

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER WELLINGTON AT SOUTHPORT THE		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S, INDIANAPOLIS, , 46227			
(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 the Investigation of Complaint IN00431377. Complaint IN00431377 - State deficiencies related to the allegations are cited at R0064. Survey dates: April 17 and 18, 2024 Facility number: 003283 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 22, 2024.	R 0000			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection	R 0064	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as	05/06/2024	

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of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.

Based on interview and record review, the facility failed to ensure a resident was free from financial exploitation for 1 of 5 residents reviewed for misappropriation of property. (Resident B, DA 2)

Findings include:

Resident B's clinical record was reviewed on 4/18/24 at 10:00 a.m. The record indicated Resident B was cognitively intact.

to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

R 064

A review identified that all residents could be affected by the deficient practice.

The employee in question was terminated.

An inservice will be conducted with all staff to educate on abuse, including misappropriation of funds.

The Executive Director or designee will randomly audit 5 staff members for compliance weekly x 4 weeks, then monthly thereafter to ensure compliance.

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During an interview on 4/17/24 at 10:10 a.m., the Business Office Manager (BOM) indicated on 3/26/24 Resident B notified the facility BOM that someone had withdrawn money out of his account without permission. Resident B informed the BOM that in February, DA 2 had used his debit card (with permission) to purchase beer and payment to Dietary Aid (DA) 2 for purchasing the beer. A week later an unauthorized \$59.64 had been taken out of his account. The facility began an internal investigation. DA 2 was suspended pending the outcome of the facility investigation. On 3/29/24, DA 2 was terminated for misappropriation of property and for violating the facility Code of Conduct policy.

During an interview on 4/17/24 at 11:45 a.m., Resident B indicated the following:

- On 2/11/24, Resident B provided his personal debit card and PIN code to DA 2 to purchase beer.
- DA 2 withdrew \$40.00 from the ATM machine, purchased the beer and kept \$20.00 for "services rendered" as was the agreement between Resident B and DA 2.
- "A week or so later" Resident B received an electronic

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notification that indicated \$59.64 has been withdrawn from his bank account.

- Resident B had not given anyone authorization to withdraw \$59.64 from his account.

- On 3/26/24 Resident B notified the facility BOM that someone had withdrawn money from his account without his permission. Resident B informed the BOM that in February DA 2 had used his debit card (with his permission) to purchase beer and to compensate DA 2 for purchasing the beer. A week later \$59.64 had been taken out of his account without the resident's permission.

On 4/17/24 at 2:00 p.m., the BOM provided copies of DA 2's personnel file. A review of the file indicated the following":

- On 6/27/23 DA 2 electronically signed the Employee Code of Conduct Handbook document. A review of the document indicated "...Section 13: theft, misappropriation, misuse...unauthorized removal of such property...any violation of Company policy or procedure, including but not limited to those stated in this policy...will be subject to appropriate performance management pursuant to all applicable policies and

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procedures, up to and including termination..."

- On 6/28/23 DA 2 signed the Abuse Prevention Policy. A review of the document indicated "...misappropriation of property: the deliberate misplacement, exploitation or wrongful temporary or permanent use of a Resident's belongings or money without the resident's consent..."

- On 6/28/23 DA 2 signed the "Appendix A: Resident Bill of Rights and Provider Bill of Rights policy. A review of the policy indicated "...each resident has the right to...be free from abuse, neglect, and exploitation..."

- On 6/28/23 DA 2 was hired as a Dietary Aide;

- On 6/28/23 DA 2 signed the Job Description and Profile. A review of the document indicated "...adheres to all established policies and procedures...reports all suspicions of abuse, neglect, and/or financial exploitations of a Resident immediately to the supervisor, as described in the Company's policies and procedures..."

- On 6/28/23 DA 2 signed the "Resident's Bill of Rights Acknowledgement" document. A review of the document indicated "...acknowledge that I

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have received a copy of the Resident Rights and these rights have been fully explained...

- On 3/29/24 DA 2 was terminated for violation of Section 13 of the Employee Code of Conduct Handbook.

The facility's internal investigation of the misappropriation of property, dated 3/29/24, indicated the following:

- On 3/26/24 Resident B notified the facility of the missing money

- On 3/26/24 at 1:45 p.m., DA 2 was interviewed and indicated Resident B provided his debit card and PIN code to withdraw \$40.00 to purchase beer. Out of the \$40.00, DA 2 was given \$20.00 in compensation for "services rendered." The \$59.64 withdraw was deposited into an online cash account for DA 2's brother. DA 2 was suspended pending the outcome of the investigation.

- Based on the investigation, DA 2 was terminated on 3/29/24 for violation of Section 13 of the Employee Code of Conduct. A review of the termination checklist document indicated "...Focus: theft/misappropriation of resident funds. Admitted to accepting resident's personal debit card and make purchases for resident in exchange for

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payment..."

During an interview on 4/17/24 at 11:25 a.m., Qualified Medication Aide (QMA) 3 indicated staff were not allowed take tips or receive any kind of reimbursement from residents for services rendered to a resident. Staff were not allowed to take any of resident's personal belongings, including money.

During an interview on 4/17/24 at 3:00 p.m., the Wellness Director indicated staff were not allowed to take or use resident funds for their own use.

During an interview on 4/18/24 at 8:30 a.m., the Dietary Manager indicated staff were not allowed to accept or take money from residents.

This citation relates to Complaint IN00431377.

Based on interview and record review, the facility failed to ensure a resident was free from financial exploitation for 1 of 5 residents reviewed for misappropriation of property. (Resident B, DA 2)

Findings include:

Resident B's clinical record was reviewed on 4/18/24 at 10:00 a.m. The record indicated

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Resident B was cognitively intact.

During an interview on 4/17/24 at 10:10 a.m., the Business Office Manager (BOM) indicated on 3/26/24 Resident B notified the facility BOM that someone had withdrawn money out of his account without permission. Resident B informed the BOM that in February, DA 2 had used his debit card (with permission) to purchase beer and payment to Dietary Aid (DA) 2 for purchasing the beer. A week later an unauthorized \$59.64 had been taken out of his account. The facility began an internal investigation. DA 2 was suspended pending the outcome of the facility investigation. On 3/29/24, DA 2 was terminated for misappropriation of property and for violating the facility Code of Conduct policy.

During an interview on 4/17/24 at 11:45 a.m., Resident B indicated the following:

- On 2/11/24, Resident B provided his personal debit card and PIN code to DA 2 to purchase beer.
- DA 2 withdrew \$40.00 from the ATM machine, purchased the beer and kept \$20.00 for "services rendered" as was the agreement between Resident B and DA 2.

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- "A week or so later" Resident B received an electronic notification that indicated \$59.64 has been withdrawn from his bank account.

- Resident B had not given anyone authorization to withdraw \$59.64 from his account.

- On 3/26/24 Resident B notified the facility BOM that someone had withdrawn money from his account without his permission. Resident B informed the BOM that in February DA 2 had used his debit card (with his permission) to purchase beer and to compensate DA 2 for purchasing the beer. A week later \$59.64 had been taken out of his account without the resident's permission.

On 4/17/24 at 2:00 p.m., the BOM provided copies of DA 2's personnel file. A review of the file indicated the following":

- On 6/27/23 DA 2 electronically signed the Employee Code of Conduct Handbook document. A review of the document indicated "...Section 13: theft, misappropriation, misuse...unauthorized removal of such property...any violation of Company policy or procedure, including but not limited to those stated in this policy...will be subject to appropriate performance

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management pursuant to all applicable policies and procedures, up to and including termination..."

- On 6/28/23 DA 2 signed the Abuse Prevention Policy. A review of the document indicated "...misappropriation of property: the deliberate misplacement, exploitation or wrongful temporary or permanent use of a Resident's belongings or money without the resident's consent..."

- On 6/28/23 DA 2 signed the "Appendix A: Resident Bill of Rights and Provider Bill of Rights policy. A review of the policy indicated "...each resident has the right to...be free from abuse, neglect, and exploitation..."

- On 6/28/23 DA 2 was hired as a Dietary Aide;

- On 6/28/23 DA 2 signed the Job Description and Profile. A review of the document indicated "...adheres to all established policies and procedures...reports all suspicions of abuse, neglect, and/or financial exploitations of a Resident immediately to the supervisor, as described in the Company's policies and procedures..."

- On 6/28/23 DA 2 signed the "Resident's Bill of Rights Acknowledgement" document.

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A review of the document indicated "...acknowledge that I have received a copy of the Resident Rights and these rights have been fully explained...

- On 3/29/24 DA 2 was terminated for violation of Section 13 of the Employee Code of Conduct Handbook.

The facility's internal investigation of the misappropriation of property, dated 3/29/24, indicated the following:

- On 3/26/24 Resident B notified the facility of the missing money

- On 3/26/24 at 1:45 p.m., DA 2 was interviewed and indicated Resident B provided his debit card and PIN code to withdraw \$40.00 to purchase beer. Out of the \$40.00, DA 2 was given \$20.00 in compensation for "services rendered." The \$59.64 withdraw was deposited into an online cash account for DA 2's brother. DA 2 was suspended pending the outcome of the investigation.

- Based on the investigation, DA 2 was terminated on 3/29/24 for violation of Section 13 of the Employee Code of Conduct. A review of the termination checklist document indicated "...Focus: theft/misappropriation of resident funds. Admitted to accepting resident's personal

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	debit card and make purchases for resident in exchange for payment..." During an interview on 4/17/24 at 11:25 a.m., Qualified Medication Aide (QMA) 3 indicated staff were not allowed take tips or receive any kind of reimbursement from residents for services rendered to a resident. Staff were not allowed to take any of resident's personal belongings, including money. During an interview on 4/17/24 at 3:00 p.m., the Wellness Director indicated staff were not allowed to take or use resident funds for their own use. During an interview on 4/18/24 at 8:30 a.m., the Dietary Manager indicated staff were not allowed to accept or take money from residents. This citation relates to Complaint IN00431377.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (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	R 0117	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not	05/06/2024

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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 interview and record review, the facility failed to ensure all shifts had at least one staff member working who was First Aid certified for 14 of 14 shifts reviewed.

Finding includes:

On 4/18/24 at 10:00 a.m., the Wellness Director provided a copy of the "as worked" staff schedule from 4/7/24 through 4/13/24. A review of the document indicated the following:

constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

R 0117

The community reviewed all employee records for deficient practices.

All employee files were audited to ensure compliance with the required first aid training documentation.

The Executive Director or designee will audit all new hire employee records prior to hire to ensure first aid compliance. The Executive Director or designee will audit 5 random employee files weekly x 4 weeks, then monthly thereafter.

The Executive Director or designee will audit all new hire employee files to ensure that all required documentation is present in the employee file.

- The work schedule identified 2
- twelve-hour shifts per day. The
"first shift" hours were from 7:00
a.m. to 7:00 p.m. and the "third
shift" hours were from 7:00 p.m.
to 7:00 a.m.

- The daily schedule was to
identify staff members who
worked that particular shift and
who were designated as being
the certified First Aid (training
course that provides individuals
the knowledge and skills to
respond to a medical
emergency until more qualified
help arrives) staff member for
that shift.

-Fourteen of 14 shifts on the
daily schedule had no staff
members listed as being First
Aid certified.

During an interview on 4/18/24
at 11:00 a.m., the Wellness
Director indicated the facility
had no certified First Aid staff
members. Therefore, during the
week of 4/7/24 through 4/13/24,
there were no certified First Aid
staff members who had worked
those shifts.

During an interview on 4/18/24
at 11:10 a.m., the Wellness
Director indicated the facility
followed the State regulations
regarding the certified First Aid
staffing requirements. The
facility lacked a specific policy
that required at least one
certified First Aid staff member

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for every shift.

Based on interview and record review, the facility failed to ensure all shifts had at least one staff member working who was First Aid certified for 14 of 14 shifts reviewed.

Finding includes:

On 4/18/24 at 10:00 a.m., the Wellness Director provided a copy of the "as worked" staff schedule from 4/7/24 through 4/13/24. A review of the document indicated the following:

- The work schedule identified 2 - twelve-hour shifts per day. The "first shift" hours were from 7:00 a.m. to 7:00 p.m. and the "third shift" hours were from 7:00 p.m. to 7:00 a.m.

- The daily schedule was to identify staff members who worked that particular shift and who were designated as being the certified First Aid (training course that provides individuals the knowledge and skills to respond to a medical emergency until more qualified help arrives) staff member for that shift.

- Fourteen of 14 shifts on the daily schedule had no staff members listed as being First Aid certified.

During an interview on 4/18/24

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	at 11:00 a.m., the Wellness Director indicated the facility had no certified First Aid staff members. Therefore, during the week of 4/7/24 through 4/13/24, there were no certified First Aid staff members who had worked those shifts. During an interview on 4/18/24 at 11:10 a.m., the Wellness Director indicated the facility followed the State regulations regarding the certified First Aid staffing requirements. The facility lacked a specific policy that required at least one certified First Aid staff member for every shift.			
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had an active	R 0118	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The	05/06/2024

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	CNA certification prior to working as a CNA for 1 of 4 CNA's reviewed for certification status. (CNA 5) Findings include: On 4/17/24 at 1:00 p.m., the Wellness Director provided Certified Nursing Assistant (CNA) 5's personnel records for review. A review of the personnel record indicated: - CNA 5 was hired as a CNA on 10/21/19. - CNA 5's Job Description and Profile document indicated "...Job position title: Nursing CNA - Certified Nursing Assistant...performs CNA duties in accordance with acceptable standards of resident care...Education and Experience: state certification...training program required..." The document was signed by CNA 5 on 5/17/22. CNA 5's CNA certification status was reviewed and indicated the certification had expired on 8/9/23. No other subsequent CNA certification was available.		Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. R 0118 The community reviewed all employee records for deficient practices. All employee files were audited to ensure compliance with licensure. The Executive Director or designee will select 5 random employee files weekly x 4 weeks, and then monthly x 3 months, then quarterly thereafter to ensure compliance with required licensing. The Executive Director or designee will audit all new hire employee files to ensure that all required documentation is present in the employee file. Systematic changes 5/06/2024	
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On 4/17/24 at 2:30 p.m., the Wellness Director provided CNA 5's "as worked schedule" from 8/12/23 through 4/16/24. A review of the report indicated CNA 5 had worked as a CNA for 108 shift - 12 hour shifts during that time period.

During an interview on 4/17/24 at 2:35 p.m., the Wellness Director indicated CNA 5 had been working as a CNA since her hire date of 10/21/19. The facility "just realized" CNA 5's certification had expired on 8/9/23.

During an interview on 4/18/24 at 10:00 a.m., the Wellness Director indicated the facility did not have a specific policy for monitoring to ensure nursing staff licenses and certifications were current, active, and valid.

Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had an active CNA certification prior to working as a CNA for 1 of 4 CNA's reviewed for certification status. (CNA 5)

Findings include:

On 4/17/24 at 1:00 p.m., the Wellness Director provided Certified Nursing Assistant (CNA) 5's personnel records for review. A review of the personnel record indicated:

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- CNA 5 was hired as a CNA on 10/21/19.

- CNA 5's Job Description and Profile document indicated "...Job position title: Nursing CNA - Certified Nursing Assistant...performs CNA duties in accordance with acceptable standards of resident care...Education and Experience: state certification...training program required..." The document was signed by CNA 5 on 5/17/22.

CNA 5's CNA certification status was reviewed and indicated the certification had expired on 8/9/23. No other subsequent CNA certification was available.

On 4/17/24 at 2:30 p.m., the Wellness Director provided CNA 5's "as worked schedule" from 8/12/23 through 4/16/24. A review of the report indicated CNA 5 had worked as a CNA for 108 shift - 12 hour shifts during that time period.

During an interview on 4/17/24 at 2:35 p.m., the Wellness Director indicated CNA 5 had been working as a CNA since her hire date of 10/21/19. The facility "just realized" CNA 5's certification had expired on 8/9/23.

During an interview on 4/18/24 at 10:00 a.m., the Wellness Director indicated the facility did not have a specific policy for

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	monitoring to ensure nursing staff licenses and certifications were current, active, and valid.			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 5 residents who housed pets in the facility. (Resident 77, Resident 84) Findings include: On 4/18/24 at 10:05 a.m., the Administrator provided a list of residents who housed pets in the facility. A review of the animal rabies vaccinations and annual veterinary examinations indicated the following: 1. On 4/18/24 at 10:35 a.m., Resident 77's feline vaccination record was reviewed. The record lacked a current rabies vaccination certification and an annual veterinary	R 0151	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. R 0151 The community reviewed all residents that have pets in the facility. All pet files were audited to ensure that all appropriate records were	05/06/2024

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examination of the feline.

During an observation on 4/18/24 at 10:55 a.m., observed Resident 77's feline resting in a feline bed next to the residents television.

During an interview at that time, Resident 77 indicated the feline was 18 years old. Resident 77 was unaware when the most recent veterinary exam and rabies vaccine were completed.

During an interview on 4/8/24 at 11:00 a.m., the Business Office Manager (BOM) indicated she was unable to locate any veterinary examinations or rabies vaccination in the felines record.

2. On 4/18/24 at 10:40 a.m., Resident 84's feline vaccination record was reviewed. The vaccination record indicated the last veterinary examinations and rabies vaccinations occurred on 7/6/2021. No expiration date was listed on the form. No other veterinary records or vaccinations were available in the felines record.

During an observation on 4/18/24 at 11:00 a.m., observed a large black and white feline in Resident 84's room. The feline was sitting in a recliner next to the resident.

During an interview that time, Resident 84 indicated the feline

within the files.

The executive director or designee will select 5 random resident pet files weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter to ensure compliance with required licensing.

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was to go to the vet today for updated vaccinations.

During an interview on 4/18/24 at 11:00 a.m., the BOM indicated Resident 84's feline immunization's had expired.

On 4/18/24 at 11:02 a.m., the BOM provided a policy titled Pet Policy, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "...2. All cats and dogs must have current vaccinations as recommended by your veterinarian and any other requirements required by applicable law or regulation. You shall be required to show proof of current vaccinations and annually submit the Resident Pet Health Statement, and shall provide upon request, any additional information about your pet's health status."

Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 5 residents who housed pets in the facility. (Resident 77, Resident 84)

Findings include:

On 4/18/24 at 10:05 a.m., the Administrator provided a list of residents who housed pets in

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the facility. A review of the animal rabies vaccinations and annual veterinary examinations indicated the following:

1. On 4/18/24 at 10:35 a.m., Resident 77's feline vaccination record was reviewed.

The record lacked a current rabies vaccination certification and an annual veterinary examination of the feline.

During an observation on 4/18/24 at 10:55 a.m., observed Resident 77's feline resting in a feline bed next to the residents television.

During an interview at that time, Resident 77 indicated the feline was 18 years old. Resident 77 was unaware when the most recent veterinary exam and rabies vaccine were completed.

During an interview on 4/8/24 at 11:00 a.m., the Business Office Manager (BOM) indicated she was unable to locate any veterinary examinations or rabies vaccination in the felines record.

2. On 4/18/24 at 10:40 a.m., Resident 84's feline vaccination record was reviewed. The vaccination record indicated the last veterinary examinations and rabies vaccinations occurred on 7/6/2021. No expiration date was listed on the form. No other veterinary records or

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	vaccinations were available in the felines record. During an observation on 4/18/24 at 11:00 a.m., observed a large black and white feline in Resident 84's room. The feline was sitting in a recliner next to the resident. During an interview that time, Resident 84 indicated the feline was to go to the vet today for updated vaccinations. During an interview on 4/18/24 at 11:00 a.m., the BOM indicated Resident 84's feline immunization's had expired. On 4/18/24 at 11:02 a.m., the BOM provided a policy titled Pet Policy, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "...2. All cats and dogs must have current vaccinations as recommended by your veterinarian and any other requirements required by applicable law or regulation. You shall be required to show proof of current vaccinations and annually submit the Resident Pet Health Statement, and shall provide upon request, any additional information about your pet's health status."			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3)	R 0274	This plan of correction is submitted as required under State and Federal law. The submission of this	05/06/2024

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FORM APPROVED

OMB NO. 0938-0391

(g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service.

(1) The supervisor must be one (1) of the following:

(A) A dietitian.

(B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management.

(C) A graduate of a dietetic technician program approved by the American Dietetic Association.

(D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management.

(E) An individual with training and experience in food service supervision and management.

(2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of

Plan of Correction does not constitute an admission on the part of The Wellington at Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

R 0274

The community reviewed all dietary staff members files to ensure that proper training was in place.

The dietary staff will complete the safe serve training at the community.

The executive director or designee will select 5 random dietary employee files weekly x 4 weeks, then monthly x 3 months, then quarterly thereafter to ensure compliance with required licensing.

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operation on a regularly scheduled basis.

(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.

Based on observation, interview, and record review, the facility failed to ensure a staff member working as the Dining Service Director (Dietary Manager) had met the educational and experience with food handling, preparation and meal service requirements for 1 of 1 Dining Service Directors reviewed.

Findings include:

On 4/17/24 at 8:30 a.m., the personnel file for the Dining Service Director was reviewed. The following documents were reviewed:

- The Dining Service Director job description indicated, "...Responsible for food services standards, policies and procedures, equipment, systems, city and state regulations and work areas while providing the highest quality food service for Residents. Knowledge, Education and Experience; 3. Serve Safe Certification..." The document was signed by the staff member on 6/1/23.

The record lacked supporting

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documentation that the Dining Service Director met the educational and experience with food handling, preparation and meal service requirements. The record also lacked supporting documentation that at least 10 months of working experience as a Dietary Manager and no preparation to receive dietary management training had been initiated.

During an interview on 4/17/24 at 12:32 p.m., the Dining Service Director indicated she did not have a Serve Safe or any other Food Services Management certification.

During an interview on 4/18/24 at 8:32 a.m., the Dining Service Director indicated she had mentioned to the Administrator upon accepting her current position that she let her Serv Safe Dietary Management certification expire. The Administrator indicated it was not needed at this facility.

During an interview on 4/18/24 at 8:45 a.m., the Director of Nursing, (DON) indicated the facility lacked a policy regarding the Dining Service Director job specific education or certification requirements.

During an interview on 4/18/24 at 11:15 a.m., the Business Office Director indicated the Dining Services Director was

hired in 2022 as a Nursing Supervisor as the Dining Services Director indicated that she was a Qualified Medication Aide. In June of 2023, the staff member was promoted to the Dining Service Director position.

Based on observation, interview, and record review, the facility failed to ensure a staff member working as the Dining Service Director (Dietary Manager) had met the educational and experience with food handling, preparation and meal service requirements for 1 of 1 Dining Service Directors reviewed.

Findings include:

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The record lacked supporting

documentation that the Dining Service Director met the educational and experience with food handling, preparation and meal service requirements. The record also lacked supporting documentation that at least 10 months of working experience as a Dietary Manager and no preparation to receive dietary management training had been initiated.

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FORM APPROVED

OMB NO. 0938-0391

hired in 2022 as a Nursing Supervisor as the Dining Services Director indicated that she was a Qualified Medication Aide. In June of 2023, the staff member was promoted to the Dining Service Director position.			
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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 SIGNATURE	TITLE	(X6) DATE
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