STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTH AND WELLNESS CENTER	10820 PARK PLACE, SAINT JOHN, , 46373

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Licensure Survey and the Investigation of NCC Intake 469135. Intake 469135 - State deficiencies related to the allegations are cited at S9999. Survey dates: June 16, 17, and 18, 2026 Facility number: 017974 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 6/29/26.	R 0000	The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.	
R 0026	Residents' Rights - Noncompliance	R 0026	1. Resident Rights have	07/07/2026

	410 IAC 16.2-5-1.2(a) (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on record review and interview, the facility failed to ensure a resident and/or responsible party was made aware of their resident rights for 1 of 7 records reviewed. (Resident 6) Finding includes: Record review for Resident 6 was completed on 6/17/26 at		been received and signed by responsible party for resident #6.Executive Director and Admissions Director have been re-educated regarding the need to ensure resident rights have been made available prior to admission and signed by either the resident or responsible party upon admission. 2. All residents are at risk from the alleged deficient practice.Audit has been completed for all newly admitted residents over past 30 days to ensure resident rights have been signed by either the resident or responsible party upon admission. 3. ED/designee will audit all newly admitted residents weekly for 3 months to ensure that resident rights have been made available prior to admission and signed by either the resident or responsible party upon admission. 4. ED/designee will present resident rights audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based	

	11:04 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance. The resident was admitted to the facility on 6/10/26. There was a lack of documentation to indicate the resident and/or responsible party had received or signed the resident rights acknowledgment. During an interview on 6/18/26 at 9:11 a.m., the Director of Nursing indicated the resident had not signed her contract yet and therefore had not received the resident rights information.		on review, along with determinations related to ongoing monitoring.	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of 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	R 0092	1. Local fire department has been contacted regarding attending a fire drill at facility every 6 months and fire department representative has been invited to attend the drill scheduled for 7/24/26.Maintenance Director has been re-educated to ensure that local fire department has been invited to attend a fire drill at the facility every 6 months. 2. All residents are at risk from the alleged deficient practice.Invite sent to local fire department to attend a fire drill every 6 months at facility moving	07/07/2026

	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 invite the fire department every six months to facility fire drills. This had the potential to affect all 25 residents in assisted living. Finding includes: The fire drills log was reviewed on 6/16/26 at 1:15 p.m. The log lacked documentation that the local fire department had been invited to attend a fire drill every six months. During an interview on 6/18/26 at 11:30 a.m., the Maintenance Director indicated he had invited the fire department once, but they had declined. He provided documentation the fire department had been invited 2/2025 and 8/2025 and they had not been invited since. He indicated he would invite them		forward. 3. Maintenance Director/designee will audit all fire drills monthly for 6 months to ensure that local fire department has been invited to attend a fire drill at facility. 4. Maintenance Director/designee will present fire drill audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	

	to the next fire drill.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to properly screen newly hired employees related to not obtaining reference checks for 1 of 10 employee records reviewed. Finding includes: The employee records were reviewed on 6/18/26 at 9:07 a.m. CNA 2's start date was 5/21/26. No reference checks had been completed. The Nursing Schedules, dated 6/10/26 through 6/16/26, indicated CNA 2 had worked on 6/10/26, 6/13/26, 6/14/26, 6/15/26, and 6/16/26. During an interview on 6/18/26	R 0116	1. Reference checks for CNA #2 have been received and placed in respective personnel file. HR has been re-educated to ensure all reference checks are received and placed in personnel file for all new employees prior to start date. 2. All residents are at risk from the alleged deficient practice.HR has audited all new employees hired over past 60 days to ensure reference checks have been completed and in personnel files prior to start date. 3. HR/designee will audit all newly hired employees weekly for 3 months to ensure reference checks have been completed and are in personnel files prior to their start date. 4. HR/designee will present audits regarding reference check compliance for all newly hired employees quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans	07/07/2026

	at 11:50 a.m., the Administrator was made aware there were no reference checks for CNA 2 in her employee record. No further information was provided.		necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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.	R 0217	1. Resident #7 has expired, no further intervention possible.Service plans for residents 2, 3, and 5 were reviewed and corrected to include outside services (i.e. physical therapy and home health) as appropriate.DON, Social Services, and nursing staff have been re-educated regarding the need to have outside services and signatures included on service plans. 2. All residents are at risk from the alleged deficient practice.DON has audited every service plan to ensure outside services and signatures are included in respective service plans according to the roster provided by outside service and physician orders for services.Service plans were updated accordingly to match services provided by outside services according to their roster. 3. DON/designee will audit	07/07/2026

	(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 the services to be provided. 4. The record for Resident 5 was reviewed on 6/16/26 at 3:27 p.m. Diagnoses included, but were not limited to, dementia, hypertension, and heart failure. A Physician's Order, dated 5/6/26, indicated physical therapy and occupational therapy was to evaluate and treat. A Service Plan was completed on 6/3/26. There was a lack of documentation to indicate the resident was receiving therapy services. During an interview on 6/17/26 at 12:14 p.m., the Director of Nursing indicated therapy services should have been included on the service plan. 3. Record review for Resident 2 was completed on 6/16/26 at 2:29 p.m. Diagnoses included,		and compare service plans to rosters provided by outside services and any new orders for outside services weekly for 3 months.Service plans will be updated accordingly as appropriate. 4. DON/designee will present audits regarding resident service plans quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	

	but were not limited to, chronic kidney disease and diabetes mellitus. A Physician's Order, dated 4/9/26, indicated Home Health was to evaluate and treat a vascular wound (caused by poor blood circulation) to the left leg. A Service Plan, updated 6/3/26, did not include the resident received Home Health services. The resident signed the Service Plan. On 6/17/26 at 10:01 a.m., Resident 2 was observed sitting in a wheelchair in his room. He indicated Home Health services came into the facility and treated his leg wound every week. During an interview on 6/17/26 at 12:11 p.m., the Director of Nursing indicated the resident's signed Service Plan should have included he received Home Health services and was unsure why it did not. Based on observation, record review, and interview, the facility failed to ensure service plans were updated to include physical therapy and home health, and failed to ensure a care plan was signed by the resident or authorized party for 4 of 7 records reviewed. (Residents 3, 7, 2 and 5)			

	Findings include: 1. On 6/18/26 at 11:00 a.m., Resident 3 was observed in the therapy gym doing exercises with the staff. The resident's record was reviewed on 6/17/26 at 9:05 a.m. Diagnoses included, but were not limited to, disorder of muscles. A Physician's Order, dated 4/10/26, indicated Physical Therapy and Occupational Therapy were to evaluate and treat. The most recent service plan, dated 6/3/26 and signed by the resident, did not indicate the resident was receiving any type of therapy. During an interview on 6/17/26 at 12:16 p.m., the Director of Nursing (DON) indicated the resident was still receiving therapy services and it should have been included on the service plan. 2. The closed record for Resident 7 was reviewed on 6/16/26 at 10:20 a.m. The resident was admitted to the facility on 8/18/25 and passed away on 5/29/26. The initial service plan, dated 9/10/25, was not signed by the resident or authorized party.			

	The most recent updated service plan was dated 3/9/26 and was also unsigned. During an interview on 6/17/26 at 12:16 p.m., the DON indicated the service plans had not been signed.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (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 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 accurately documented related to medication administration for 1 of 7 records reviewed. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 6/17/26 at 11:04 a.m. Diagnoses included, but	R 0349	1. Physician for resident 6 was notified that medication was not documented on MAR as being administered for dates identified.Clarification orders received regarding medication administration for resident 6.Resident 6 was evaluated for any adverse outcomes.DON and nursing have been re-educated regarding completeness and accuracy of clinical record documentation. 2. All residents are at risk from the alleged deficient practice.MARs documentation reviewed by DON for all residents for entire month of June to determine if there were any further documentation lapses. 3. DON/designee will audit 5 random medication administration records weekly for 3 months regarding completeness and accuracy of	07/07/2026

	were not limited to, hypothyroidism and gastroesophageal reflux disease (GERD). A Physician's Order, dated 6/11/26, indicated levothyroxine sodium (thyroid medication) 100 micrograms (mcg) once a day. A Physician's Order, dated 6/11/26, indicated pantoprazole (medication used to treat GERD) 40 milligrams (mg) once a day. The Medication Administration Record (MAR), dated 6/2026, indicated the resident had never received the levothyroxine and pantoprazole medications. During an interview on 6/18/26 at 9:11 a.m., the Director of Nursing indicated the medications had been given as ordered. The nurse had updated the medication administration times for the medication orders on 6/17/26 and it had somehow erased all the previous medication administration documentation for the levothyroxine and pantoprazole medications on the MAR.		documentation. 4. DON/designee will present audits regarding completeness and accuracy of documentation quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible	R 0356	1. Resident 6 has had emergency information updated to include hospital preference, photograph, and	07/07/2026

	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 a current emergency information file was complete for 1 of 5 records reviewed. (Resident 6) Finding includes: The Memory Care Emergency Binder was reviewed on 6/17/26		emergency contact.ED, Social Services, and Admissions have been re-educated regarding ensuring resident emergency information demographics are complete upon admission. 2. All residents are at risk from the alleged deficient practice.DON has reviewed emergency binder for completeness of required demographics for all residents.No other resident files were identified as being deficient. 3. ED/designee will audit emergency binder weekly for 3 months to ensure all newly admitted residents have emergency information demographics completed upon admission and present in binder.Emergency binder will be updated accordingly with required information as appropriate. 4. ED/designee will present emergency binder audits quarterly for review and discussion by the Interdisciplinary Team through the Quality Assurance process for six months, and any corrective action plans necessary will be put into	

	at 11:00 a.m. There was no hospital preference, photograph, or emergency contact for Resident 6. During an interview on 6/18/26 at 9:11 a.m., the Director of Nursing indicated the resident's photograph had not yet been taken. She was not sure why the hospital preference and emergency contacts had not printed when the face sheet was put in the binder.		place as indicated based on review, along with determinations related to ongoing monitoring.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURENathan Wolf	TITLEExecutive Director	(X6) DATE07/15/2026