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	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN OAKS OF GOSHEN	282 JOHNSTON STREET GOSHEN, IN 46528

(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: March 27 & 28, 2025 Facility number: 015205 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 4/2/2025	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure required dementia training and in-services were completed for 1 of 5 employees reviewed for in-services. (Housekeeper 3) Finding includes: An employee record review was completed on 3/27/2025 at 9:16 A.M. for Housekeeper 3. Housekeeper 3 was hired on 9/11/2024 and the employee record lacked the documentation to show completion of the required 6 hours of dementia training. During an interview, on 3/27/2025 at 10:30 A.M., the Administrator indicated the employee did not have the required dementia training. On 3/27/2025 at 10:56 A.M., a policy regarding dementia training and in-services was requested	R 0120	The The The community was alleged to be out of compliance by failing to ensure required dementia training and in-services were completed for 1 0f 5 employees reviewed for in-services. A Required in-services were completed by Housekeeper 3. B Employee files were audited for completion of required dementia training. C The Business Office Manager was educated by the administrator/ designee regarding dementia training. System review and change to request necessary training being completed before staff provide resident care. D An audit will be completed by	05/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carlos Romero	Executive Director	04/11/2025

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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	but one was not provided prior to the survey exit.		the Business Office Manager weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to ensure admission weights were completed and documented in the residents record for 1 of 8 residents reviewed for admission weights (Resident 5). Finding includes: A record review was completed on 3/26/2025, at 1:18 P.M. for Resident 5. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that an admission weight was completed. During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated the resident should have had an admission weight completed and documented in their record. On 3/27/2025 at 9:10 A.M., a policy regarding admission weights was requested but one was not provided prior to the survey exit.	R 0216	The community was alleged to be out of compliance by failing to ensure admission weights were completed and documented in the resident's record for 1 of 8 residents reviewed for admission weights. A Resident no longer resides in facility B A house wide audit completed to ensure residents admission weights were obtained. C Nursing staff were educated by DON/ designee on obtaining admission weights. D An audit will be completed by DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	05/16/2025
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were completed, with dates and signed by the resident or their	R 0217	The community was alleged to be out of compliance by failing to ensure service plans were	05/16/2025

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	representative for 6 of 8 residents reviewed for service plans. (Residents 2, 3, 4, 5, 6 and 8) Findings include: 1. The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A document titled, "Rsp [Resident service plan]", was completed on 8/3/2024. The signature line for Resident 2 was not signed by the resident and/or their representative. A document titled, "Rsp [Resident service plan]", was completed on 1/25/2025. The signature line for Resident 2 was not signed by the resident and/or their representative. During an interview, on 3/27/2025 at 9:05 A. M., the Director of Nursing indicated the service plans should have been signed by the resident and were not.2. A record review was completed, on 3/26/2025 at 2:15 P.M. Resident 4's diagnoses included but were not limited to, cerebral infarct, chronic obstructive pulmonary disease, asthma and altered mental status. Resident 4's service plans were completed on 6/9/2024 and 2/7/2025. A signature was not found for review of the service plan with the resident and/or their resident representative. During an interview, on 3/27/2025 at 9:05 A.M., the Director of Nursing indicated resident 4's service plan should had been signed by the resident and/or the resident's representative. 3. A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included,		completed, with dates and signed by residents or their representatives for 6 of 8 residents reviewed for service plans. A Service care plans were completed and signed for residents 2,3,4,5,6, and 8. Resident 5 no longer resides in facility. B A house wide audit was completed to ensure residents had an up to date service care plan signed by resident or their representative. C Nursing staff were educated by DON/ designee on Service Care Plans. D An audit will be completed by DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

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	but were not limited to: anxiety, depression, sleep disorder and seizure disorder. A document titled, "Rsp [Resident service plan]", was completed on 12/6/2024 and 2/27/2025. A signature line for Resident 9 was not signed by Resident 9 and there was just an "X" on the signature line. During an interview, on 3/27/2025 at 10:59 A.M., the Director of Nursing indicated Resident 9 was able to sign his sign service plan and he should have signed the service plan.4. A record review was completed for Resident 5 on 3/26/2025 at 1:18 P.M.. The resident was admitted to the facility on 11/30/2024. Resident 5's record lacked documentation that a service place had been completed. 5. A record review was completed for Resident 6 on 3/26/2025 at 11:05 A.M. The resident was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that a service plan had been completed. 6. A record review was completed for Resident 8 on 3/26/2025 at 2:06 P.M. The resident was admitted to the facility on 9/3/2024. Resident 8's record lacked documentation that a service plan had been completed. During an interview, on 3/27/2025 at 9:05 A.M., the DON indicated Residents 5, 6 and 8 should have had a service plan completed. She also indicated the residents that had service plans completed, should have signed their service plans.			

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	On 3/27/2025 at 9:39 A.M., the DON provided a policy titled, "Service Plans," dated 6/2022 and indicated it was the policy currently being used by the facility. The policy indicated, " Each resident will have a written plan of care that is developed based on initial/assessment, semi annual assessments, and with any changes in resident needs. D. 4. The agreed upon service plan shall be signed and dated by the resident and a copy of the service plan shall be given to the resident upon request...."			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on record review and interviews, the facility failed to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. (Residents 3 & 2) Findings include: 1. A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation. A Physician's Order, dated 3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg. The Medication Administration Record, dated March 2025, indicated a QMA had administered the treatment on 3/20/2025, 3/21/2025, 3/24/2025, 3/26/2025 and 3/27/2025.	R 0241	The community was alleged to be out of compliance by failing to ensure comprehensive care related to wounds were not provided by Qualified Medication Aides (QMAs) out of their scope of practice for 2 of 2 residents reviewed for wound care. A QMA Scope of Practice was reviewed immediately with QMAs B Audit initiated to identify proper documentation of wound care C Nursing staff were educated by DON / designee on Qualified Medication Aides (QMA) Scope of Practice. D An audit will be completed for wound care documentation by DON/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI	05/16/2025

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	There were no progress notes or wound care notes in the medical record related to the left leg wound. The wound was identified as a venous stasis ulcer. During the survey, Resident 3 refused to have the leg wound observed as the dressing was intact and did not want the dressing disturbed. During an interview, on 3/27/2025 at 11:20 A.M., the Director of Nursing indicated QMA's should not be providing treatments that involve a debriding agent. 2. The record for Resident 2 was reviewed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A Nurse Practitioner's Note, dated 3/14/2025, indicated Resident 2 had a stage 2 pressure ulcer/chronic nonhealing wound on their abdomen.The note further indicated: " Plan: Order for bacitracin (antibiotic ointment), apply dime sized amount to skin breakdown area. Order medihoney calcium alginate dressing, 1 to be applied to wound area 3 x weekly until improved. The placement of the mepilex is no longer prophylactic at this time, it has to be connected to a nurse placing it for now. " A Physician's Order, dated 1/4/2024, indicated to apply a mepilex boarder 6" x 6" to abdominal wound three times weekly on Monday, Wednesday and Friday. A Physician's Order, dated 3/14/2025, indicated to apply medihoney 4' x 5" dressing topically to abdominal wound every Monday, Wednesday and Friday then apply mepilex over the dressing for 14 days.		committee to review monthly and to make recommendations as necessary.	

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	A Treatment Administration Record, (TAR) dated February 2025, indicated QMA 5 provided the ordered treatment on 3/19, 3/24 and 3/26. During an interview, on 3/27/2025 at 10:32 A.M., the Director of Nursing indicated a QMA should not have provided the ordered treatments to the abdominal wound. On 3/27/2025 at 10:43 A.M., the Director of Nursing provided the policy titled, "Qualified Medication Aide - Scope of Practice", and indicated the policy was the one currently used by the facility. The policy indicated "...The following tasks shall NOT be included in the QMA scope of practice: ...(6) Administer a treatment that involved advanced skin conditions, including stage II, III and IV decubitus ulcers...." On 3/27/2025 at 12:45 P.M., the Director of Nursing indicated the facility did not have a policy for wound care.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This deficient practice had the potential to affect 100 of 100 residents who consumed food from the kitchen. Findings include: During a tour in the kitchen, with the Dietary Manager, on 3/26/2025 at 9:33 A.M., the following was observed in the walk-in freezer: - two gallon size zip lock bags with cut up pieces	R 0273	The community was alleged to be out of compliance by failing to store food under sanitary conditions related to foods not tightly sealed and outdated foods, for 1 of 1 kitchen observed. This deficient practice had the potential to affect 100 of 100 residents who consumed food from the kitchen. A The foods that were expired were discarded immediately. The foods that were not labeled appropriately, were labeled as such.	05/16/2025

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	of pork with an opened date of 9/16 and used by date of 10/16. - A container of cut peppers with a used by date of 3/25/2025. During an interview, on 3/26/2025 at 9:42 A.M., the Dietary Manager indicated foods should have a used by date labeled on them and the expired foods should have been removed. In the dry storage area the following was observed: - An opened and undated gallon of liquid vanilla with a sticky substance on the outside of the container along with runs of a brown color down the sides. - An opened box of pancake mix not sealed tightly. During an interview, on 3/26/2025 at 9:45 A.M., the Dietary Manager indicated the vanilla had been opened a couple days ago and should have been dated. During a follow-up tour of the kitchen, on 3/26/2025 at 10:55 A.M., the following was observed: - the cooking surface of 6 skillets had no observable Teflon coating left. During an interview, on 3/26/2025 at 11:01 A.M., the Dietary Manager indicated the skillets should not have been used. During an interview, on 3/27/2025 at 11:12 A.M., the Dietary Manager indicated the facility did not have a policy for utensil cleaning and indicated the facility followed the State Regulations. On 3/27/2025 at 10:00 A.M., the Dietary Manager		B Kitchen was audited for items not stored according to professional standards. No other items were identified. C The Dietary staff were educated by the Dietary Manager on proper storage of food. D An audit will be completed by the Dietary Manager/designee three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

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	provided a policy titled," Refrigerated Storage", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation ...." On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled, " Ready-to-Eat Hazardous Food, Date Marking ", and indicated the policy was the one currently used by the facility. The policy indicated "...All ready-to eat potentially hazardous foods prepared on site and held for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises... Ready-to-eat potentially hazardous foods prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in the kitchen and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises or discarded...." On 3/27/2025 at 10:00 A.M., the Dietary Manager provided a policy titled, "Dry Food Storage", and indicated the policy was the one currently used by the facility. The policy indicated "... a) Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be in a clean, covered container except during periods of preparation or service... f). The delivery date shall be written or identified on each product..."			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to ensure physician ordered medications	R 0297	The community was alleged to be out of compliance by failing to	05/16/2025

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	were available for 1 of 8 residents reviewed for medications. (Resident 2) Finding includes: The record for Resident 2 was completed on 3/26/2025 at 1:42 P.M. Diagnoses included, but were not limited to diabetes, abdominal hernia, obesity and depression. A MAR (Medication Administration Record), dated March 2025, indicated Resident 2 received Sertraline (antidepressant) 100 mg (milligram) 1 tablet every evening. On 3/13, 3/14, 3/15 and 3/16 on the MAR, the medication was initialed with an O (other). Under the Notes section on the MAR, the documentation indicated: 3/13 other- Not available. 3/14 -other. 3/15- other- Awaiting pharmacy delivery. 3/16 other- Awaiting pharmacy delivery. During an interview, on 3/27/2025 at 10:36 A.M., the Director of Nursing indicated the EDK (emergency drug kit) only contained minimal medications like Tylenol and Ibuprofen. The DON indicated the staff should have called the pharmacy and the physician about the medication unavailability. She indicated the pharmacy had delivered the next cycle (roll) of medications, which had started on 3/17/2025. On 3/27/2025 at 11:47 A.M., the Director of Nursing provided a policy titled, "Medication Management, Administration & Storage (Indiana and Ohio Only), and indicated the policy was the one currently used by the facility. The policy indicated "... B. Medication Administration: Medication administration will be administered as ordered by the resident's provider...6... If the Community is offering medication administration		ensure physician ordered medications were available for 1 of 8 residents reviewed for medications. A Medication for resident 2 was received from pharmacy. B An house wide audit completed to ensure physician ordered medication were available. C Nursing staff were educated by DON / designee on obtaining physician ordered medication. D An audit will be completed by the DON/designee twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	

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	services for a resident, for quality and safety purposes, the resident will have all medications packaged in pharmacy prepared pill package and in the same scheduling cycle as the Community's primary pharmacy...." 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the clinical record reagarding wound documentation was complete and accurate for 1 of 7 residents reviewed. (Resident 3) Finding includes: A record review for Resident 3 was completed, on 3/26/2025 at 11:38 A.M. Diagnoses included, but were not limited to: dementia, anxiety and atrial fibrillation. A Physician's Order, dated 3/14/2025, indicated Medihoney (wound healing and debridement ointment) to be applied to the affected area on the left leg. There were no progress notes or wound care notes in the medical record related to the left leg wound. During an interview, on 3/27/2025 at 1:30 P.M., the facility Nurse Practitioner indicated Resident 3 had started seeing wound care specialists about two and a half weeks ago. The Nurse Practitioner indicated he put "everything on here on pause" when a specialist was involved. He indicated, "I am in the dark as far as what they [wound care specialist] are doing", and he was not aware of the wound care specialist's recommendations for the left leg wound. He indicated during visits here, the			
R 0349 Bldg. 00		R 0349	The community was alleged to be out of compliance by failing to ensure the clinical record regarding wound documentation was complete and accurate for 1 of 7 residents. A Resident 3 wound record was obtained from MMMD and Goshen Wound Care. B A house wide audit was completed to ensure wound documentation records were obtained for residents receiving wound care. C Nursing staff were educated by DON / designee on obtaining wound documentation from outside providers. D An audit will be completed by the DON/designee twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	05/16/2025

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	Resident's legs were wrapped in dressings. He could not provide any progress notes he had created related to Resident 3's leg wound. A policy was requested for an accurate and complete medical record, on 3/27/2025 at 1:48 P.M. The Director of Nursing indicated at 2:07 P.M., the facility did not have a policy for an accurate and complete medical record and followed the state regulations.			
R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency Based on record review and interview, the facility failed to screen and obtain a history of treatment and behaviors for a resident with a major mental illness prior to admission. (Resident 9) Finding includes: A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: personality disorder, generalized anxiety, major depressive disorder and sleep disorder. Resident 9 admitted to the facility on 8/5/2024. A Pre-Admission Evaluation indicated Resident 9 had anxiety, depression and a mood disorder. The evaluation indicated the resident was being seen by a local "psychological provider." Resident 9 received the following medications according to Physican Orders: -alprazolam (antianxiety medication) 1 milligram four times a day -Suboxone (narcotic analgesic) 12-3 milligrams twice daily	R 0378	The community was alleged to be out of compliance by failing to screen and obtain a history of treatment and behaviors for a resident with a major mental illness prior to admission. A Mental health records were obtained for resident 9. B A house wide audit was completed to ensure major mental health records were obtained for residents with a diagnosis of major mental health illness. C Nursing staff were educated by DON / designee on obtaining major mental health records from mental health facilities for residents with a major mental health diagnosis prior to admission. D An audit will be completed by the DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as	05/16/2025

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	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN OAKS OF GOSHEN	282 JOHNSTON STREET GOSHEN, IN 46528

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	-citalopram (antidepressant) 20 milligrams at bedtime -Suboxone 8-2 milligrams three times daily -mirtazapine (antidepressant) 45 milligrams at bedtime -trazadone (antidepressant) 50 milligrams at bedtime An Assisted Living Facilities/Adult Care Home Assessment and Care Screening completed by the facility, on 2/13/2025, indicated Resident 9 had indicators for delirium and becoming agitated or disoriented which impacted ptoentially endangered his safety or required protection by others. Resident 9 had exhibited persistent anger with himself or others for 1-5 days of the 30-day assessment period. In addition, Resident 9 had indicators of depressed, sad or anxious moods that were not easily altered. Resident 9 also had exhibited verbally abusive behaviors and intimidating behaviors in the past seven days and had a history of these behaviors in the past six months. The facility had requested mental health history records from the local psychological facility on 3/7/2025. During an interview, on 3/27/2025 at 11:04 A.M., the Director of Nursing indicated the facility was aware of Resident 9 having been seen by the local mental health provider, but records had not been obtained from the facility prior to Resident 9's admission. She indicated an initial screening of Resident 9's mental health had not been completed prior to admission. A policy was requested for mental health screening, on 3/27/2025 at 1:48 P.M. The Director of nursing indicated at 2:07 P.M., the facility did		necessary.	

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	not have a policy for mental health screening and followed the state regulations for this policy.			
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency Based on record review and interview, the facility failed to develop, in cooperation with a mental health facility a comprehensive care plan for mental illness for 1 of 9 residents reviewed for mental illness. (Resident 9) Finding includes: A record review for Resident 9 was completed on 3/26/2025 at 11:12 P.M. Diagnoses included, but were not limited to: anxiety, depression, sleep disorder and seizure disorder. Resident 9 admitted to the facility on 8/5/2024. A Service Plan, dated 2/27/2025, indicated Resident 9 needed monitoring related to a history of mood disturbances with a history of anger and physical aggression. Resident 9 presented with behaviors episodically with delusional ideation, as his dog talks to him, and needed support related to anxiety and depression. Resident 9's service plan was not developed in collaboration with the local mental health facility Resident 9 attended as the records for Resident 9 had not been requested until 3/7/2025. During an interview, on 3/27/2025 at 11:04 A.M., the Director of Nursing indicated a comprehensive mental health care plan was not developed in collaboration with Resident 9's mental health provider.	R 0383	The community was alleged to be out of compliance by failing to develop, in cooperation with a mental health facility a comprehensive care plan for a major mental illness for 1 of 9 residents reviewed for mental illness. A A comprehensive care plan was developed in cooperation with resident 9's mental health facility. B A house wide audit was completed to ensure comprehensive care plans for major mental health in cooperation with mental health facility were obtained for residents with a diagnosis of major mental health illness. C Nursing staff were educated by DON/ designee on developing, in cooperation with a mental health facility, a comprehensive care plan for residents who have a major mental health illness diagnosis. D An audit will be completed by the DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	05/16/2025

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		A. BUILDING 00 B. WING	03/28/2025

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	A policy was requested for comprehensive care planning for mental health, on 3/27/2025 at 1:48 P.M. The Director of nursing indicated at 2:07 P.M., the facility did not have a policy for a comprehensive mental health care plan and followed the state regulations for this policy.			
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 residents received annual TB (tuberculosis) risk assessments for 1 of 8 residents reviewed for TB compliance (Resident 6). Finding includes: A record review was completed for Resident 6 on 3/26/2025 at 11:06 A.M. Resident 6 was admitted to the facility on 8/29/2024. Resident 6's record lacked documentation that an annual TB risk assessment had been completed. During an interview, on 3/27/25 at 9:05 A.M., the DON indicated the resident should have had an annual TB risk assessment. On 3/27/2025 at 9:39 A.M., the DON provided a policy titled "Tuberculosis Skin Testing and Follow-up for Employees and Residents," dated 8/2023 and indicated it was the policy currently being used by the facility. The policy indicated "...E.1. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats and weight loss..."	R 0412	The community was alleged to be out of compliance by failing to ensure residents received an annual TB risk assessment for 1 of 8 residents reviewed for TB compliance. A Resident 6 annual TB risk assessment was completed. B A house wide audit was completed to ensure all residents had a annual TB risk assessment completed. C Nursing staff were educated by DON/ designee on completing Annual TB risk assessments for all residents D An audit will be completed by the DON/designee weekly for 4 weeks and monthly thereafter until found in substantial compliance. QAPI committee to review monthly and to make recommendations as necessary.	05/16/2025