STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON PLACE	460 FORKS OF THE WABASH WAY, HUNTINGTON, , 46750

(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. Survey dates: November 21 and 22, 2024 Facility number: 003376 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 2, 2024.	R 0000		
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and	R 0042	**R 042 410 IAC 16.2-5-1.2(p) Residents' Rights – Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have**	01/15/2025

	interview, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 23 of 23 residents residing in the facility. Findings include: During an observation, on 11/21/24 at 11:12 a.m., a sign on the wall by the facility's front desk indicated State Survey results were located at the facility's front desk located by the main facility entrance. No State Survey results were observed to be at the front desk. During an observation, on 11/21/24 at 2:55 p.m., no State Survey results or staff personnel were visible at the facility's front desk. During an observation, on 11/21/24 at 4:30 p.m., State Survey results were not visible at the facility's front desk. During an observation, on 11/22/24 at 9:05 a.m., no State Survey results or staff personnel were visible at the facility's front desk. During an interview, on 11/22/24 at 12:13 p.m., the Business Office Assistant procured the binder containing the State Survey results from behind a partial wall on the edge of the front desk from a file organizer.		**been affected by the deficient practice:** The State Survey Binder for Tipton place was immediately moved from behind the partition and will be prominently displayed at the front desk by the main entrance. The sign will remain on the wall exhibiting the State survey binder to ensure that this book will be readily accessible to all residents, family members, visitors and staff members. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** This Binder will be prominently displayed and will be in an area that can be viewed without any visual hindrances or difficulty with physical accessibility **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient**	

	A document was in front of the binder and obscured the binder from view. The binder was not in reach from the resident/visitor side of the front desk. The Business Office Assistant indicated the binder had previously been located on the other side of the desk. During an observation, on 11/22/24 at 1:32 p.m., the survey results remained behind a document in a file organizer behind the partial wall on the front desk. The State Survey results were not visible or within reach from the resident/visitor side of the front desk. Staff personnel were not manning the desk. During an interview, on 11/22/24 at 4:40 p.m., the Administrator indicated the sign on the wall indicated the survey results were at the desk. If someone wanted the State Survey results, they would have to ask the facility staff. The facility did not have a policy on posting the State Survey results. The facility followed the state regulations. Based on observation and interview, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 23 of 23 residents residing in the facility.		**practice does not recur:** The BOA will be responsible for checking the location of the binder each day. The BOA will make sure that the binder and the signage remains in place for all to view. All staff, including the BOA will be in-serviced and educated on placement of this book and ensuring its availability at all times. This training for all staff will take place Thursday, December 19, 2024, by the Executive Director **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:** An audit sheet was created for monitoring purposes. The binder monitor will be added to the BOA's daily checklist and will be reviewed monthly during the quality / safety meeting to ensure the binder is up to date and accessible to all. The newly initiated audit	

	Findings include: During an observation, on 11/21/24 at 11:12 a.m., a sign on the wall by the facility's front desk indicated State Survey results were located at the facility's front desk located by the main facility entrance. No State Survey results were observed to be at the front desk. During an observation, on 11/21/24 at 2:55 p.m., no State Survey results or staff personnel were visible at the facility's front desk. During an observation, on 11/21/24 at 4:30 p.m., State Survey results were not visible at the facility's front desk. During an observation, on 11/22/24 at 9:05 a.m., no State Survey results or staff personnel were visible at the facility's front desk. During an interview, on 11/22/24 at 12:13 p.m., the Business Office Assistant procured the binder containing the State Survey results from behind a partial wall on the edge of the front desk from a file organizer. A document was in front of the binder and obscured the binder from view. The binder was not in reach from the resident/visitor side of the front desk. The Business Office Assistant indicated the binder had previously been located on the		sheets will be monitored daily for three weeks, weekly for three weeks then monthly for four months. Findings suggestive of compliance will result in cessation for monitoring **5 By what date the systemic changes will be completed:** 1/15/2025	

	other side of the desk. During an observation, on 11/22/24 at 1:32 p.m., the survey results remained behind a document in a file organizer behind the partial wall on the front desk. The State Survey results were not visible or within reach from the resident/visitor side of the front desk. Staff personnel were not manning the desk. During an interview, on 11/22/24 at 4:40 p.m., the Administrator indicated the sign on the wall indicated the survey results were at the desk. If someone wanted the State Survey results, they would have to ask the facility staff. The facility did not have a policy on posting the State Survey results. The facility followed the state regulations.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:	R 0120	**R 120 410 IAC 16.2-5-1.4(e)(1-3) Personnel – Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Director reviewed company	01/15/2025

	(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure required dementia training was completed for 2 of		policy and protocols regarding employee annual training to ensure accuracy & completion. All employees are required to have accurate, complete training per state regulations. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All employees identified as non-compliance with Inservice education will be corrected and in compliance by the date of correction. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director will audit all employee files	

	5 employee records reviewed (QMA 4 and CNA 5). The employee record list, provided by the Administrator on 11/21/24 at 10:20 a.m., indicated QMA 4 was hired on 12/20/16 and CNA 5 was hired on 11/9/23. 1. Review of QMA 4's in-service records, provided by the Administrator, on 11/22/24 at 10:53 a.m., indicated QMA 4 had a total of 1.5 hours of annual dementia training. Review of QMA 4's in-service record, provided by the Administrator, on 11/22/24 at 11:15 a.m., indicated QMA 4 completed an additional 0.75 hours of dementia training on 11/22/24. 2. Review of CNA 5's in-service record, provided by the Administrator, on 11/22/24 at 10:53 a.m., indicated CNA 5 had completed 2.25 hours of dementia training in the first six months after hire. She completed an additional 1.75 hours of dementia training following the first six months after hire.		to ensure that dementia specific training is completed per state regulations for all current employees. Will conduct a monthly All Staff meetings to include 2 hours of dementia specific training in addition to company assigned dementia to be covered throughout the year. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:** All employee files will be audited weekly for 4 months, then monthly for 4 months and then quarterly thereafter for 100% compliance. **5 By what date the systemic changes will be completed:** 1/15/2025	

During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she was unable to retrieve the in-services completed prior to 1/1/24 from the electronic in-service provider.

During an interview, on 11/22/24 at 4:40 p.m., the Administrator indicated she was still unable to retrieve completed in-services prior to 1/1/24. The facility did not have a policy on dementia training. They followed the state regulations.

Based on interview and record review, the facility failed to ensure required dementia training was completed for 2 of 5 employee records reviewed (QMA 4 and CNA 5).

The employee record list, provided by the Administrator on 11/21/24 at 10:20 a.m., indicated QMA 4 was hired on 12/20/16 and CNA 5 was hired on 11/9/23.

1. Review of QMA 4's in-service records, provided by the Administrator, on 11/22/24 at 10:53 a.m., indicated QMA 4 had a total of 1.5 hours of annual dementia training.

Review of QMA 4's in-service record, provided by the Administrator, on 11/22/24 at 11:15 a.m., indicated QMA 4 completed an additional 0.75 hours of dementia training on

	11/22/24. 2. Review of CNA 5's in-service record, provided by the Administrator, on 11/22/24 at 10:53 a.m., indicated CNA 5 had completed 2.25 hours of dementia training in the first six months after hire. She completed an additional 1.75 hours of dementia training following the first six months after hire. During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she was unable to retrieve the in-services completed prior to 1/1/24 from the electronic in-service provider. During an interview, on 11/22/24 at 4:40 p.m., the Administrator indicated she was still unable to retrieve completed in-services prior to 1/1/24. The facility did not have a policy on dementia training. They followed the state regulations.			
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	R 0217	**R 217 410 IAC 16.2-5-2(e)(1-5) Evaluation- Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	01/15/2025

	individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were reviewed with the resident and/or their representative and		All Service plans deficient of a signature will be made compliant by 1/15/2025 **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 12/09/2024, an audit of completed service plans for all residents was conducted by the Wellness Director identifying missing signatures. All deficient Service plans will be signed and compliant by 1/15/2025 **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All resident care plans upon completion will be reviewed and discussed with facility and resident or representative at assigned CP meeting within 7 days of assessment completion. A signature will be obtained at that time. If Representative declines meeting, a discussion will occur regarding any	

	acknowledged by signature for 3 of 6 residents reviewed for service plans. (Residents 5, 6, and 8). Findings include: 1. Resident 5's clinical record was reviewed on 11/21/24. Diagnoses included diabetes mellitus type 2, hypertension, hypothyroidism, seizure disorder, muscle weakness and chronic pain. His service plan was dated 4/30/24 and lacked signatures by the Administrator and the resident or his representative. During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she was unable to find the original signed service plans prior to September 2024. 2. Resident 6's clinical record was reviewed on 11/21/24. Diagnoses included essential hypertension (high blood pressure), hyperlipidemia (high levels of fat or lipids in the blood), anxiety, recurrent falls and muscle weakness. Her service plan was dated 4/6/24 and signed by the Administrator on 4/12/24. The service plan was not signed by the resident or her representative. Her prior service plan was dated 1/8/24 and signed by the		changes made to the care plan, notation will be made of who the changes were communicated to, and a copy of the completed service plan will be mailed to obtain signature. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:** A Resident tickler system was put into place and a monthly list will be created. Weekly audits will be completed by the Wellness Director to ensure service plans are compliant per policy. The Wellness Director or designee will audit random Service Plans monthly for 6 months. The monthly list will be reviewed at the QI meeting monthly to ensure 100% compliance.Findings suggestive of compliance will result in cessation for monitoring plans at that time **5** **By what date the systemic changes will be completed**	

	Administrator on 1/10/24. The service plan was not signed by the resident or her representative. During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she found the service plans in a filing cabinet, but they were unsigned. 3. Resident 8's clinical record was reviewed on 11/22/24 at 11:23 AM. Diagnoses included schizophrenia, malnutrition, chronic obstructive pulmonary disease (lung disease that makes it hard to breathe), and congestive heart failure. A service plan, dated 9/30/24, was signed by the resident representative on 9/30/24. The physical clinical record lacked biennial assessments and corresponding service plans. An unsigned service plan, dated 5/12/24, provided by the Administrator on 11/22/24 at 2:15 p.m., indicated the resident had a total score of 50 points for services provided (to demonstrate a level of services required). An unsigned service plan, dated 6/27/24, provided by the Administrator, on 11/22/24 at 2:15 p.m., indicated the resident had a total score of 60 points for the services provided. The increase in services		1/15/2025	

	provided from 5/12/24 included the following: The resident went from bathing independently to requiring physical assistance with showers. The resident had an increase in chronic illnesses. The resident required an increase in staff member assistance with medication administration. During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she had been unable to find signed service plans for the resident. She had printed off service plans from the computer to demonstrate they had been completed. During an interview, on 11/22/24 at 2:38 p.m., the Administrator indicated the service plans were discussed with the resident and resident representative but could not find signed ones. A facility policy, dated 6/10/24 and titled "Assessment and Service Plan Policies," provided by the Administrator on 11/22/24 at 4:53 p.m., indicated the following:" ...Whenever an Assessment is updated the Service Plan should also be updated ..." Based on record review and interview, the facility failed to ensure service plans were reviewed with the resident and/or their representative and acknowledged by signature for 3			

	of 6 residents reviewed for service plans. (Residents 5, 6, and 8). Findings include: 1. Resident 5's clinical record was reviewed on 11/21/24. Diagnoses included diabetes mellitus type 2, hypertension, hypothyroidism, seizure disorder, muscle weakness and chronic pain. His service plan was dated 4/30/24 and lacked signatures by the Administrator and the resident or his representative. During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she was unable to find the original signed service plans prior to September 2024. 2. Resident 6's clinical record was reviewed on 11/21/24. Diagnoses included essential hypertension (high blood pressure), hyperlipidemia (high levels of fat or lipids in the blood), anxiety, recurrent falls and muscle weakness. Her service plan was dated 4/6/24 and signed by the Administrator on 4/12/24. The service plan was not signed by the resident or her representative. Her prior service plan was dated 1/8/24 and signed by the Administrator on 1/10/24. The			

service plan was not signed by the resident or her representative.

During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she found the service plans in a filing cabinet, but they were unsigned.

3. Resident 8's clinical record was reviewed on 11/22/24 at 11:23 AM. Diagnoses included schizophrenia, malnutrition, chronic obstructive pulmonary disease (lung disease that makes it hard to breathe), and congestive heart failure.

A service plan, dated 9/30/24, was signed by the resident representative on 9/30/24. The physical clinical record lacked biennial assessments and corresponding service plans.

An unsigned service plan, dated 5/12/24, provided by the Administrator on 11/22/24 at 2:15 p.m., indicated the resident had a total score of 50 points for services provided (to demonstrate a level of services required).

An unsigned service plan, dated 6/27/24, provided by the Administrator, on 11/22/24 at 2:15 p.m., indicated the resident had a total score of 60 points for the services provided.

The increase in services provided from 5/12/24 included

	the following: The resident went from bathing independently to requiring physical assistance with showers. The resident had an increase in chronic illnesses. The resident required an increase in staff member assistance with medication administration. During an interview, on 11/22/24 at 2:15 p.m., the Administrator indicated she had been unable to find signed service plans for the resident. She had printed off service plans from the computer to demonstrate they had been completed. During an interview, on 11/22/24 at 2:38 p.m., the Administrator indicated the service plans were discussed with the resident and resident representative but could not find signed ones. A facility policy, dated 6/10/24 and titled "Assessment and Service Plan Policies," provided by the Administrator on 11/22/24 at 4:53 p.m., indicated the following:" ...Whenever an Assessment is updated the Service Plan should also be updated ..."			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on	R 0296	**R 296 410 IAC 16.2-5-6(b) Pharmaceutical Services – Noncompliance**	01/15/2025

	medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review, and interview, the facility failed to ensure medications were administered according to professional guidelines for 1 of 5 residents reviewed (Resident 15). Findings include: During a medication administration observation on 11/22/24 at 11:15 a.m., the following was observed: QMA 4 prepared a Humalog (short acting insulin) pen for Resident 15 to inject 25 units. She did not dial up the units before trying to administer the medication into the resident's left arm. She realized her error and removed the needle from the resident's skin. She then dialed up the 25 units and injected the medication into the resident's left arm. She did not prime the insulin pen or switch out the used pen needle before injecting the 25 units. During an interview, on 11/22/24 at 11:20 a.m., QMA 4 states she should have primed the Humalog pen with 2 units before administering the medication. During an interview, on 11/22/24		**1** **What** **corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** QMA was educated by the Director of Health & Wellness on errors and issued a note to file memo. **2** **How the** **facility will identify other residents having the potential to be affected by** **the same deficient practice and what corrective action will be taken:** Residents receiving insulin injections via pen have the potential to be affected The Director of Health & Wellness will initiate education on Medication Errors, proper med pass guidelines, Technique and	

	at 11:30 a.m., QMA 4 indicated she should have changed the pen needle before administering the medication. Resident 15's medication orders were reviewed on 11/22/24 at 11:20 a.m. She had a current physician order for, but not limited to, Humalog (short acting insulin) 25 units subcutaneously daily before lunch. During an interview, on 11/22/24 at 2:45 p.m., the Corporate Nurse indicated QMA 4 should have primed the pen and changed out the pen needle before administering the medication. A Cleveland Clinic document titled "Insulin Pens," dated 2/12/24, was retrieved on 11/25/24 from https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections. The guidance included: " ... needles for insulin pens are single- use, which means you only use them for one injection and then throw them away. Each needle comes in a sterile protective container ... Prime the insulin pen. Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator ...."		procedures to be followed when administering medication to all facility LPN's and QMA's on 12/19/2024 at the monthly all-staff meeting and signatures will be obtained. Any staff who have not participated in the education will not be allowed to work until it has been completed. This education will also be added to the new hire orientation checklist **3** **What** **measure will be put into place or what systemic changes the facility will make** **to ensure that the deficient practice does not recur:** Director of Health & Wellness will ensure that all staff are educated and aware of proper technique and procedure by administering Medication administration competencies for all licensed LPN's and QMA's to be completed by 1/15/2025 and then quarterly thereafter **4** **How the** **corrective action(s) will be**	

	Based on observation, record review, and interview, the facility failed to ensure medications were administered according to professional guidelines for 1 of 5 residents reviewed (Resident 15). Findings include: During a medication administration observation on 11/22/24 at 11:15 a.m., the following was observed: QMA 4 prepared a Humalog (short acting insulin) pen for Resident 15 to inject 25 units. She did not dial up the units before trying to administer the medication into the resident's left arm. She realized her error and removed the needle from the resident's skin. She then dialed up the 25 units and injected the medication into the resident's left arm. She did not prime the insulin pen or switch out the used pen needle before injecting the 25 units. During an interview, on 11/22/24 at 11:20 a.m., QMA 4 states she should have primed the Humalog pen with 2 units before administering the medication. During an interview, on 11/22/24 at 11:30 a.m., QMA 4 indicated she should have changed the pen needle before administering the medication. Resident 15's medication orders		**monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:** Insuli Administration performance will be monitored by the Director of Health & Wellness once weekly for four weeks, biweekly for 4 weeks then monthly for 4 months to ensure 100% compliance. All findings of concern will be immediately addressed and discussed at monthly safety committee meetings **5 By what date the systemic changes will be completed** 1/15/2025	

	were reviewed on 11/22/24 at 11:20 a.m. She had a current physician order for, but not limited to, Humalog (short acting insulin) 25 units subcutaneously daily before lunch. During an interview, on 11/22/24 at 2:45 p.m., the Corporate Nurse indicated QMA 4 should have primed the pen and changed out the pen needle before administering the medication. A Cleveland Clinic document titled "Insulin Pens," dated 2/12/24, was retrieved on 11/25/24 from https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections. The guidance included: " ... needles for insulin pens are single- use, which means you only use them for one injection and then throw them away. Each needle comes in a sterile protective container ... Prime the insulin pen. Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator ...."			
R 0328	Activities Programs - Noncompliance 410 IAC 16.2-5-7.1(c)(1-3) (c) An activities director shall be	R 0328	**R 328 410 IAC 16.2-5-7(c)(1-3) Activities Programs - Noncompliance** **1**	01/15/2025

	designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division. Based on interview and record review, the facility failed to employ an Activity Director. Findings include: During an interview, on 11/21/24 at 10:55 a.m., the Administrator indicated the facility did not currently have an Activity Director. During an interview, on 11/22/24 at 2:45 p.m., the Business Office Assistant indicated the Activity Director position had been vacant since 3/1/24. During an interview, on 11/22/24 at 4:43 p.m., the Administrator indicated they did not have anyone in the Activity Director position. A regional staff member called the facility monthly to discuss any concerns and reviewed the activity calendar uploaded by the facility. The facility did not have a policy regarding		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An activity calendar was/is in place and activities are carried out by team members. Activities will continue daily, as well as efforts to recruit a qualified activity director. Activity Program Calendars will be reviewed, approved, and signed off on by activity director within company that meets the State requirement by holding a certification through the National Certification Council for Activity Professionals. **2** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An activity calendar was/is in place and activities are carried out by team members. Executive Director will monitor job postings and continue recruitment efforts for a qualified activity director.	

	employment of an Activity Director. A current facility job description, provided by the Administrator on 11/22/24 at 4:53 p.m., indicated " ... Assists in planning, scheduling and conducting programs that provide physical, intellectual, social, emotional and spiritual opportunities for the resident's ...." Based on interview and record review, the facility failed to employ an Activity Director. Findings include: During an interview, on 11/21/24 at 10:55 a.m., the Administrator indicated the facility did not currently have an Activity Director. During an interview, on 11/22/24 at 2:45 p.m., the Business Office Assistant indicated the Activity Director position had been vacant since 3/1/24.		Executive Director will ensure monthly activity program is reviewed, approved, and signed off on by Certified Activity Director before implementation. **3** **What** **measure will be put into place or what systemic changes the facility will make** **to ensure that the deficient practice does not recur:** Executive Director will monitor job postings and continue recruitment efforts for a qualified activity director. Executive Director will ensure monthly activity program is reviewed, approved, and signed off on by Certified Activity Director before implementation. **4** **How the** **corrective action(s) will be monitored to ensure the deficient practice will** **not recure, i.e., what quality assurance program will be put into place:** **Activity** **program compliance will be monitored by the Executive Director to ensure compliance.** Executive Director will monitor job postings and applicants weekly	

	During an interview, on 11/22/24 at 4:43 p.m., the Administrator indicated they did not have anyone in the Activity Director position. A regional staff member called the facility monthly to discuss any concerns and reviewed the activity calendar uploaded by the facility. The facility did not have a policy regarding employment of an Activity Director. A current facility job description, provided by the Administrator on 11/22/24 at 4:53 p.m., indicated " ... Assists in planning, scheduling and conducting programs that provide physical, intellectual, social, emotional and spiritual opportunities for the resident's ...."		until an Activity Director is hired. Executive Director will monitor the activity program on a monthly basis to ensure the program has been reviewed, approved, and signed off on by a qualified staff member. Monitoring will continue on a monthly basis until 6 months of compliance has been achieved, or a qualified Activity Director has been hired. **5 By what date the systemic changes will be completed** 1/15/2025	
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and	R 0407	**R 407 410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**The Director of Health & Wellness was reeducated on policies, procedures & state regulations pertaining to Infection control	01/15/2025

	immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure a system was in place to analyze patterns of infection prior to September 2024 for 23 of 23 residents currently residing in the facility. Findings include: A facility binder, titled "Infection Control," provided by the Administrator on 11/21/24 at 10:20 a.m., was reviewed on 11/22/24 at 9:58 a.m. The binder contained surveillance line lists and corresponding facility maps from 9/2024 through 11/2024. The binder contained no documentation prior to 9/2024. During an interview, on 11/22/24 at 10:39 a.m., the Corporate Nurse indicated she worked primarily in another facility and began completing the infection control surveillance in October to assist the facility while they were attempting to hire a new Director of Nursing (DON). During an interview, on 11/22/24 at 11:15 a.m., the Administrator indicated she was unable to locate information for the infection control surveillance prior to September 2024. The		tracking. **2** **How the** **facility will identify other residents having the potential to be affected by** **the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. The Director of Health & Wellness completed an observational audit of infection control practices with residents in transmission based precautions on 12/09/2024 **3** **What** **measure will be put into place or what systemic changes the facility will make** **to ensure that the deficient practice does not recur:** The Director of Health & Wellness will	

former DON was upset when she left and had torn up and threw away many facility documents prior to leaving. The DON was typically responsible for the infection control program.

A facility policy, dated 2/1/22, titled "Infection Control Communicable Diseases," provided by the Administrator, on 11/22/24 at 4:40 p.m., indicated the following: "The Community will have procedures in place to ensure a Resident with a reportable disease is reported immediately ...appropriate infection control procedures will be implemented as directed by the local health authority ...."

Based on interview and record review, the facility failed to ensure a system was in place to analyze patterns of infection prior to September 2024 for 23 of 23 residents currently residing in the facility.

Findings include:

A facility binder, titled "Infection Control," provided by the Administrator on 11/21/24 at 10:20 a.m., was reviewed on 11/22/24 at 9:58 a.m. The binder contained surveillance line lists and corresponding facility maps from 9/2024 through 11/2024. The binder contained no documentation prior to 9/2024.

re-educate staff by 1/15/2025 on corporate policy and state regulations for tracking all infections within the building to ensure compliance.

An Infection tracking log and community map for color coding has been initiated on all residents that live in the community.

4
How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:

The Wellness Director will review both infection forms to ensure proper infection control procedures are being followed for 100% compliance. These forms will be monitored weekly for 4 weeks, then biweekly for 4 weeks, then monthly thereafter to ensure constant compliance.

5

	During an interview, on 11/22/24 at 10:39 a.m., the Corporate Nurse indicated she worked primarily in another facility and began completing the infection control surveillance in October to assist the facility while they were attempting to hire a new Director of Nursing (DON). During an interview, on 11/22/24 at 11:15 a.m., the Administrator indicated she was unable to locate information for the infection control surveillance prior to September 2024. The former DON was upset when she left and had torn up and threw away many facility documents prior to leaving. The DON was typically responsible for the infection control program. A facility policy, dated 2/1/22, titled "Infection Control Communicable Diseases," provided by the Administrator, on 11/22/24 at 4:40 p.m., indicated the following: "The Community will have procedures in place to ensure a Resident with a reportable disease is reported immediately ...appropriate infection control procedures will be implemented as directed by the local health authority ...."		**By what date the systemic changes will be completed** 1/15/2025	

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	TITLE	(X6) DATE

SIGNATURE		