

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

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                  |                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                             |                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>02/22/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>CHAPTERS LIVING OF JEFFERSONVILLE |                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>2700 WATERS EDGE PKWY,<br>JEFFERSONVILLE, , 47130 |                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                                 | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                   | ID PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION...                                                                                                                                                                                                                                                                                                                 | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                                                | <p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: February 22, 2023</p> <p>Facility number: 004001</p> <p>Residential Census: 35</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on February 27, 2023.</p>                                                                | R 0000                                                                                            |                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                 |
| R 0117                                                                | <p>Personnel - Deficiency</p> <p>410 IAC 16.2-5-1.4(b)</p> <p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the</p> | R 0117                                                                                            | <p>The facility shall ensure at least one staff is present at all times who are properly trained and certified in CPR to be able to provide CPR until emergency medical services arrive.</p> <p>All nursing department employee files will be reviewed to identify anyone not currently certified in CPR. Once expired CPR staff members are</p> | 03/10/2023                                                      |                                                 |

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specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on record review and interview the facility failed to maintain a minimum of one staff member on duty with current First Aid and CPR training 24 hours a day. This deficient practice had the potential to affect all 35 residents currently residing in the facility.

Findings include:

The review of the staff schedule for February 15, 16, 17, 18, 19, 20, 21, and 22 indicated the following:

identified, they will obtain a current CPR certification.

As means to ensure ongoing compliance with all nursing staff employees being CPR certified, all CPR certifications will be kept in a binder. The Director of Nursing will be responsible to review the binder ongoing (which exceed the minimum) for upcoming expirations. If a nursing staff members CPR expires, the Director of Nursing will either take the employee off the schedule until their CPR certification is current or ensure another CPR certified staff member is scheduled to work with them. The facility will be in compliance by 3/10/23.

As verification, I have attached a copy of employee CPR certifications. In addition, I have attached the class roster of the CPR class held on 3/8/23 (the CPR cards will not be available for 2-3 weeks).

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On 2/15/23 there was no CPR or First Aid coverage from 12:00 a.m. to 8:30 a.m., or from 6:00 p.m. to 12:00 a.m.

On 2/16/23 there was no CPR or First Aid coverage from 12:00 a.m. to 8:30 a.m., or from 1:30 p.m. to 12:00 a.m.

On 2/17/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 6:00 p.m. to 12:00 a.m.

On 2/18/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 10:00 p.m. to 12:00 a.m.

On 2/19/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 10:00 p.m. to 12:00 a.m.

On 2/20/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 10:00 p.m. to 12:00 a.m.

On 2/21/23 there was no CPR or First Aid coverage in the entire 24 hour period.

During an interview on 2/22/23 at 1:30 p.m., the ED (Executive Director) indicated she knew the facility was out of compliance with their First Aid and CPR. She could provide some staffing CPR and First Aide certifications but she knew they could not provide all of them.

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During an interview on 2/22/23 at 1:39 p.m., the ED indicated she identified they were out of compliance back in November of 2022.

During an interview on 2/22/23 at 2:08 p.m., the DON indicated they could not provide any further CPR or First Aide certifications aside from her own and LPN (Licensed Practical Nurse) 3.

During an interview on 2/22/23 at 2:25 p.m. the ED indicated she was still trying to obtain a copy of the First Aid policy, but they would follow the State regulations.

The Cardiopulmonary Resuscitation policy, last revised 7/18, provided on 2/22/23 at 2:20 p.m., by the ED included, but was not limited to, "... The facility shall ensure there are an adequate number of staff present at all times who are properly trained and/or certified in CPR to be able to provide CPR until emergency medical services arrives..."

Based on record review and interview the facility failed to maintain a minimum of one staff member on duty with current First Aid and CPR training 24 hours a day. This deficient practice had the potential to affect all 35 residents currently residing in the facility.

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Findings include:

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On 2/15/23 there was no CPR or First Aid coverage from 12:00 a.m. to 8:30 a.m., or from 6:00 p.m. to 12:00 a.m.

On 2/16/23 there was no CPR or First Aid coverage from 12:00 a.m. to 8:30 a.m., or from 1:30 p.m. to 12:00 a.m.

On 2/17/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 6:00 p.m. to 12:00 a.m.

On 2/18/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 10:00 p.m. to 12:00 a.m.

On 2/19/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 10:00 p.m. to 12:00 a.m.

On 2/20/23 there was no CPR or First Aid coverage from 12:00 a.m. to 6:00 a.m., or from 10:00 p.m. to 12:00 a.m.

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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

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|                                                                             |       |           |
|-----------------------------------------------------------------------------|-------|-----------|
| instructions.)                                                              |       |           |
| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE | TITLE | (X6) DATE |