. (Residents 33 and 42)	R 0216	1. The facility will ensure that the deficient practice be corrected by conducting an in-service regarding the Self-Administration of Medication policy with Licensed	06/10/2025

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	Finding includes: During a medication administration observation, on 4/22/25 at 9:00 a.m., QMA 12 completed hand hygiene and gathered supplies to provide medication to Resident 33. QMA 12 removed one aspirin (to reduce the risk of heart attack) 81 milligram (mg) tablet, one Losartan (an antihypertensive) 100 mg tablet, one Lexapro (to treat depression) 10 mg tablet, one calcium (a supplement) 600 mg tablet, and one carvedilol (an antihypertensive) 6.25 mg tablet from the medication cart and placed them into a medication cup. QMA 12 removed the Breo Ellipta (to treat chronic obstructive pulmonary disease) inhaler device for Resident 33. QMA 12 knocked on Resident 33's door. The resident opened the door and QMA 12 handed her the medication cup. Resident 33 sat the cup on the counter by the kitchen sink. QMA 12 handed the resident the Breo Ellipta and reminded her to rinse out her mouth after she completed the medication. QMA 12 left the room and closed the residents door. During a medication administration observation, on 4/22/25 at 9:30 a.m., QMA 12 completed hand hygiene and gathered supplies to provide medication to resident 42. QMA 12 removed one hydroxyurea (to treat cancers) 500 mg tablet, one Buspar (to treat anxiety) 7.5 mg tablet, one lamotrigine (to treat epilepsy) 50 mg tablet, one sodium chloride (an electrolyte) 1 gram (gm) tablet, one aspirin (to reduce the risk of heart attack) 81 mg tablet, one vitamin D3 (a supplement) 50 micrograms (mcg) tablet, and one multivitamin tablet from her medication cart and placed them into a medication cup. QMA 12 measured out 17 grams of Miralax (a laxative) into a plastic drinking cup. She added eight (8) ounces		Practical Nurses (LPN) and Qualified Medication Aides (QMA) to ensure knowledge and compliance regarding following physician orders regarding residents with orders for self-administering medications, as well administering resident medications safely and appropriately. Any LPN and/or QMA not following policy will be disciplined accordingly. 2. The facility will conduct an audit of residents that have physician orders to self-administer mediations and in-service the Licensed Practical Nurses (LPN) and Qualified Medication Aides (QMA) regarding such to ensure compliance. 3. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will be responsible for monitoring the medication pass to ensure safe and appropriate medication delivery, per physician orders, ensuring compliance per the Self-Administration of Medication policy. Nursing team members, specifically Licensed Practical Nurses (LPN) and Qualified Medication Aides (QMA) not practicing medication pass per policy, or not safely and appropriately administering	

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	(oz) of water to the plastic drinking cup and stirred the mixture. QMA 12 knocked on resident 42's door. Resident 42 opened the door and QMA 12 handed her the filled medication cup and the plastic drinking cup with the Miralax mixture. Resident 42 closed the door. During an interview, at the time of the observation, QMA 12 indicated she left medications with residents in the unlocked assisted living apartments often. She usually worked on the secured unit and knew she needed to watch those resident take the medications she brought. 1. Resident 33's clinical record was reviewed on 4/22/25 at 10:50 a.m. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, and age related osteoporosis. Current orders included aspirin 81 mg once daily, Losartan 100 mg in the morning, Lexapro 10 mg in morning, calcium 600 mg in the morning, Coreg 6.25 mg every morning, and Breo Ellipta 1 puff inhale in the morning. The clinical record lacked an order to leave medications at bedside. A 4/9/25, Resident Level of Care Assessment, indicated Resident 33 required staff to administer medications and had cognitive impairments. The clinical record lacked a self administration assessment. 2. Resident 42's clinical record was reviewed 4/22/25 at 11:07 a.m. Diagnoses included hypo-osmolality and hyponatremia, major depressive disorder and hyperlipidema.		medications per physician orders will receive additional training and corrective disciplinary action for continued non-compliance. 4. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will ensure that the deficient practice is corrected by monitoring bi-weekly med passes for thirty (30) days on varied shifts to ensure compliance of safe and appropriate medication passing. 5. The systematic changes will be completed by June 10, 2025.	

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	Current orders included hydroxyurea 500 mg once daily, Buspar 7.5 mg twice daily, lamotrigine 50 mg twice daily, sodium chloride 1 gm in the morning, aspirin 81 mg once daily, vitamin D3 50 mcg once daily, one multivitamin once daily and Miralax 17 gm in eight (8) ounces of water once daily. The clinical record lacked an order to leave medications at bedside. A 12/11/24, Resident Level of Care Assessment, indicated Resident 42 required staff to administer medications and was cognitively intact. The clinical record lacked a self administration assessment. During an interview, on 4/22/25 at 2:23 p.m., the Director of Nursing (DON) indicated medications should not be left with residents or in resident rooms when the facility is responsible for medication administration. The residents allowed to do self administer medications required an assessment and a physician's order. A facility policy, dated 4/1/19, titled, "Medication Management Guidelines", provided by the DON on 4/22/25 at 3:40 p.m., indicated the following: "... Self- Administration: A resident who is capable of taking his/her medications independently and who has received documented physician approval to self-administer medications...Assessments: An initial "Self-Administration of Medication Assessment" is completed for all residents with documented physician approval to self-administer medications (in accordance with the Self-Administration of Medications policy.)..."			

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review the facility failed to ensure each resident had a service plan signed by the resident or their representative for 7 of 7 resident records reviewed (Residents 68, 5, 15, 75, 200, 201, and 48). Findings include: 1. Resident 15's clinical record was reviewed on 4/21/25 at 11:05 a.m. Current diagnoses included anxiety, depression, and vascular dementia. The resident's clinical record lacked a service plan that was signed by the resident or their representative. 2. Resident 68's clinical record was reviewed on 4/21/25 at 1:00 p.m. Current diagnoses included chronic kidney disease, and hypothyroidism. The resident's clinical record lacked a service plan that was signed by the resident or their representative. 3. Resident 48's clinical record was reviewed on 4/22/25 at 9:43 a.m. Current diagnoses included depression and hypertension. The resident's clinical record lacked a service plan that was signed by the resident or their representative. 4. Resident 75's clinical record was reviewed 4/21/25 at 3:00 p.m. Current diagnoses included hypertension and hypothyroidism. The resident's clinical record lacked a service plan that was signed by the resident or their representative. 5. Resident 200's closed clinical record was reviewed on 4/21/25 at 3:32 p.m. Diagnoses included depression and anxiety. The resident's clinical record lacked a service plan that was signed by the resident or their representative.	R 0217	1. The facility will ensure that the deficient practice be corrected by conducting a resident audit of all resident service plans to ensure that compliance is met by ensuring that service plans are signed by the resident or their representative. The facility will ensure that the service plans are specific to the individual resident's scope of care, frequency, need and care preference and are updated as resident needs and desires change. 2. The facility will conduct an audit of all residents service plans to ensure that the resident and or representative have signed the service plan. the facility will update service plans accordingly with resident and/or representative changes in condition and or service change preferences. The facility will ensure that all residents moving into the community will a service plan of their scope of care, frequency of need and care preferences, having the resident or their representative sign, acknowledging their agreement. 3. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the	06/10/2025

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	6. Resident 5's clinical record was reviewed on 4/21/25 at 1:45 p.m. Current diagnoses included chronic kidney disease and hypertension. The resident's clinical record lacked a service plan that was signed by the resident or their representative. 7. Resident 201's closed clinical record was reviewed on 4/22/25 at 9:25 a.m. Diagnoses included depression and gastro-esophageal ireful disease. The resident's clinical record lacked a service plan that was signed by the resident or their representative. During an interview on 4/22/25 at 1:30 p.m., the ADON indicated service plans for the five active residents were signed on 4/21/25 & 4/22/25. The DON and ADON took the Service Plan Report (from the most current service plan) to each resident/resident representative and asked them to sign the documents. The facility was not able to locate the signed service plans for Residents 68, 5, 15, 75, 200, 201, and 48 for the time of the last annual review or origination of said service plan. No policy related to service plans was provided by the 5:00 p.m. exit on 4/22/25.		absence of the DHW and/or ADHW will ensure that the deficient practice is corrected by ensuring that all newly admitted residents have signed service plans, signed by resident and/or representative, within three (3) days of admission, to ensure that the deficient practice is corrected. 4. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will be responsible for monitoring and correcting this deficient practice for a thirty (30) day period to ensure compliance. Residents without service plan signatures will be contacted to discuss care services and signatures will be obtained by the resident and/or representative within thirty (30) days to ensure compliance. 5. The systematic changes will be completed by June 10, 2025.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, interview, and record review, the facility failed to clarify medication-specific administration instructions and failed to obtain physician orders to crush medications for 2 of 5 residents reviewed for	R 0241	1. The facility will ensure that the deficient practice be corrected by conducting an in-service regarding following medication-specific administration, per physician	06/10/2025

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		A. BUILDING 00 B. WING	04/22/2025

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	medication administration. (Residents 53 and 1) Finding includes: During a medication administration observation, on 4/22/25 at 9:00 a.m., QMA 12 handed Resident 53 a Breo Ellipta (to treat chronic obstructive pulmonary disease) inhaler. Resident 53 took one puff and returned the inhaler device. QMA 12 exited the resident room. During an interview, on 4/22/25 at 10:05 a.m., QMA 12 indicated she had forgotten to ask or remind Resident 53 to rinse her mouth out and spit after she used the inhaler. The residents who utilized a Breo Ellipta inhaler ran a risk of fungal infections of the mouth. During a medication administration observation, on 4/22/25 at 11:55 a.m., QMA 13 removed two acetaminophen 500 milligrams (mg) tablets from the pharmacy medication card for Resident 1. QMA 13 crushed the two tablets. She placed the crushed medication into a medication cup and added a tablespoon of strawberry jelly. QMA 13 indicated she was familiar with Resident 1. Resident 1's medication was given crushed and placed in strawberry jelly for administration. 1. Resident 53's clinical record was reviewed on 4/22/25 at 10:16 a.m. Diagnoses included hypertension, chronic obstructive pulmonary disease, and osteoporosis. Current orders included Breo Ellipta inhaler, inhale one puff daily for asthma. The order lacked special instructions to rinse and spit after use. 2. Resident 1's clinical record was reviewed on 4/22/25 at 1:55 p.m. Diagnosis included		orders, including orders specific to crushing medications with Licensed Practical Nurses (LPN) and Qualified Medication Aides (QMA) to ensure knowledge and compliance of following physician orders regarding residents with orders for administering resident medications safely and appropriately. Any LPN and/or QMA not following policy will be disciplined accordingly. 2. The facility will conduct an audit of residents that have physician orders specific for crushing medications and in-service the Licensed Practical Nurses (LPN) and Qualified Medication Aides (QMA) regarding such to ensure compliance of following safe medication administration. 3. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will be responsible for monitoring the medication pass to ensure safe and appropriate medication delivery, per physician orders, ensuring compliance. 4. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will ensure that the	

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	Alzheimer's disease and hyperlipidema. Current orders included acetaminophen 1000 mg, give three times daily for pain. The order lacked instructions to crush medication and place in food. During an interview, on 4/22/25 at 2:23 p.m., the Director of Nursing (DON) indicated the Breo Ellipta inhaler order needed to include special instructions to rinse and spit after use. If any resident required medications crushed and placed in food needed a physician's order. A facility policy, dated 4/1/19, titled, "Medication Management Guidelines", provided by the DON on 4/22/25 at 3:40 p.m., indicated the following: "... A valid physician's order must include the date, resident name, name of medication, dose, directions for use, route, parameters and duration..."		deficient practice is corrected by monitoring bi-weekly med passes for thirty (30) days on varied shifts to ensure compliance of safe and appropriate medication passing. 5. The systematic changes will be completed by June 10, 2025.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on interview and record review, the facility failed to develop and implement an infection control program which enabled the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence. This deficient practice had the potential to impact 84 of 84 residents who resided in the facility. Finding includes: Review of the infection control log, provided by the Assistant Director of Nursing (ADON) on 4/22/25 at 3:30 p.m., indicated there was no infection control tracking for the following	R 0407	1. The facility will ensure that the deficient practice be corrected by updating and continuing to implement the facility infection control program. The infection control program will be utilized to analyze patterns of known infectious symptoms, to prevent the spread of infection within the facility and/or to implement measures within the facility to prevent the transmission of infection. 2. The facility will maintain	06/10/2025

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	months: March 2025, February 2025, January 2025, December 2024, November 2024, October 2024, September 2024, August 2024, July 2024, and June 2024. During an interview, on 4/22/25 at 4:17 p.m., the ADON indicated the previous DON had been responsible for the infection control program. She had printed out the antibiotic reports for the months of January 2025, February 2025, and March 2025 and placed them into the infection control binder. There was no further infection tracking documents available. A facility policy, revised 10/1/17, titled, "Infection Prevention and Control Program Overview", provided by the DON on 4/22/25 at 4:35 p.m., indicated the following: "...The Infection Prevention and Control Program (IPCP) is designed to prevent, identify and reduce the risk of acquiring and transmitting infections among residents, team members, providers, volunteers, students, contractors, and visitors based upon a community assessments and national standards. The IPCP incorporates a broad range of education, surveillance, and infection control practices involving all departments and is managed by the IPC Coordinator...."		documentation tracking that will be utilized to prevent the spread of infection in the facility, to ensure compliance. The facility will monitor all infectious symptoms via an Infectious Log Binder, to both track infectious symptoms and to implement measures to prevent the spread of infectious symptoms, by analyzing patterns of known infectious symptoms and implementing precaution measures. The facility will provide orientation and in-service education on infection prevention and universal precautions. 3. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will be responsible for tracking, analyzing, monitoring and implementing measures with the infectious Log control program, to ensure a safe environment for all residents, while providing team and resident education as an infection prevention measure. 4. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and/or ADHW will ensure that the deficient practice is corrected by documenting, tracking and analyzing infectious symptoms	

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			per the infection control program and will monitor weekly and as needed at the Interdisciplinary Team Meeting (IDT) for thirty (30) days to ensure compliance is met to promote a safe environment for all residents. 5. The systematic changes will be completed by June 10, 2025.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to complete the 2-step tuberculin skin testing (TST) required prior to or upon admission for 2 of 7 residents reviewed for tuberculin skin testing. (Residents 75 and 200) Finding includes. 1. Resident 75's clinical record was reviewed 4/21/25 at 3:00 p.m. The resident's admission date was 1/7/25. A current immunization report indicated Resident 75 had one of the 2-step Tuberculin (TB) skin tests on 1/2/25. 2. Resident 200's closed clinical record was reviewed on 4/21/25 at 3:32 p.m. The resident's admission date was 2/11/25. An immunization report indicated Resident 200 had one of the 2-step TB skin tests on 2/10/25. During an interview, on 4/22/25 at 1:30 p.m., the Assistant Director of Nursing (ADON) indicated the facility had no additional documentation to	R 0410	1. The facility will ensure that the deficient practice is corrected by auditing all community residents, including those newly admitted to ensure that the 2nd step PPD was administered for resident that have recently moved in, and that all residents, residing in the community for a period of one year, have received the annual tuberculin PPD. The facility will ensure that all newly admitted resident admit with PPD and/or chest x-ray results. 2. The facility will monitor and insure that newly admitted residents have the PPD Tuberculin skin test or chest x-ray results prior admission and ensuring that the PPD is administered and received prior to admission and additionally, the second step is administered within three (3) weeks of admission and the assessment annually thereafter.	06/10/2025

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	provide for TB skin testing and testing results. During an interview, on 4/22/25 at 3:46 p.m., the Director of Nursing (DON) indicated new residents should have the 2-step TB skin testing prior to or at admission. He indicated he was new to the company and would continue to look for the appropriate policy related to TB testing. No additional policy was provided by the 5:00 p.m. exit on 4/22/25.		The facility will conduct an audit of all residents to ensure that the facility is in compliance of the annual PPD assessment, ensuring compliance of all residents to meet PPD/chest x-ray administration guidelines. 3. The facility will ensure that the deficient practice will be corrected by ensuring that all residents submit a health assessment history of significant past or present infectious disease in addition to evidence of being free of tuberculosis , prior to admission, that is within three (3) months prior to admission to the facility. A chest x-ray will be required that is within six (6) months prior to admission to the facility. Residents admitting to the facility with recent tuberculin skin test will only be admitted with test that have been read within a forty-eight (48) to seventy-two (72) hour reading. 4. The the audit and compliance measures, the PPD will be monitored and observed for compliance for a thirty (30) day period for all newly admitting residents. The facility will conduct an audit of residents that that have been admitted recently and within one (1) year, to ensure that they have the required annual PPD Tuberculin skin test and/or chest	

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			x-ray. 5. The systematic changes will be completed by June 10, 2025.	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure annual tuberculosis (TB) risk assessments were completed for 3 of 7 residents reviewed for annual health assessments. (Residents 15, 68, and 48) Findings include: 1. Resident 15's clinical record was reviewed on 4/21/25 at 11:05 a.m. The resident's admission date was 2/21/24. The clinical record lacked an annual TB risk assessment for the current 2025 year. 2. Resident 68's clinical record was reviewed on 4/21/25 at 1:00 p.m. The resident's admission date was 10/25/23. The clinical record lacked an annual TB risk assessment for the 2024 year. 3. Resident 48's clinical record was reviewed on 4/22/25 at 9:43 a.m. The resident's admission date was 5/6/23. The clinical record lacked an annual TB risk assessment for the 2024 year. During an interview, on 4/22/25 at 1:30 p.m., the Assistant Director of Nursing (ADON) indicated	R 0412	1. The facility will ensure that the deficient practice will be corrected by ensuring that an audit all residents that have resided in the community for over a period of one (1) year, to ensure that they have the required annual PPD Tuberculin skin test completed and documentation from their physician indicating that they are free of communicable diseases. The facility will ensure that all newly admitted residents are also in compliance per regulations. 2. The facility monitor and insure that residents submit PPD Tuberculin skin test or chest x-ray results prior admission and ensuring that the PPD is administered and received prior to admission and additionally, the second step is administered within three (3) weeks of admission and the assessment annually thereafter. The facility will conduct an audit of all residents to ensure that the facility is in compliance of the annual PPD skin assessment, ensuring compliance of all residents to meet the PPD skin	06/10/2025

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	the facility had no more documentation to provide for annual TB risk assessments. During an interview, on 4/22/25 at 3:46 p.m., the Director of Nursing (DON) indicated residents should have an annual assessment every year. He indicated he was new to the company and would continue to look for all the appropriate policies related to TB annual risk assessments and testing. No additional policy was provided by the 5:00 p.m. exit on 4/22/25.		assessment, requiring a chest x-ray for those residents with positive reactions to the tuberculin per guidelines. 3. The Director of Health and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) and/or designee, in the absence of the DHW and ADHW will ensure that the deficient practice be corrected by ensuring that all residents, at admission, submit the PPD Tuberculin skin test and/or chest x-ray and annually thereafter and that all residents meet annual PPD skin assessment compliance. 4. The PPD will be monitored and observed for compliance for a thirty (30) day period to ensure compliance. 5. The systematic changes will be completed by June 10, 2025.	