

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 02/24/2022	
NAME OF PROVIDER OR SUPPLIER ELKHART PLACE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2024 COUNTY ROAD 24, ELKHART, , 46517					
(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: February 23 & 24, 2022 Facility number: 004353 Residential Census: 18 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/3/22.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of t he truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.				
R 0092	Administration and Management - Noncompliance	R 0092	R092 – Elkhart Place assisted living will conduct fire drills on each	04/04/2022			

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	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 varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to complete 12 required monthly fire drills over the past 12 months. Finding includes: On 2/24/2022 at 12:15 P.M.,		shift randomly once a week for three weeks to ensure a total of twelve or more fire drills conducted in the last twelve months. After the three weeks, Elkhart Place will resume calendar schedule of one shift rotating monthly to ensure each shift is done quarterly and total twelve fire drills in twelve months. Each fire drill will be properly documented and every six months Elkhart Place will attempt to hold a fire and disaster drill in conjunction with the local fire department every 6 months. Each month at the community safety and quality assurance meeting the fire drills will be reviewed by the Executive Director, Care Services Manager and Maintenance Technician to ensure to conduct and document 12 monthly fire drills each year, quarterly on each shift Education provided by the Regional director of facility management on requirement to conduct and document 12 monthly fire drills per year, quarterly on each shift. To be implemented and completed by 04/04/2022	
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the Administrator supplied a binder with fire drills that had been conducted. Fire drills were completed on 1/ 1/2021, 7/22/2021, 7/23/2021, 8/25/2021, 9/17/2021, 10/13/2021, 11/5/2021, 12/29/2021, 1/26/2022. The binder lacked the documentation to show that fire drills had been completed monthly from February to June 2021.

During an interview, on 2/24/2022 at 12:15 P.M., the Administrator indicated there should have been fire drills performed every month.

On 2/24/2022 at 1:07 P.M., the Administrator provided the policy titled," Fire, Wildfire, Explosion, Natural Gas Leak, Hazardous Spill", dated 2019, and indicated the policy was the one currently used by the facility. The policy indicated," ...Fire drills will be conducted by ED, Nurse or designated alternate at least quarterly for each shift. Always notify the monitoring company before activating alarm, maintenance, repairs, or modification to any life safety system. The overnight shift is the only shift where staff is permitted to conduct silent (mock) alarms in a 12-month period, unless required by other states to use coded announcements"

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Based on record review and interview, the facility failed to complete 12 required monthly fire drills over the past 12 months.

Finding includes:

On 2/24/2022 at 12:15 P.M., the Administrator supplied a binder with fire drills that had been conducted. Fire drills were completed on 1/ 1/2021, 7/22/2021, 7/23/2021, 8/25/2021, 9/17/2021, 10/13/2021, 11/5/2021, 12/29/2021, 1/26/2022. The binder lacked the documentation to show that fire drills had been completed monthly from February to June 2021.

During an interview, on 2/24/2022 at 12:15 P.M., the Administrator indicated there should have been fire drills performed every month.

On 2/24/2022 at 1:07 P.M., the Administrator provided the policy titled," Fire, Wildfire, Explosion, Natural Gas Leak, Hazardous Spill", dated 2019, and indicated the policy was the one currently used by the facility. The policy indicated," ...Fire drills will be conducted by ED, Nurse or designated alternate at least quarterly for each shift. Always notify the monitoring company before activating alarm, maintenance,

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	repairs, or modification to any life safety system. The overnight shift is the only shift where staff is permitted to conduct silent (mock) alarms in a 12-month period, unless required by other states to use coded announcements"			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on record review and	R 0148	R148 – Elkhart Place assisted living Will schedule an annual inspection of the heating and ventilation systems. Upon Completion the following inspection will scheduled to ensure no lapse in routine preventative maintenance. All documentation will be maintained for a minimum of two years on property. Each month at the community safety and quality assurance meeting the heating and ventilation records will be reviewed by the Executive Director, Care Services Manager and Maintenance Technician to ensure compliance. Education provided by the Regional Director of Facilities management on 3/1/22 To be implemented and completed by 3/9/22 and scheduled for 3/1/2023	03/09/2022

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interview, the facility failed to ensure the heating and ventilation system was inspected on an annual basis. This had the potential to affect 18 of 18 residents residing in the facility.

Finding includes:

During an interview, on 2/24/2022 at 2:45 P.M., the Administrator indicated there had been work on the ventilation system, but there had been no inspection of the heating/ventilation system in the facility in 2021. He indicated there had been turnover in the maintenance staff last year and it just didn't get scheduled by the previous staff.

On 2/24/2022 at 2:48 P.M., a policy was requested but one was not provided.

Based on record review and interview, the facility failed to ensure the heating and ventilation system was inspected on an annual basis. This had the potential to affect 18 of 18 residents residing in the facility.

Finding includes:

During an interview, on 2/24/2022 at 2:45 P.M., the Administrator indicated there had been work on the ventilation system, but there had been no inspection of the

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	heating/ventilation system in the facility in 2021. He indicated there had been turnover in the maintenance staff last year and it just didn't get scheduled by the previous staff. On 2/24/2022 at 2:48 P.M., a policy was requested but one was not provided.			
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 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.	R 0356	R356 – Elkhart Place assisted living will create an emergency binder that includes the following for each resident: (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	04/04/2022

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(7) A photograph (for identification of the resident).

(8) Copy of advance directives, if available.

Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 20 of 20 residents.

Finding includes:

On 2/24/2022 at 11:49 A.M., an emergency binder was provided. The following items were observed missing:

13 of 20 face sheets lacked sex;

3 of 20 face sheets lacked the name of the residents physician of record;

4 of 20 face sheets lacked the physician of records phone number;

2 of 20 face sheets lacked allergies;

4 of 20 face sheets lacked the residents hospital preference;

20 of 20 face sheets lacked a photo of the resident.

During an interview, on 2/24/2022 at 12:35 P.M., the Administrator indicated the emergency file should have

of the resident).

(8) Copy of advance directives, if available.

Upon completion this binder will maintained on premises at

all times and updated accordingly. Each month at the community

safety and quality assurance meeting the emergency

Binder will be reviewed by the Executive Director,

Care Services Manager to ensure it is up to date and

remain in compliance.

Education provided to the Executive director, Care service manager

detailing the steps to be implemented resident Emergency binder.

To be implemented and completed by 04/04/2022

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been completed with all the required resident information.

During an interview, on 2/24/2022 at 1:12 P.M., the Administrator indicated he could not provide a policy for the emergency binder.

Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 20 of 20 residents.

Finding includes:

On 2/24/2022 at 11:49 A.M., an emergency binder was provided. The following items were observed missing:

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During an interview, on

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2/24/2022 at 12:35 P.M., the Administrator indicated the emergency file should have been completed with all the required resident information.

During an interview, on 2/24/2022 at 1:12 P.M., the Administrator indicated he could not provide a policy for the emergency binder.

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