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	04/24/2024

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00426987, IN00429218, and IN00433132. Complaint IN00426987 - No deficiencies related to the allegations are cited. Complaint IN00429218 - State deficiencies related to the allegations are cited at R0349. Complaint IN00433132 - State deficiencies related to the allegations are cited at R0029. Survey dates: April 23 and 24, 2024 Facility number: 015221 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/01/24.	R 0000	/b>	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on record review and interview, the facility failed to ensure a resident was treated with consideration and respect by a staff member for 1 of 1 residents reviewed for abuse. (Resident C) Finding includes:	R 0029	Facility will educate Activities Director on communication styles. The Activities Director will train with the Corporate Experience Director on various ways to communicate with residents. The Activities Director will also be	06/25/2024

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

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	Resident C's record was reviewed on 4/23/24 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, history of stroke, morbid obesity, anxiety disorder, and intervertebral disc degeneration. The Service Plan, initiated on 2/18/24, indicated the resident exhibited normal, functional behavior patterns and was able to communicate and make her needs known. During an interview on 4/24/24 at 9:28 a.m., Resident C indicated that she had an ongoing situation occurring with the Activity Director which made her feel discriminated against. The situation began a few weeks ago when she was told the ramp on the facility transportation bus was broken and she could not go on a scheduled shopping outing. The following week she was told the ramp on the bus was still broken, however another resident that was on a scooter was able to go on the outing. The Activity Director had indicated to her that the ramp was broken and she had to figure out how to get it fixed. She brought up the fact that her electric wheelchair is 230 pounds and there are weight limits on the ramp. The Activity Director told Resident C that she could find transportation elsewhere such as senior transportation bus services, because she was not going to be able to use the facility transportation any more. After this conversation, she felt very uncomfortable with the Activity Director because she felt that she was being singled out because of her weight. The Activity Director then put a new rule into place only allowing one wheelchair/scooter/electric wheelchair on the bus for outings. The residents had to ask for permission to go on the outings if they were using any one of those mobility devices		assigned monthly Relias training regarding neglect, abuse & communication. The facility will in-service all staff members on resident rights, neglect, and abuse. Facility will audit yearly to ensure all staff goes over residents right, neglect and abuse. Resident in question will continue to be monitored monthly or until needed. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	

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	and it was up to the discretion of the Activity Director whether you could actually go on the outing or not. There was another situation with the Activity Director in which she was speaking about Resident C to another resident in the hallway. CNA 1 overheard the conversation, felt it was inappropriate, and could tell the resident was very uncomfortable as the two residents were friends. CNA 1 told Resident C that she reported it to the Administrator immediately. Resident C also went to the Administrator and had told her that she had felt like she was being discriminated against. She did not think the Administrator had addressed the situation. Resident C indicated she had never thought about her weight in a negative way, however after this situation she became more self-conscious about it. She felt very hurt and singled out. She was observed crying when speaking about the situation that had occurred. She indicated she had been avoiding the Activity Director because of the proceeding events. During an interview on 4/24/24 at 11:17 a.m., CNA 1 indicated that there was a situation in which the Activity Director was talking about Resident C to another resident. She was overheard saying that she (Activity Director) did not feel bad for the resident for being that big and that she needed to do something about it. She was causing too much wear and tear on the bus, she was too big for the bus, and other comments about the resident pushing the weight limits for the ramp. As soon as CNA 1 overheard the conversation, she reported it immediately to the Administrator as it was inappropriate. She also noticed the other resident appeared very uncomfortable with the			

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	conversation taking place. CNA 1 indicated she had noticed a change in Resident C's behavior, as she was found crying since the situation had taken place, had removed herself from some activities, and had been staying in her room more often. CNA 1 had talked to Resident C and she had said she had felt singled out and had never been self-conscious about her weight until this incident occurred. During an interview on 4/24/24 at 11:40 a.m., CNA 2 indicated she had residents who had come to talk to her about the situation between Resident C and the Activity Director. She was told the Activity Director was outside of another resident's room and was talking about Resident C's weight to her. She was telling the other resident how Resident C had almost fallen during an outing, and if she fell she would be stuck there. She said Resident C always purchased too many things when they went on outings. They had placed a new sign up in the elevators within the last week that indicated residents had to sign up for outings, and only one wheelchair/scooter/electric wheelchair was allowed for an outing. Resident C had voiced that she felt the Activity Director implemented the change so that she could single her out and tell her she was unable to go to any outside activities. She had noticed Resident C crying and found her crying a lot in the dining room one day. During an interview on 4/24/24 at 11:50 a.m., the Activity Director indicated she was the primary bus driver and she had to take it upon herself to service the bus. The bus was not able to be used for a couple of days because it was being serviced. It was scheduled on days that there were no appointments and they were trying to limit use of the ramp for the wheelchairs and			

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	scooters until all maintenance was complete. The Activity Director indicated Resident C was pushing the boundaries for the weight limit of that lift and it was starting to lean to one side and was not wanting to go up. Resident C was not able to go to a couple of outings and then just started giving the Activity Director the "cold shoulder." The Activity Director indicated she was not allowed to use the lift for safety reasons, as the lift was making loud noises when it was trying to lift her and the wheelchair up to the bus. The lift was still being used for other residents in wheelchairs and scooters who were not as large because "they were nowhere near the weight limit." Once they had the lift fixed, she was able to go on outings again. She had overheard from other residents that Resident C had felt discriminated against, but she was just identifying necessity versus outings. If Resident C was needing transportation to an appointment, she would have had to find alternative transportation. Resident C was "taking it all personal" and it was just for safety reasons. The Activity Director indicated she had told the Administrator about the situation that had occurred between the two of them. The Activity Director indicated she had watched a safety video for the bus and determined it was better to have one wheelchair/scooter/electric wheelchair in the back of the bus versus two because when there were two, there was not much room between the chairs for her to strap them in. She would have to reach down in between the two chairs and there was not much room for her, and it was difficult for her to do it. It was a lot of work for her to get the two chairs in and then fold and strap all of the walkers onto the bus as well. She also indicated the mechanic at the repair shop had told her that the lift was safe for Resident C to use, as it was an 800 pound weight limit.			

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	The Activity Director indicated she had never spoken of the resident's weight to any other residents, however they had come to her saying Resident C was upset with her because of the missed outings. She tried to address the situation by asking Resident C why she was ignoring her. During an interview on 4/24/24 at 1:01 p.m., the Administrator indicated she was aware of a situation between Resident C and the Activity Director. She had told the resident that the ramp was broken and she could not use it for her own safety. The ramp was scheduled to get fixed the following week. She told the Activity Director to update the resident once the lift was fixed. CNA 1 had talked to the Administrator regarding a situation that she felt was inappropriate. She was under the impression that the Activity Director was discussing the situation with Resident C directly. Another resident may have been with Resident C at the time, as they were together a lot. The Administrator told the Activity Director to no longer talk about residents in the hallways. A Policy titled, "Elder Abuse Policy and Procedure," indicated, "...Residents have the right to be free from physical, verbal, sexual, mental abuse, misappropriation of property, corporal punishment, and involuntary seclusion." This citation relates to Complaint IN00433132.			
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or			

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	discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves			

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	sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone			

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	number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure transfer and discharge paperwork was completed and documented for 2 of 8 resident records reviewed. (Residents 4 and 5) Findings include: 1. Resident 4's record was reviewed on 4/23/24 at 10:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hypertension. An Alert Note, dated 3/6/24, indicated the resident had complained of severe pain in her back and difficulty breathing. 911 was called and the resident was transferred to the hospital. A Health Status Note, dated 3/7/24, indicated the resident had been admitted to the hospital for abnormal labs and pneumonia. There were no transfer or discharge papers in the record. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated when a resident was transferred, they sent the face sheet, medication orders and transfer form. She indicated that was not documented and no copies were available in the record. 2. Resident 5's closed record was reviewed on 4/23/24 at 1:44 p.m. Diagnoses included, but were	R 0045	Facility will create Emergency binder to keep at front desk & nurses station containing all information needed during a transfer/discharge. The facility will in-service all nurses and QMA's on how to properly send out transfer/discharge papers. Emergency Binder will be audited monthly by the Director of nursing on the 1st –5th to ensure all information is still correct. This will be on going every month. Results will be gone over in Monthly QA to ensure it was completed. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024

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	not limited to, atherosclerotic heart disease and vascular dementia. A Health Status Note, dated 12/12/23, indicated the resident was found in her room unable to stand, incontinent and slow to verbally respond. The family was contacted and wanted her sent to the hospital for evaluation. 911 was called and the resident was transferred to the hospital. There were no additional progress notes. There were no transfer or discharge papers in the record. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated when a resident was transferred, they sent the face sheet, medication orders and transfer form. She indicated that was not documented and no copies were available in the record. She also indicated Resident 5 had been admitted to the hospital with a urinary tract infection and went to a skilled rehab facility after hospital discharge. There was no documentation that the resident had been discharged from the facility.			
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			

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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 record review and interview, the facility failed to report a COVID-19 outbreak to the State Agency. This had the potential to affect all 84 residents in the facility.	R 0090	The Administrator will notify the state of any unusual occurrences within 24 hours. The facility will use the Priority Life Care covid tracker and will discuss	06/25/2024

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	Finding includes: On 4/24/24 at 10:55 a.m., the Infection Control Program was reviewed. A document was provided that indicated between 3/15/24 to 3/21/24, 14 residents tested positive for COVID-19 in the facility. During an interview on 4/24/24 at 1:10 p.m., the Administrator indicated the outbreak had not been reported to the State Agency.		any unusual occurrences or results during daily morning meetings & be reviewed at monthly QA. All concierge employees have been coached on proper covid tracker usage. Tracker will be kept at sign in desk. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel			

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	shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certificate scheduled for 5 of 21 shifts and first aid certificate scheduled for 8 of 21 shifts reviewed. This had the potential to affect all 84 residents residing in the facility. Finding includes: Facility staffing schedules for 4/15/24 through 4/21/24 were reviewed on 4/23/24 at 3:05 p.m. The schedules indicated there were no staff members who were CPR or first aid certified on the following dates and shifts: No CPR certification: - Day shift: 4/20/24 and 4/21/24 - Evening shift: 4/19/24 - Midnight shift: 4/19/24 and 4/21/24 No first aid certification: - Day shift: 4/20/24 and 4/21/24 - Evening shift: 4/19/24 - Midnight shift: 4/15/24, 4/17/24, 4/18/24, 4/19/24, and 4/21/24 During an interview on 4/24/24 at 2:01 p.m., the Director of Nursing indicated they had no additional staff CPR or first aide certifications to provide.	R 0117	The Director of Nursing has become a certified CPR/First Aide instructor. The Director of nursing will develop several training courses for current employees to attend. Director of nursing will be the trainer during these courses, and they will be held at our building. The facility will require all new hires to submit a CPR/First Aide License before hire. Scheduler will be responsible for ensuring the correct CPR/first aide license are on each shift, they will be documented on daily schedules. All employee license expiration dates will be audited at Monthly QA Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the			

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	residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on record review and interview, the facility failed to ensure the heating and ventilation system was inspected annually. This had the potential to affect all 84 residents in the facility. Finding includes: On 4/23/24 the annual heating and ventilation inspection was requested for review. During an interview on 4/23/24 at 9:35 a.m., the Maintenance Director indicated he had been in the position since September and there had not been an inspection done since then. The last inspection was requested at that time. No additional information was provided.	R 0148	The Facility will have a yearly HVAC inspection scheduled. Inspection results will be audited yearly & discussed at monthly QA with any changes. Maintenance director will be responsible for scheduling these inspections, and they will be documented in TELS once completed. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure pets were up to date on	R 0151	The facility will have current residents update vaccine records.	06/25/2024

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	vaccinations for 2 of 4 pet vaccination records reviewed. (Room 403) Finding includes: The Pet Policy and pet vaccination records were reviewed on 4/24/24. There were no records available for two cats living in Room 403. During an interview on 4/24/24 at 9:00 a.m., the Administrator indicated there were two cats in the facility that had never been to the vet. She was unsure if she was supposed to make the residents take the pets to the vet. The current policy for pets indicated, "...Registration...All pet owners must register their pets with Provider before the pet is brought into the Community, and must update the registration at least annually...A certificate signed by a licensed veterinarian or a State or local authority empowered to inoculate animals stating that the pet has received all inoculations required by applicable State and local law."		The facility will not accept any new animals into the facility without vaccines records. Administrative assistant will be responsible for corresponding vaccine records with new residents & will follow up with families monthly upon expiring records. These records will be discussed/audited at monthly at QA Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications.			

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	(d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to record weights upon admission and ensure a medication self-administration evaluation was completed for a resident who was self-administering medications, for 2 of 8 residents reviewed. (Residents 2 and 3) Findings include: 1. Resident 2's record was reviewed on 4/23/24 at 11:15 a.m. Diagnoses included, but were not limited to, atrial fibrillation, dementia, depression, and anxiety. The resident was admitted to the facility on 2/6/24. A Service Plan, dated 2/6/24, was completed upon entrance to the facility. There was no documentation of any weights completed for the resident. During an interview on 4/23/24 at 1:43 p.m., the Director of Nursing (DON) indicated she could not provide documentation any weights had been completed.2. Resident 3's record was reviewed on 4/23/24 at 1:15 p.m. Diagnoses included, but were not limited to, malignant neoplasm of prostate, obstructive and reflux uropathy, acute embolism, thrombosis of deep veins of lower extremities, and major depressive disorder. The resident was admitted to the facility on 3/14/24. There was no documentation of a weight obtain upon admission to the facility. A Physician's Order, dated 4/2/24, indicated the resident may self-administer medications.	R 0216	The facility will complete all admissions records before the resident moves in. The director of Nursing will audit all new move ins before and after move in date. Director of nursing & Assistant director of nursing have been coached on acceptable documentation at move in. New move-ins with be audited at Monthly QA. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024

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	There was no evaluation completed for self-administration of medications. During an interview on 4/23/24 at 2:00 p.m., the Director of Nursing indicated the resident did not have a self medication evaluation completed. She also indicated that the residents weights were not completed. 410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) 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. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of			
R 0217 Bldg. 00				

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	the services to be provided. Based on record review and interview, the facility failed to update a Service Plan related to elopement after a resident eloped, for 1 of 8 resident records reviewed. (Resident 5) Finding includes: The closed record for Resident 5 was reviewed on 4/23/24 at 1:44 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease and dementia. A Reportable Incident, dated 11/7/23, indicated the resident was observed by staff wandering in the parking lot of the adjacent hospital. She was approached by staff and said she was looking for her son that had gone to the carnival. She was directed back to the facility. The resident's Service Plan indicated the resident had unspecified behaviors. On 11/17/23, the Service Plan was updated to include to report changes from baseline behaviors to nurse, and the resident responds to reorientation and redirection when wandering. There were no updates related to the elopement or exit seeking behaviors. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated Service Plans should be updated following an elopement.	R 0217	The Director of nursing will update services plans with any changes in behaviors or conditions. These will be discussed in daily morning meetings. The facility will create a monthly weight clinic on the 1st –3rd of the month where all resident weights will be recorded. Any abnormal findings will be discussed in morning meeting. Service plans & weight clinics will be facilitated by Director of Nursing. All new residents will be audited at monthly QA by Director of Nursing, assistant director of nursing & the administrator. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024
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			

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	standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to maintain proper kitchen sanitation related to low dishwasher temperatures, dry food storage bins open to room air, food touching the ceiling in the freezer, a thermometer used to check food temperatures cleaned improperly, and sanitation buckets not at proper sanitation level. This had the potential to affect all 84 residents who received food from the kitchen. Findings include: 1. During the initial kitchen tour with Cook 1 and the Dietary Director on 4/23/24 at 8:53 a.m., the following was observed: a. There were 5 dry food storage bins uncovered and open to room air. b. The freezer was noted to have food items touching the ceiling. During an interview on 4/23/24 at 8:45 a.m., Cook 1 indicated the storage bins were usually closed. During an interview on 4/23/24 at 8:47 a.m., the Dietary Director indicated the food should not touch the ceiling. 2. On 4/23/24 at 9:36 a.m., Kitchen Aide 1 was observed running a load of dirty dishes through the dishwasher. The dishwasher was observed to reach 113 degrees Fahrenheit on the wash cycle display screen. The dishwasher was a high temperature dishwasher. During an interview on 4/23/24 at 9:42 a.m., the Dietary Director indicated he was not aware the dishwasher wasn't reaching the correct	R 0273	The Facility will provide in-service all kitchen staff on proper storage and sanitation standards. The Dietary Director will audit proper temperatures for food & dishwasher in a daily log. The facility will discuss these temperature logs at Monthly QA meetings. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024

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	temperature. 3. On 4/23/24 at 11:05 a.m., Cook 1 was observed checking food temperatures on the steam table. Cook 1 proceeded to insert the thermometer into the pan of string beans, obtained the temperature, removed the thermometer, and cleaned off the thermometer with the sanitation bucket towel. Cook 1 reinserted the thermometer into the pan of Salisbury steak, obtained the temperature, removed the thermometer, and cleaned off the thermometer with the same sanitation bucket towel. During an interview on 4/23/24 at 11:09 a.m., Cook 1 indicated she always used the towel to clean the thermometer. 4. The sanitation buckets were observed on 4/24/24 at 9:25 a.m. Two sanitation buckets filled with solution were tested with the Dietary Director and Kitchen Aide 1. Bucket 1's microlab test strip indicated the sanitation level was 200 parts per million (ppm). Bucket 2's test strip indicated the sanitation level was 150 ppm. Neither strip turned the proper sanitation color (green), which indicated a 400 ppm sanitation level. During an interview on 4/24/24 at 9:28 a.m., the Dietary Director indicated he usually checked the sanitation levels on all the sanitation buckets, and they should read at least 400 ppm for proper sanitizing.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that			

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	responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to lack of monitoring a resident on antibiotics and medications not signed out as administered, for 2 of 8 records reviewed. (Residents 5 and B) Findings include: 1. Resident 5's closed record was reviewed on 4/23/24 at 1:44 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease and vascular dementia. On 11/10/23 the resident was positive for a urinary tract infection (UTI). A Physician's Order, dated 11/11/23, indicated to give Cipro (an antibiotic) 500 milligrams, twice daily for 7 days for the UTI. There were no progress notes related to the resident's status and there were no vital signs, including temperature, documented while having the UTI and receiving antibiotic treatment. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated when residents had an infection, they should be monitored every shift for adverse medication effects, improving or worsening symptoms and temperature. 2. Resident B's record was reviewed on 4/23/24 at 9:31 a.m. Diagnoses included, but were not limited to, bipolar disorder, hypothyroidism and high blood pressure.	R 0349	All nurses & QMA's will be in-serviced by Director of Nursing on the correct clinical charting. The facility will set up an infection control binder that will be updated as needed and audited monthly at the monthly QA meeting by director of nursing & administrator. The Nurses & QMA's will monitor and chart any antibiotic use for the use of the antibiotic & 3 days after. The Director of nursing will monitor charting daily. The Director of nursing will monitor the MAR daily to ensure all medications are being administered. Results will be discussed at monthly QA by director of nursing, assistant director of nursing & Administrator. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	06/25/2024

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	The Service Plan, dated 1/27/24, indicated Resident B was oriented and able to make safe judgments. She required help with medications due to cognitive loss. The April 2024 Physician's Order Summary (POS), indicated the resident was prescribed the following medications: - amlodipine besylate (high blood pressure medication) 10 milligram (mg) tablet once a day - aripiprazole (bipolar treatment) 10 mg tablet once a day - atorvastatin calcium (high cholesterol treatment) 40 mg tablet once a day - celebrex (anti-inflammatory drug) 200 mg capsule twice a day - clonazepam (anxiety treatment) 0.5 mg tablet at bedtime - clonidine (high blood pressure treatment) 0.1 mg tablet three times a day - ditropan (overactive bladder treatment) extended release tablet 5 mg once a day - duloxetine (depression treatment) 40 mg capsule - levothyroxine sodium (hypothyroidism treatment) 150 microgram (mcg) tablet once a day - lisinopril (high blood pressure treatment) 20 mg tablet once a day - Tylenol 500 mg, two tablets three times a day The February 2024 Medication Administration Record (MAR) indicated the following medications were not marked as administered on the following dates and times: - clonazepam on 2/1/24, 2/3/24, and 2/4/24 at 8:00 p.m. - clonidine on 2/1/24, 2/5/24, and 2/8/24 at 2:00 p.m. - levothyroxine on 2/3/24, 2/12/24, 2/17/24, 2/18/24, and 2/21/24 at 6:00 a.m. - Tylenol on 2/1/24, 2/5/24, and 2/8/24 at 2:00 p.m.			

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	The March 2024 MAR indicated the levothyroxine medication was not marked as administered on 3/17/24 at 6:00 a.m. The April 2024 MAR was blank for the medications on the following dates and times: - amlodipine, aripiprazole, atorvastatin, celebrex, ditropan, duloxetine, lisinopril, and Tylenol on 4/4/24 at 9:00 a.m. During an interview on 4/24/24 at 1:30 p.m., the Director of Nursing indicated she had no further information to provide. This citation relates to Complaint IN00429218.			
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 record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to lack of Physician Orders for testing and isolation, lack of Physician and family notification, and lack of monitoring for COVID-19 positive residents during isolation, for 3 of 3 residents reviewed for infection control. (Residents 2, 9 and B) The facility also did not adhere to work restriction guidelines for a COVID-19 positive staff member. (Employee 1) Findings include:	R 0406	The facility will notify physicians of any symptoms to receive a physician order. Once submitted, the family will be noticed by the clinical staff. Any cases will be discussed at morning meetings. The facility will chart daily on residents' symptoms & will be discussed at morning meeting. The Director of nursing will audit physicians' orders daily and will be discussed during monthly QA. Director of nursing and assistant Director of nursing has been coached on correct order entering	06/25/2024

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	The Infection Control Program was reviewed on 4/24/24 at 10:55 a.m. An untitled document indicated residents who had tested positive for COVID-19, the date, and their symptoms. 1. Resident 2 tested positive for COVID-19 on 3/18/24. He had symptoms that included cough and congestion. There were no Physician Orders for COVID-19 testing or type and duration of isolation after testing positive. There was no documentation the Physician or family had been notified. There were no Progress Notes related to COVID-19 infection or vital signs documented. A Progress Note, dated 3/20/24, indicated the resident was in the hospital. The resident returned on 4/3/24. There was no documentation why the resident had been hospitalized. During an interview on 4/24/24 at 12:09 p.m., the Director of Nursing (DON) indicated residents should be monitored every shift to ensure there were no worsening symptoms or temperature. She was made aware of the missing documentation. 2. Resident 9 tested positive for COVID-19 on 3/21/24. She had symptoms of cough and weakness. There were no Physician Orders for COVID-19 testing or type and duration of isolation after testing positive. There was no documentation the Physician or family had been notified.		by the regional Director of nursing. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	

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	There were no Progress Notes between 2/20/24 and 3/26/24, or vital signs documented. During an interview on 4/24/24 at 12:09 p.m., the Director of Nursing (DON) indicated residents should be monitored every shift to ensure there were no worsening symptoms or temperature. She was made aware of the missing documentation. 3. Resident B tested positive for COVID-19 on 3/19/24. She had symptom of congestion. There were no Physician Orders for COVID-19 testing or type and duration of isolation after testing positive. There was no documentation the Physician had been notified. A Progress Note, dated 3/19/24, indicated the resident was complaining of cough and congestion. A COVID-19 test had been given and was positive. The daughter was notified. There were no additional Progress Notes or vital signs documented. The undated document, "COVID-19 Clinical Updates", indicated, "...Ensure Physicians and families of residents are notified of any positive cases...", and "...If you have an outbreak in a specified unit, we will begin monitoring daily for s/s (signs and symptoms) of covid, including a temp, until you are out of outbreak...." During an interview on 4/24/24 at 12:09 p.m., the Director of Nursing (DON) indicated residents should be monitored every shift to ensure there were no worsening symptoms or temperature. She was made aware of the missing documentation.			

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	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO SENIOR VILLAGE	74 E JOURNEY WAY VALPARAISO, IN 46383

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	4. During an interview on 4/24/24 at 12:09 p.m., the DON indicated one staff member (Employee 1) had tested positive on 3/18/24. The employee returned to work on 3/21/24 because she was having symptoms of fever and congestion long before she tested positive. The DON was not aware the employee was still required to be restricted from work for 10 days. The Indiana Department of Health document, "Infection Control Guidance Refresher for COVID-19", dated 8/24/23, indicated, "...Restrict from work for 10 days if asymptomatic, or mild to moderate illness. Return at that time if improving symptoms, and fever free without fever reducing meds for 24 hours..."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to ensure infection control measures were in place and implemented, related to opening a medication capsule with bare hands during a medication pass, for 1 of 1 staff observed during medication pass. (QMA 1 and Resident 10)	R 0407	The facility will provide in-service Nurses & QMA's on proper administering and passing procedures. Yearly trainings will be provided by the Director of Nursing. Employees will be audited yearly	06/25/2024

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	Finding includes: On 4/23/24 at 9:30 a.m., QMA 1 was observed preparing Resident 10's medications. She had put 3 different pills into a medication cup. She indicated they were to be crushed. She removed one of the pills from the cup with her hand, opened the capsule and poured the medication into the medication cup. She was not wearing any gloves when she opened the capsule. She then proceeded to crush the other medications and added apple sauce to the medication cup. She then administered the medications to Resident 10. During an interview after the observation, the QMA indicated she was aware she should have donned a pair of gloves before opening the medication capsule.		by the Director of nursing. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in monthly QA.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had an annual signed health statement, for 3 of 8 residents reviewed for annual health statements. (Residents C, 4, and 5) Findings include: 1. Resident C's record was reviewed on 4/23/24 at 1:25 p.m. Diagnoses included, but were not limited to, anxiety disorder, stroke, and intervertebral disc degeneration. The resident was admitted to the facility on 1/12/22.	R 0409	The facility will discuss annual health assessments needed during monthly QA and audit files monthly. Director of nursing will audit these the 1-3rd of the month. Administrative assistant will offer resident surveys monthly to ensure if residents feel they are being treated fairly or have any other issues that need to be addressed. Will go over results in	06/25/2024

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	The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated the annual health statement should be on the Physician Order Summary. 2. Resident 4's record was reviewed on 4/23/24 at 10:30 a.m. Diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, and chronic obstructive pulmonary disease. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated the annual health statement should be on the Physician Order Summary. 3. Resident 5's record was reviewed on 4/23/24 at 1:44 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, type 2 diabetes mellitus, and major depressive disorder. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 4/23/24 at 2:35 p.m., the Director of Nursing indicated the annual health statement should be on the Physician Order Summary.		monthly QA.	