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	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HI JILL'S HOUSE LLC	751 E TAMARACK TRAIL BLOOMINGTON, IN 47408

(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 2 and 3, 2024 Facility number: 013824 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 5, 2024.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective April, 24,2024. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC and supporting documents submitted.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shonte Halliday	Director of Operations	04/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation, interview, and record review, the facility failed to ensure a notice was posted of the availability of the most recent annual State survey, the survey book maintained the most recent annual survey and, the last two	R 0090	/p> Based on observation, interview, and record review, the facility failed to ensure a notice was posted of the availability of the most recent annual State	04/16/2024

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	years of surveys for 1 of 2 days of the survey. Findings include: On 4/2/24 at 11:37 a.m., during an initial tour of the facility, the State survey book was located in the foyer area desk drawer. The survey book did not contain the most recent annual survey or the last two years of surveys. A sign alerting residents to where the most recent survey book was located was not observed. During an interview on 4/2/24 at 11:37 a.m., the Director of Operations (DOO) indicated there was no sign alerting residents to where the State survey book was located, the most recent annual survey was not in the book nor the last two years of surveys. She believed a resident may have gone through the book and removed some pages. During an interview on 4/3/24 at 11:20 a.m., the DOO indicated they facility did not have a policy related to a sign which indicated where the most recent State survey book was located or keeping the most recent annual survey and the last two years of surveys in the book. The DOO indicated the facility followed the State rules.		survey, the survey book maintained the most recent annual survey and, the last two years of surveys for 1 of 2 days of the survey. Findings include: On 4/2/24 at 11:37 a.m., during an initial tour of the facility, the State survey book was located in the foyer area desk drawer. The survey book did not contain the most recent annual survey or the last two years of surveys. A sign alerting residents to where the most recent survey book was located was not observed. During an interview on 4/2/24 at 11:37 a.m., the Director of Operations (DOO) indicated there was no sign alerting residents to where the State survey book was located, the most recent annual survey was not in the book nor the last two years of surveys. She believed a resident may have gone through the book and removed some pages. During an interview on 4/3/24 at 11:20 a.m., the DOO indicated	

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			they facility did not have a policy related to a sign which indicated where the most recent State survey book was located or keeping the most recent annual survey and the last two years of surveys in the book. The DOO indicated the facility followed the State rules. 1. Corrective action taken: Survey binder immediately updated and framed sign placed above drawer containing survey binder to notify all of it's location. 2. How other residents were identified: Survey binder corrected and replaced immediately and monitoring put into place. See attached monitoring form. 3. Measure in place/system changes: The Director of Operations or designee will monitor compliance of R 090 by auditing placement of survey binder weekly times 4 weeks and then monthly X 11 months. See attached monitoring tool. 4.Monitoring of Corrective actions	

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			taken: Compliance of R 090 will be reviewed during management meeting weekly X 4 weeks and then monthly X 11 months. 5. Date of compliance: 04/16/2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure staff disposed of expired foods by the expiration date in 1 of 2 kitchen observations. Findings include: On 4/2/24 at 10:20 a.m., initial kitchen tour was competed with Cook 1. Six cartons cartons of heavy whipping cream were observed in the refrigerator with an expiration date of 3/26/24. Cook 1 indicated they were expired and they should of been thrown out. Cook 1 was observed to throw away the 6 cartons of heavy whipping cream. On 4/3/24 at 11:30 a.m., the Facility Director indicated the facility used the State Health Department regulations regarding food storage.	R 0273	=”” p=””> R 273 Food and Nutritional Services Based on observation and interview, the facility failed to ensure staff disposed of expired foods by the expiration date in 1 of 2 kitchen observations. Findings include: On 4/2/24 at 10:20 a.m., initial kitchen tour was competed with Cook 1. Six cartons cartons of heavy whipping cream were observed in the refrigerator with an expiration date of 3/26/24. Cook 1 indicated they were expired and they should of been thrown out. Cook 1 was observed to throw away the 6 cartons of heavy whipping cream. On 4/3/24 at 11:30 a.m., the Facility Director indicated the facility used the State Health Department	05/07/2024

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			regulations regarding food storage. 1. Correction Action taken: Regarding the expired 6 cartons of heavy whipping cream found in the kitchen on 04/02/2024. Dietary staff immediately disposed of expired products. Dietary staff was inserviced on monitoring for and disposing of expired products. On 4/3/24 the facility director indicated the facility use the state health department regulations regarding food storage. See attached inservice, monitoring tool and policy 2. How other residents were identified: All refrigerated products in kitchen were inspected for expiration date on 4/2/24 with no other items noted to be expired. See attached inspection on 4/2/24. 3. Measures in place/system changes: The registered Dietitian, Certified Dietary Manager or designee will monitor compliance of R 273 by auditing 100% of refrigerated items in the facility kitchen monthly for 6 months and then quarterly for 6 months and random checks performed weekly X 4 weeks and then quarterly.. 4. Monitoring of corrective actions taken: Compliance of R 273 will be reviewed by the management meeting monthly. See attached monitoring tool and policy. 5. Date of Compliance: May 7, 2024	

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R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to maintain infection control practices for 1 of 5 residents observed for medication administration. A staff member administered medication to a resident after it was dropped on the floor. (RN 1, Resident 9) Findings include: On 4/3/24 at 12:05 p.m., RN 1 was observed to prepare isosorbide dinitrate (a medication used to prevent chest pain) for Resident 9. RN 1 dropped the pill on the ground and the pill rolled approximately 5 feet before coming to a stop. RN 1 was observed to give the medication, which fell to the floor, and the resident swallowed the pill. During an interview on 4/3/24 at 12:10 p.m., RN 1 indicated she wondered if she should have given the pill to the resident. However, she indicated she would have to throw away a lot of medication if she disposed of every pill that fell to the ground. On 4/3/24 at 12:11 p.m., Resident 9's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and hypertension. A physician's order, dated 8/24/23, indicated the resident was prescribed isosorbide dinitrate 20 milligrams, three times a day.	R 0406	R 406 Infection Control-Offense Based on observation, interview, and record review, the facility failed to maintain infection control practices for 1 of 5 residents observed for medication administration. A staff member administered medication to a resident after it was dropped on the floor. (RN 1, Resident 9) Findings include: On 4/3/24 at 12:05 p.m., RN 1 was observed to prepare isosorbide dinitrate (a medication used to prevent chest pain) for Resident 9. RN 1 dropped the pill on the ground and the pill rolled approximately 5 feet before coming to a stop. RN 1 was observed to give the medication, which fell to the floor, and the resident swallowed the pill. During an interview on 4/3/24 at 12:10 p.m., RN 1 indicated she wondered if she should have given the pill to the resident. However, she indicated she would have to throw away a lot of medication if she disposed of every pill that fell to the ground. On 4/3/24 at 12:11 p.m., Resident 9's clinical record was reviewed. The diagnoses	05/07/2024

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	During an interview on 4/3/24 at 12:12 p.m., the Director of Operations indicated RN 1 should have disposed of the medication and not administered it to the resident. She further indicated the facility did not have a policy in regard to disposal of medications dropped on the ground.		included, but were not limited to, dementia and hypertension. A physician's order, dated 8/24/23, indicated the resident was prescribed isosorbide dinitrate 20 milligrams, three times a day. During an interview on 4/3/24 at 12:12 p.m., the Director of Operations indicated RN 1 should have disposed of the medication and not administered it to the resident. She further indicated the facility did not have a policy in regard to disposal of medications dropped on the ground. 1: Corrective Action Taken: Regarding Resident 9, the Registered Nurse (RN) one (1) was in-serviced on the Infection Control policy and Medication Management policy. 2. How other residents were identified: There were no other residents identified. All registered and licensed nurses and QMA's were in-serviced on the facility Infectious Processes and Medication Management policies. See attached documentation if staff in-service and policies. 3. Measures in place/system changes: The Wellness Director/designee will monitor compliance of R 406 per the facility Medication Management Policy and Infectious Processes policy. Medication administration	

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			and management audits will be conducted weekly X 4 weeks on 4 residents and monthly X 4 months on 4 residents. See attached monitoring and audit tool. 4. Monitoring of corrective actions taken: Monitoring of R 406 will be reviewed by the management meeting weekly X 4 weeks and then monthly X 4 months. 5. Date of Compliance: 05/07/2024	