STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00367476, IN00368516, IN00370148 and IN00374153. Complaint IN00367476 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00368516 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00370148 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00374153 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: March 14, 15, 16, 17, 18 and 21, 2022. Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 71 SNF: 9 Residential: 26 Total: 106 Census Payer Type: Medicare: 9 Medicaid: 57 Other: 14 Total: 80	F 0000		

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

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/28/22.			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Comprehensive assessment was accurately completed related to oxygen use for 1 of 18 MDS assessments reviewed. (Resident 63) Finding includes: Resident 63's record was reviewed on 3/17/22 at 9:46 a.m. The resident was admitted on 2/11/22. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The Admission MDS assessment, dated 2/17/21, indicated the resident was cognitively intact, did not use oxygen while not a resident, and did not use oxygen while a resident at the facility. A Physician's Order, dated 2/11/22, indicated the resident was to use oxygen at 2 liters per minute to maintain an oxygen saturation above 90%. Interview with the resident on 3/17/22 at 10:35 a.m., indicated she used oxygen every night when at home and every night while at the facility. Interview with MDS Nurse 1 on 3/17/22 at 10:40 a.m., indicated assessments were completed by	F 0641	**It is the policy of Crown Point Christian Village to follow all federal, state, and local guidelines, laws, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents, or other individuals. The response to the alleged insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission, and implementation of this plan of correction will serve as credible allegation of compliance.** **F-641** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** A modification was completed of R63's 2/17/2022 Admission/Medicare - 5-day	04/08/2022

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	reviewing the resident's record and Physician orders. She indicated her oxygen needs had not been correctly assessed.		assessment for coding of oxygen therapy services. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Director of Nursing and Resident Assessment Coordinators conducted a review of residents receiving oxygen services to identify other residents having the potential to affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 3/28/2022, an in-service educational program was conducted by the Corporate Director of Clinical Reimbursement with the Resident Assessment Coordinators (RACs) addressing the accuracy of MDS coding, updating the comprehensive care plans with the residents' diagnoses, the baseline care process, and the importance of identifying respiratory care services in the resident's care plan. The RACs will review the residents' medical record to ensure: 1) all diagnoses documented by a practitioner in a 60-day look back and active in the	

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			7-day look back are included in the MDS and care plan, 2) any treatments included in physician orders, including respiratory care, etc. are included in the MDS and care plan as applicable. Before signing the care plan review, the RAC will validate that the following are included in the residents' care plan: 1) all diagnoses documented by a practitioner and active in 7-day look back and 2) any treatments included in physician orders, including respiratory care. To accomplish these tasks, the RACs will run the diagnosis report and review Section I to verify active diagnoses are included in MDS and care plan as applicable, review the residents' physician orders to check for any treatments, including respiratory care, and verify they are addressed on the care plan. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Director of Nursing or designee will complete weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of scheduled MDS ARDs to ensure compliance with accuracy of diagnoses coding, and	

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			physician orders on the baseline care plans and comprehensive care plans. Concerns identified in the auditing process will be reported to the Corporate Director of Clinical Reimbursement for follow up staff re-education or other corrective actions. The RACs or designee will present the audit findings to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic changes for the alleged deficiency will be completed:** 4/08/2022	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-			

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	(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review and interview, the facility failed to complete a Baseline Care Plan for respiratory care for 1 of 18 Care Plans reviewed. (Resident 63) Finding includes: Resident 63's record was reviewed on 3/17/22 at 9:46 a.m. The resident was admitted on 2/11/22. Diagnoses included, but were not limited to,	F 0655	**It is the policy of Crown Point Christian Village to follow all federal, state, and local guidelines, laws, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents, or other individuals. The response to the alleged**	04/08/2022

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	chronic obstructive pulmonary disease. The Admission MDS assessment, dated 2/17/21, indicated the resident was cognitively intact, did not use oxygen while not a resident, and did not use oxygen while a resident at the facility. A Physician's Order, dated 2/11/22, indicated the resident was to use oxygen at 2 liters per minute to maintain an oxygen saturation above 90%. A Baseline Care Plan had been completed and signed by the resident on 2/15/22. The care plan did not include respiratory care or oxygen use. Interview with the resident on 3/17/22 at 10:35 a.m., indicated she used oxygen every night when at home and every night while at the facility. Interview with MDS Nurse 1 on 3/17/22 at 10:40 a.m., indicated assessments were completed by reviewing the resident's record and Physician orders. She indicated there was not a Baseline Care Plan for the resident's respiratory care including oxygen.		**insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission, and implementation of this plan of correction will serve as credible allegation of compliance.** **F-655** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/17/2022, R63's plan of care was updated to address respiratory care services. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Director of Nursing and Resident Assessment Coordinators conducted a review of residents receiving respiratory care services to identify other residents having the potential to affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	

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			On 3/28/2022, an in-service educational program was conducted by the Corporate Director of Clinical Reimbursement with the Resident Assessment Coordinators (RACs) addressing the accuracy of MDS coding, updating the comprehensive care plans with the residents' diagnoses, the baseline care process, and the importance of identifying respiratory care services in the resident's care plan. The RACs will review the residents' medical record to ensure: 1) all diagnoses documented by a practitioner in a 60-day look back and active in the 7-day look back are included in the MDS and care plan, 2) any treatments included in physician orders, including respiratory care, etc. are included in the MDS and care plan as applicable. Before signing the care plan review, the RAC will validate that the following are included in the residents' care plan: 1) all diagnoses documented by a practitioner and active in 7-day look back and 2) any treatments included in physician orders, including respiratory care. To accomplish these tasks, the RACs will run the diagnosis report and review Section I to verify active diagnoses are included in MDS and care plan as applicable, review the residents' physician	

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			orders to check for any treatments, including respiratory care, and verify they are addressed on the care plan. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Director of Nursing or designee will complete weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of scheduled MDS ARDs to ensure compliance with accuracy of diagnoses coding, and physician orders on the baseline care plans and comprehensive care plans. Concerns identified in the auditing process will be reported to the Corporate Director of Clinical Reimbursement for follow up staff re-education or other corrective actions. The RACs or designee will present the audit findings to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic changes for the alleged deficiency will be completed:** 4/08/2022	

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			MDS Accuracy, Baseline Care Plan, and Comprehensive Care Plan Audit **Audit Date:** _____ Instructions: Complete weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of scheduled MDS ARDs to ensure compliance with accuracy of diagnoses coding, and physician orders on the baseline care plans and comprehensive care plans. Record N/A if the resident is not eligible for a baseline care or initial review is for the baseline care plan only. Audit Conducted By: _____ _____ **Resident's Name** **ARD** **Diagnosis Report reviewed with MDS Section I – Care Plan current with Diagnoses** **Baseline Care Plan Updated with Physician's Orders** **Comprehensive Care Plan Updated with Physician's Orders** **Comments/ Corrective Actions** **Yes** **No** **Yes** **No** **N/A** **Yes** **No**	

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			N/A	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.			

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	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure a Care Plan was reviewed and revised as needed related to medication use for 1 of 21 residents whose Care Plans were reviewed. (Resident 36) Finding includes: The record for Resident 36 was reviewed on 3/17/22 at 9:50 a.m. Diagnoses included, but were not limited to, high blood pressure, thyroid disorder, and Alzheimer's disease. The Annual Minimum Data Set (MDS) assessment, dated 1/24/22, indicated the resident was cognitively severely impaired and had behaviors that changed in severity. A Physician's Order, dated 5/5/21, indicated to administer a Synthroid tablet (a medication used for treatment of underactive thyroid), 50 micrograms, one time a day. The record lacked a Care Plan related to hypothyroidism. Interview with the MDS Coordinator on 3/17/22 at 1:59 p.m., indicated the resident should have a care plan related to hypothyroidism as it was one of her diagnoses listed on the recent MDS assessment. 3.1-35(b)(1)	F 0657	**F-657** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/17/2022, R36's plan of care was updated to address the hypothyroidism diagnosis. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Resident Assessment Coordinators conducted a review of residents with thyroid or hypothyroidism diagnoses to identify other residents having the potential to affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 3/28/2022, an in-service educational program was conducted by the Corporate Director of Clinical Reimbursement	04/08/2022

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			with the Resident Assessment Coordinators (RACs) addressing the accuracy of MDS coding, updating the comprehensive care plans with the residents' diagnoses, the baseline care process, and the importance of identifying respiratory care services in the resident's care plan. The RACs will review the residents' medical record to ensure: 1) all diagnoses documented by a practitioner in a 60-day look back and active in the 7-day look back are included in the MDS and care plan, 2) any treatments included in physician orders, including respiratory care, etc. are included in the MDS and care plan as applicable. Before signing the care plan review, the RAC will validate that the following are included in the residents' care plan: 1) all diagnoses documented by a practitioner and active in 7-day look back and 2) any treatments included in physician orders, including respiratory care. To accomplish these tasks, the RACs will run the diagnosis report and review Section I to verify active diagnoses are included in MDS and care plan as applicable, review the residents' physician orders to check for any treatments, including respiratory care, and verify they are addressed on the care plan.	

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			How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place): The Director of Nursing or designee will complete weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of scheduled MDS ARDs to ensure compliance with accuracy of diagnoses coding, and physician orders on the baseline care plans and comprehensive care plans. Concerns identified in the auditing process will be reported to the Corporate Director of Clinical Reimbursement for follow up staff re-education or other corrective actions. The RACs or designee will present the audit findings to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic changes for the alleged deficiency will be completed: 4/08/2022** MDS Accuracy, Baseline Care Plan, and Comprehensive Care Plan Audit	

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			Audit Date: _____ Instructions: Complete weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of scheduled MDS ARDs to ensure compliance with accuracy of diagnoses coding, and physician orders on the baseline care plans and comprehensive care plans. Record N/A if the resident is not eligible for a baseline care or initial review is for the baseline care plan only. Audit Conducted By: _____ _____ **Resident's Name** **ARD** **Diagnosis Report reviewed with MDS Section I – Care Plan current with Diagnoses** **Baseline Care Plan Updated with Physician's Orders** **Comprehensive Care Plan Updated with Physician's Orders** **Comments/ Corrective Actions** **Yes** **No** **Yes** **No** **N/A** **Yes** **No** **N/A**	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who required staff assistance for activities of daily living (ADLs) received necessary services related to bathing for 1 of 3 sampled residents reviewed for ADLs. (Resident B) Finding includes: Resident B's closed record was reviewed on 3/15/22 at 2:38 p.m. Diagnoses included, but were not limited to, hypertension, dementia, and anxiety disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 11/2/21, indicated the resident was mildly cognitively impaired and required an extensive assist of one with transferring, dressing, and personal hygiene. A Care Plan indicated the resident required extensive assistance with transfers, bed mobility,	F 0677	**F677 ADL Care Provide for Dependent Residents 483.24(a)(2)** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident R-B no longer resides in the community. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Director of Nurses and unit managers conducted reviews of residents' ADL bathing records to determine other residents having the potential to be affected by the alleged deficient practice with	04/11/2022

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	and toileting. The interventions included, "...prefers to let staff know when she wants to shower, still offer as scheduled..." The bathing tasks charted in the computer, dated 10/2021 and 11/2021, indicated the resident's shower/bathing days were Tuesdays and Fridays. There was lack of documentation the resident received any shower or bathing on 10/8/21, 10/29/21, and 11/2/21. The resident only received partial bathing on 10/5/21, 10/12/21, 10/26/21, and 11/12/21. Interview with the Assistant Director of Nursing (ADON) on 3/16/22 at 12:58 p.m., indicated all showers or bathing should have been documented in the computer under the ADL bathing task. Refusals would be documented there as well. This Federal Tag relates to Complaint IN00374153. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)		additional showers or baths provided as indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Nursing or designee will conduct in-service education to direct care personnel addressing resident preferences in bathing, showers/bathing schedules, documentation of bathing ADLs, and facility expectations that resident shower or baths be given as scheduled. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The unit managers or designee(s) will monitor Point of Care reports to ensure that showers and baths were documented as required. The unit managers will conduct random bathing audits reviewing resident showers and baths four (4) times per week for eight (8) weeks then two (2) times per week for 18 weeks to ensure compliance with providing showers or baths for dependent residents including accurate documentation and validating showers or baths as given. Concerns identified from the audit will be reported to the	

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			Director of Nursing or designee for follow up corrective actions. Findings from the environmental audits will be presented to the Quality Assurance Committee for review and recommendations in sustaining substantial compliance with providing ADLs showers and baths for dependent residents. **By what date the systemic changes for the alleged deficiency will be completed:** 4/11/2022 **Shower and Bath Validation Audit** **Audit Date:** _____ **Purpose: Assure compliance with residents receiving baths and showers as scheduled.** **Instructions: Target residents scheduled for baths or showers in the past 24 – 72 hours.** **Resident's Name** **Shower or Bath on Bathing Schedule** **Bathing or Shower Preference Recorded** **Bathing or Shower Documented as Given** **Resident Refusals Documented** **If Interview-able, ask the resident if they received a shower or bath** **Comments** **Yes** **No**	

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			Yes **No** **N/A** **Yes** **No** **Yes** **No** **N/A** **Yes** **No** **N/A**	

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			Corrective or Other Follow-up Actions: **Audit Conducted By:** -- -_____ _____	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure treatment for edema was initiated as ordered for 1 of 1 residents reviewed for edema. (Resident 75) Finding includes: On 3/14/22 at 12:53 p.m., Resident 75 was observed seated in her room. She had shoes on with no socks, and her legs were reddened and swollen. On 3/16/22 at 9:50 a.m., the resident was in the dining room, she had no socks on and her legs were red and swollen. The resident's record was reviewed on 3/16/22 at 9:12 a.m. Resident diagnoses included, but were not limited to, congestive heart failure and Diabetes Mellitus. The Quarterly Minimum Data Set assessment, dated 2/23/22, indicated the resident had moderately impaired cognition and required extensive one person assistance for dressing. A Physician's Order, dated 2/18/21, indicated to resume tubi-grips (compression socks), and elevate legs. Review of the February and March 2022 Treatment Administration Record (TAR), did not include the order for the resident to wear tubi-grips or to elevate legs. Interview with the Assistant Director of Nursing,	F 0684	**F-684** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/16/2022, R75's primary care physician was updated on the status of the resident's Tubigrip orders with clarification orders given to include an application and removal schedule. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Director of Nursing and unit managers conducted a review of physician orders to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Nursing or designee will conduct in-service training for licensed nursing staff regarding the importance of reviewing new orders to ensure	04/11/2022

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	on 3/16/22 at 1:00 p.m., indicated the nurse had put the order in, but it had never transferred over to the TAR. She indicated it would be corrected. 3.1-37(a)		compliance with the scheduling the application and removal of compressions devices. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Director of Nurses, unit managers, or designee will complete random weekly audits of 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of new or current orders for compression dressings or devices to ensure compliance with scheduling and application as ordered. Findings from the quality of care compression orders audit will be presented to the Quality Assurance Committee for review and recommendations in achieving and maintaining substantial compliance with standards of practices. **By what date the systemic changes for the alleged deficiency will be completed:** 04/11/2022 F-684 Quality of Care Compression Dressing or Device Audit **Audit Date:**	

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			Instructions: Complete random weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of new or current compression dressings or devices to ensure compliance with scheduling and application as ordered. Record N/A if the resident does not have orders for a compression dressing or device. Audit Conducted By: _____ _____ Resident's Name and Room Number **Does the resident have orders for a compression dressing or device such as Tubigrip?** **If yes, record the name of the compression dressing or device. Otherwise record N/A** **Does the compression dressing or device orders include parameters for application and removal?** **Does the visual observation of the resident validate compliance with the compression dressing/device orders?** **Comments/Follow-up Actions** **Yes** **No** **Yes** **No** **N/A** **Yes** **No** **N/A**	

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F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident was provided with medically-related social services related to hearing aids for 1 of 1 residents reviewed for vision and hearing. (Resident 36) Finding includes: Interview with Resident 36's family on 3/14/22 at 2:20 p.m., indicated the resident had not had hearing aids for 3 years and there had not been any follow up with the family. The record for Resident 36 was reviewed on 3/18/22 at 11:42 a.m. Diagnoses included, but were not limited to, high blood pressure, thyroid disorder, and Alzheimer's disease. The Annual Minimum Data Set (MDS) assessment, dated 1/24/22, indicated the resident	F 0745	**F-745** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/18/2022, the Social Services coordinator completed a reconsideration for a hearing aid on behalf of R-36 and the reconsideration remains pending review at this time with the resident's son updated on 3/23/2022 regarding the status of the hearing aid reconsideration review. **How other residents having the potential to be affected by the**	04/08/2022

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	was cognitively severely impaired and had minimal difficulty hearing without the use of hearing aids. The Care Plan, revised on 1/24/22, indicated the resident had a communication problem related to a hearing deficit. An intervention, dated 4/10/2020, indicated for the resident to have a hearing consult from audiology. Social Service Notes indicated the following: - 9/2/2021 at 11:21 a.m., indicated the audiologist completed a visit with the resident on 8/31/21 with no new orders. A recommendation was made for a hearing aid and the ear impression was completed. - 12/7/21 at 2:29 p.m., the forms from the audiologist were received and indicated the Physician or Nurse Practitioner had not completed the forms. - 1/13/22 at 1:19 p.m., contacted audiologist and were awaiting a response. - 1/17/22 at 1:46 p.m., contacted audiologist about the hearing aid and audiologist indicated that Medicaid had denied the request for a new hearing aid. A reconsideration and a decision had not been made at this time. Interview with the Social Service Director (SSD) on 3/17/22 at 2:43 p.m., indicated the request for the hearing aid was suspended until further information was provided to the audiologist. The SSD indicated there was a lack of follow up with the resident and the family about the hearing aid. 3.1-34(a)		**same alleged deficient practice will be identified and what corrective action(s) taken:** The Social Services Director and designee completed a review of resident issues or concerns to identify other residents having the potential to be affected by the same alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 3/30/2022, the Social Service Director and Social Services coordinator completed an educational review of the policies addressing medically-related social services needs and how those needs are being addressed. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** As of 3/29/2022, the Social Services director, coordinator, or designee will establish an ongoing tracking log for requested or required medically-related services. The tracking log shall include the requested services, vendor recommendations, resident/responsible party notifications, and follow up efforts to ensure timely compliance in meeting the residents' physical,	

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			mental and psychosocial need such as hearing aids. The Social Services director or designee will submit an overview of the tracking log issues or concerns monthly to the Quality Assurance Committee for review and recommendations in sustaining substantial compliance with providing timely medically-related service needs. **By what date the systemic changes for the alleged deficiency will be completed: 04/08/2022**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or			

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	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure correct parameters for insulin and parameters for a blood pressure medication were in place, parameters were followed for a blood pressure medication, and follow up on laboratory results was completed for 3 of 5 residents reviewed for unnecessary medications. (Residents 17, 16, and 36) Findings include: 1. Resident 17's record was reviewed on 3/17/22 at 1:07 p.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus. A Physician's Order, dated 2/17/22, indicated the resident was to receive Novolog (insulin) two times a day based on the following sliding scale for blood glucose levels: 201-250 give 4 units 301-350 give 6 units 351-400 give 10 units The sliding scale lacked units of insulin to give if blood glucose was between 251-300. Interview with the Assistant Director of Nursing on 3/17/22 at 3:05 p.m., indicated she was not aware the order was missing parameters. During a follow up interview on 3/18/22 at 8:35 a.m., she indicated the Nurse Practitioner had input the orders incorrectly, and it had now been corrected.2. The record for Resident 16 was reviewed on 3/17/22 at 9:30 a.m. Diagnoses included, but were not limited to, hypertension, osteoarthritis, and type 2 diabetes mellitus.	F 0757	**F-757** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/16/2022, R-36's primary medical provider was updated on the resident's blood pressure medications and previous lab orders. The resident received orders to obtain a TSH on 3/17/2022. The TSH results were received on 3/18/2022 and reported then nurse practitioner with no new orders received. On 3/17/2022, R-17 was examined by the geriatric medicine practitioner with orders received clarifying the parameters for the resident's insulin medication. On 3/17/2022, R-16's primary medical practitioner was updated on the resident's status and gave orders clarifying the blood pressure medication to include heart rate parameters. On 3/25/2022, the consultant pharmacist conducted additional medication regimen reviews for R-16, R-17, and R-36 with any recommendations reported to the residents' primary medical provider for corresponding orders and implementation.	04/11/2022

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	A Care Plan, last updated 1/20/22, indicated the resident had hypertension. The nursing interventions included to administer antihypertensive medications as ordered. The March 2022 Physician Order Summary indicated an order for metoprolol (a medication to treat high blood pressure) 25 mg (milligrams) two times a day. Hold the medication if the heart rate was less than 60. The Medication Administration Record (MAR), dated 3/2022, indicated the metoprolol medication had been given twice a day except for being held once on 3/3/22 and once on 3/8/22. There was lack of documentation of any heart rate monitoring on the MAR. Interview with the Director of Nursing (DON) on 3/17/22 at 12:52 p.m., indicated the medication should have been given or held according to the parameters and the pulse should have been monitored. 3. The record for Resident 36 was reviewed on 3/17/22 at 9:50 a.m. Diagnoses included, but were not limited to, high blood pressure, thyroid disorder, and Alzheimer's disease. The Annual Minimum Data Set (MDS) assessment, dated 1/24/22, indicated the resident was cognitively severely impaired and had behaviors that changed in severity. A Physician's Order, dated 1/21/21, indicated to administer amlodipine besylate (a medication used to lower the blood pressure) 10 milligrams (mg) tablet one time a day in the evening and hold the medication if the systolic blood pressure (top number - the pressure exerted when the heart beats and blood is ejected into the arteries) is less		**How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Director of Nursing and unit managers conducted a review of physician orders for blood pressure and insulin medications to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Nursing or designee will complete in-service training for the licensed and certified staff conducting medication administration addressing adequate monitoring, administration parameters, and timely follow up of laboratory results. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Director of Nurses, unit managers, or designee will complete random weekly audits of 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks	

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	than 130. The February 2022 Medication Administration Record (MAR) indicated the amlodipine besylate was signed out as the blood pressure medication administered with systolic blood pressures under 130 on the following dates at 8:00 p.m. The systolic blood pressure is represented by the first number. - 2/9/22: 126/76 - 2/19/22: 128/70 - 2/23/22: 128/68 - 2/24/22 120/70 - 2/28/22: 126/74 The March 2022 MAR indicated the amlodipine besylate was signed out as the blood pressure medication administered with systolic blood pressures under 130 on the following dates at 8:00 p.m. - 3/1/22: 114/76 - 3/6/22: 120/74 - 3/9/22: 128/76 - 3/10/22: 128/76 - 3/13/22: 126/70 - 3/15/22: 128/76 A Physician's Order, dated 9/23/21, indicated a laboratory blood draw was to be completed on the first Wednesday of June and December. The blood draw was to include a complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid stimulating hormone (TSH), Vitamin B12, and Vitamin D levels. A Nurse Note, dated 12/1/21 at 5:31 p.m., indicated the laboratory levels was received, the Physician was notified, and there were no new orders received.		of new or current medication orders to ensure compliance with appropriate indications, administration parameters, and/or timely monitoring of labs for use of cardiac drugs (B/P) and insulin. Findings from the unnecessary medication audit will be presented to the Quality Assurance Committee for review and recommendations in achieving and maintaining substantial compliance with standards of practices. **By what date the systemic changes for the alleged deficiency will be completed: 4/11/2022** **F-757 Unnecessary Medication Audit** **Audit Date:** _____ Instructions: Complete random weekly audits for 6 residents for twelve (12) consecutive weeks then every other week for twelve (12) weeks of new or current medication orders to ensure compliance with appropriate indications, administration parameters, and/or monitoring of labs for use of cardiac drugs (B/P) or insulin are clearly documented in the medical record and ongoing staff compliance with medication parameters.	

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	The record lacked laboratory results for TSH, vitamin B12 and vitamin D. The Care Plan, dated 1/24/22, indicated the resident had hypertension with need for treatment. Interventions included, but were not limited to, give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a form of low blood pressure that happens when you stand up from sitting or lying down) and increased heart rate (tachycardia) and the effectiveness. Interview with the Assistant Director of Nursing (ADON) on 3/17/22 at 9:23 a.m., indicated the staff should have completed the resident's blood pressure monitoring and then followed the parameters for the blood pressure medication to be administered or held, per the Physician's Order. Interview with ADON on 3/17/22 at 1:55 p.m., indicated there was not any follow up on the missing laboratory results. She requested the missing results from 12/1/21 to be faxed immediately. The laboratory results, received on 3/17/22, indicated an abnormal TSH level of 5.047 micro-international units per milliliter (uIU/mL). Normal range is 0.550-4.780 uIU/mL. 3.1-48(a)(4)		Audit Conducted By: **Resident's Name and Room Number** **Does the resident have orders for B/P medications or insulin?** **Cardiac (B/P) order includes heart rate and B/P monitoring parameters** **Insulin orders include parameters for use** **Staff compliance with monitoring or administration parameters** **Ordered labs completed and reported with timely follow up** **Comments/Follow-up Actions** **Yes** **No** **Yes** **No** **N/A** **Yes** **No** **N/A** **Yes** **No** **N/A** **Yes** **No** **N/A**	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, 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 personal protective equipment (PPE) not worn properly and not following aerosol generating procedure (AGP) guidelines, for random observations for infection control. (Eden B Hall) Findings include: The following observations were made on the Eden B Hall on 3/14/22 at 9:52 a.m. A resident in room 107 was observed lying in her bed in her room. She had a BiPap mask (a machine that with a mask to help push air into your lungs) on her face that was in use. The door was wide open. There	F 0880	**F-880** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/14/2022, the IP completed educational training addressing appropriate personal protective equipment and aerosol generating procedures with R-14, LPN 4, CNA 4, and CNA 5. R-14's care plan was updated to reflect the educational components for aerosol generating procedures. **How other residents having the**	04/14/2022

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	was a 3 drawer bin next to her door with PPE equipment and a sign that was on top of the bin. This sign read: an aerosol-generating procedure was in progress, PPE required to enter (gowns, gloves, hand hygiene, N95 and eye wear) and keep door closed during use and 1 hour post treatment. LPN 4 was observed in the hallway preparing a medication for another resident and indicated the door should be shut while the BiPap machine was in use. On 3/14/22 at 11:00 a.m., CNA 4 and CNA 5 entered Room 107 with just a surgical mask. The resident still had her BiPap mask on her face and in use. The resident removed the BiPap mask and placed her oxygen tubing in her nose as the CNAs had entered her room. The CNAs were asked to step out of the room. Interview with CNA 4 at that time indicated she was in the resident's room to perform care. She was told by the nurse to only don PPE for a breathing treatment, and the resident usually had on her BiPap all day. CNA 5 indicated she was going to don PPE, but was told she did not have to wear it when the resident had her BiPap in use. Interview with the Infection Control Nurse on 3/14/22 at 3:01 p.m., indicated she was unaware that a BiPap mask was considered an aerosol treatment. The resident wears her BiPap during the day, even though the mask is only prescribed for bedtime. She takes it on and off her self. The COVID-19 Infection Control Guidance in Long-term Care Facilities, updated on 2/8/22, indicated: ..."Aerosol Generating Procedures (AGPs)... When possible, a private room is preferred with AGPs with the door shut for the duration of the procedure including 1 hour after		**potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Infection Preventionist or designee(s) completed a review of physician orders to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 4/04/2022, the DON, IP, Administrator, and Executive Director, with consultation from the Medical Director, conducted a Long-Term Care Infection Control Self-Assessment and Root-Cause Analysis in determining the underlying cause for the alleged deficiency. The self-assessment and RCA determined nursing staff were unclear that BiPAP/CPAP activities are designated as Aerosol Generating Procedures and thinking that Aerosol Generating Procedures only included nebulizer treatments. The IP, DON, or designee will provide in-service education to the community staff and residents on the proper procedures for Aerosol Generating Procedures and the Infection Control Practices before/after AGP. The training program will specifically include	

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	the procedure ends... Staff providing direct care within six feet of the resident while AGP is in progress should wear full PPE including N95 mask and eye protection for all types of scenarios...." 3.1-18(b)(1)(A)		commonly performed AGPs such as CPAP, BiPAP, nebulizer administration, and suction inducing procedures. The IP, DON, or designee will conduct directed in-service education to the facility staff on the donning and doffing of PPE. The education will focus on how and when to don/doff PPE **with return demonstrations**, including mask, respirator devices, gloves, gown, and eye protection **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Infection Preventionist or designee(s) will complete random weekly audits of 6 residents for twelve (12) consecutive weeks then, 2 residents every week for twelve (12) weeks with new or current orders for aerosol generating procedures to ensure compliance with associated wearing appropriate PPE for entering the resident's room for the required time period during and after the procedures. Concerns identified from this auditing process will be reported to the Director of Nursing services or designee for corrective actions. Findings from the aerosol	

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			generating procedure audits will be presented to the Quality Assurance Committee for review and recommendations in achieving and maintaining substantial compliance with standards of practices. **By what date the systemic changes for the alleged deficiency will be completed: 4/14/2022** **F-880 Infection Control - Aerosol Generating Procedures Audit** **Audit Date:** _____ Instructions: Complete random weekly audits for 6 residents for twelve (12) consecutive weeks then, 2 residents every week for twelve (12) weeks with new or current orders for aerosol generating procedures to ensure compliance with associates wearing appropriate PPE for the required time period during and after the procedures. Record N/A if the resident has not utilized any aerosol generating procedures during the review period. Audit Conducted By: _____ _____ **Resident's Name and Room Number** **Has the resident utilized any aerosol generating procedures such as CPaP/BiPaP in the**	

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			review period? **If yes, does the resident have signage on the door of their room for transmission-based precautions used for aerosol generating procedure(s), Otherwise record N/A** **Is the IDOH AGP signage posted indicating the required PPE to enter the resident's room?** **Does the visual observation of associates entering the resident's room validate compliance with the PPE required for AGP?** **Comments/Follow-up Actions** **Yes** **No** **Yes** **No** **N/A** **Yes** **No** **N/A**	

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	155637	A. BUILDING 00 B. WING	03/21/2022

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00367476, IN00368516, IN00370148 and IN00374153. Complaint IN00367476 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00368516 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00370148 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00374153 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: March 14, 15, 16, 17, 18 and 21, 2022. Facility number: 001198 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/28/22.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of			

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	emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to complete required annual fire drills and did not invite the fire department to attend fire drills as required. This had the potential to affect all 26 residents on Assisted Living. Finding includes: The annual fire drill record was reviewed on 3/21/22 at 10:35 a.m. The record indicated there were no fire drills completed from January to April, 2021. There was no documentation the fire department had attended or been invited to any fire drill. Interview with the Maintenance Director on 3/21/22 at 11:10 a.m., indicated he had been hired in April 2021, and the position had been vacant since December 2020. There had been no fire drills	R 0092	**It is the policy of Crown Point Christian Village to follow all federal, state, and local guidelines, laws, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents, or other individuals. The response to the alleged insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission, and implementation of this plan of correction will serve as credible allegation of compliance.**	04/14/2022

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	conducted during that time. He also indicated he was not aware the fire department was required to be invited twice annually to attend fire drills.		**R 092 410 IAC 16.2-5-1.3(l)(1-2) Administration and Management – Noncompliance** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** The Executive Director or designee conducted a review of facility occurrence reports from 1/01/2021 through 4/30/21 and found no evidence of possible injury to any AL resident related to the alleged deficient practice. On 4/04/2022, the maintenance director set the fire drills for the rest of the year with once a quarter per shift. The next scheduled fire drill is on 4/22/2022. An email was sent to the Winfield Fire Department on 4/04/2022 inviting their participation for the upcoming April and September fire drills. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The community determined that all residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to**	

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			ensure that the deficient practice does not recur: The maintenance director created a fire drill calendar with monthly fire drill dates recorded through December 2022 to ensure compliance with the fire drill requirements. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The executive director or designee will conduct an audit of the fire drill logs monthly to validate that fire drills were conducted as scheduled on the fire drill calendar. Findings or concerns from this validation audit will be presented to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic changes for the alleged deficiency will be completed: 4/14/2022** **FIRE DRILL SCHEDULE CPCV 2022** **4/22** 9AM Assisted Living **5/19** 5PM Kitchen	

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			6/23 1AM Eden **7/19** 10AM Pathway **8/10** 6PM Grace Point **9/20** 2AM Eden **10/19** 11AM Laundry/HK **11/10** 7PM Assisted Living **12/22** 3AM Main Entrance All dates are subject to change per Maintenance Director	
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 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	R 0117	**R 117 410 IAC 16.2-5-1.4(b)**	04/14/2022

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	failed to ensure a staff member with current First Aid certification was on site at all times for 9 of 21 shifts reviewed. Finding includes: Staffing sheets for the week of March 13-19, 2022 and First Aid certificates were reviewed on 3/21/22. There was no documentation a staff member with a First Aid certificate was on site in the facility during the following shifts: 3/13/22- First and second shift 3/14/22- Second shift 3/15/22- Second shift 3/16/22- Second shift 3/17/22- Second and third shift 3/19/22- First and second shift Interview with the Assistant Director of Nursing on 3/21/22 at 3:45 p.m., indicated there were no additional First Aid certificates and she was unaware of the requirement.		**Personnel - Deficiency** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** The Assistant Director of Nursing and the Resident Services Coordinator conducted an analysis of the nine shifts lacking a staff member with current First Aid certification and determined that no residents suffered an injury or potential complications related to the alleged deficient practice. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Assistant Director of Nursing and the Resident Services Coordinator completed reviews of personnel records and the pending schedules to identify other staff having the potential to affect residents from the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** After reviewing personnel records, the Resident Services Coordinator revised the upcoming schedules to ensure that a staff member with current First Aid certification is onsite as required.	

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			The staffing scheduled was modified to validate that a staff member with current First Aid certification is onsite each shift. The Assistant Director of Nursing, Resident Services Coordinator, or designee will audit the schedule weekly and with schedule modifications to ensure compliance with having staff on duty with current First Aid certifications. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Assistant Director of Nursing, Resident Services Coordinator, or designee will audit the schedule weekly and with schedule modifications to ensure compliance with having staff on duty with current First Aid certifications. Any concerns identified in this audit process will be reported to the Executive Director or designee for corrective actions. The Resident Services Coordinator will present the audit findings to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic**	

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			changes for the alleged deficiency will be completed: 4/14/2022	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the Emergency Binder had complete information for 5 of 5 resident records reviewed. (Residents 2, 3, 4, 5 and 6) Finding includes: The resident Emergency Binder was reviewed on 3/18/22 at 2:00 p.m. The following items were missing: Resident 2- lacked allergies and hospital preference.	R 0356	**R 356 410 IAC 16.205-8.1(l)(1-8) Clinical Records – Noncompliance** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/18/22, The Resident Services Coordinator updated the emergency files for residents 2, 3, 4, 5, and 6 to reflect the required information.	04/14/2022

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	Resident 3- lacked allergies, Physician and hospital preference. Resident 4- lacked allergies and hospital preference. Resident 5- lacked age/date of birth and allergies. Resident 6- lacked allergies. Interview with the Assisted Living Director on 3/18/22 at 3:00 p.m., indicated the records would be corrected to include the missing information.		**How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Director of Nursing and Resident Services Coordinator completed a medical records review to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 4/07/2022, the Medical Records designee will conduct a more detailed resident record audit to ensure that the current emergency information file for each AL resident is accurate and immediately accessible in the emergency binder. The Resident Services Coordinator or designee will update the residents' emergency information files with changes in the resident's required information and add the emergency information on new admissions to the emergency binder. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put**	

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			into place): The Resident Services Coordinator or designee will conduct a tracking audit of any new admissions and 4 random residents weekly to validate that their emergency information is current with the required data and appropriately filed in the AL emergency information binder. Any concerns identified in this audit process will be reported to the Executive Director or designee for corrective actions. The Resident Services Coordinator will present the audit findings to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic changes for the alleged deficiency will be completed:** 4/14/2022 **R 356 Emergency Information File/Binder Audit** **Instructions: Review any new admissions and 4 other random residents weekly to validate that their emergency information is current with the required data and appropriately filed in the AL emergency information binder. Record "Yes" in the box if the requested information is**	

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			present. Otherwise specify what information is missing and corrective actions taken. **Resident's Name and Apartment Number** **Emergency Information Review Date** **Name, Sex, Apartment Number, Phone Number and Date of Birth** **Name of Hospital Preference and Physician with Contact Information** **Name and Phone Number of Family Member or Other Contact Person(s)** **Allergies** **and Copy of Advanced Directives** **Photograph** **Comments and/or Corrective Actions Taken**	

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			Executive Director Review Dates:	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at			

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	forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident received a two step Tuberculin test upon admission for 1 of 7 resident records reviewed. (Resident 2) Finding includes: Resident 2's record was reviewed on 3/18/22 at 2:10 p.m. The resident was admitted to the facility on 11/5/21. The record lacked documentation that a two step Tuberculin test had been given prior to or upon admission. Interview with the Assisted Living Director on 3/21/22 at 12:05 p.m., indicated the resident had not received the test on admission. They had initiated the first step the evening of 3/18/22.	R 0410	**R 410 210 IAC 16.2-5-12(e)(f)(g) Infection Control – Noncompliance** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/18/2022, Resident 2 was given a Tuberculin test and her 2-step process was reinitiated. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** The Resident Services Coordinator conducted a medical records review of the AL residents to	04/14/2022

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			identify other residents potentially affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 3/18/2022, the Resident Services Coordinator provided appropriate designees with in-service education regarding the Tuberculin skin test procedures. The Resident Services Coordinator will conduct a weekly audit of new admissions and 4 other random residents to ensure compliance with the tuberculin skin test policies. Audit findings will be reviewed by the Associate Director of Nursing Service for validation of compliance with Tuberculin skin test policies. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Resident Services Coordinator will conduct a weekly audit of new admissions and 4 other random residents to ensure compliance with the tuberculin skin test policies. Audit findings will be reviewed by the Associate Director of Nursing Service for validation of compliance with Tuberculin skin	

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			test policies. The Resident Services Coordinator will present the audit findings to the QAA/QAPI committee monthly for 6 months to review and receive recommendations for further corrective actions or continued auditing as deemed necessary to maintain compliance. **By what date the systemic changes for the alleged deficiency will be completed:** 4/14/2022 **Tuberculin Skin Test Compliance Audit** **Audit Week:** _____ Instructions: Complete a review of new admissions and 4 residents weekly to ensure compliance with the 2-step tuberculin skin test requirements. Record N/A if the resident does not require a 2-step TST upon admission/re-admission or ii not due for annual testing during the review month. Audit Conducted By: _____ _____ **Resident's Name** **Admission Date** **Initial Tuberculin Skin Test for 2-step Completed** **Annual or 2nd step Tuberculin Skin Test Completed** **Comments and/or Corrective**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			Actions Taken **Yes** **No** **N/A** **Yes** **No** **N/A**	

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