STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANDLER PLACE	2879 S LIMA RD, KENDALLVILLE, , 46755

(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 IN00453415. Complaint IN00453415- No deficiencies related to the allegations are cited. Survey dates: February 20 and 21, 2025 Facility number: 004440 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 24, 2025.	R 0000	POC completed 3/7/2025	
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must,	R 0045	1. We will immediately use Indiana form 46996 for all transfers or discharges and forms will be complete with date and all required information.	03/31/2025

	on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9).		2. The Executive Director or Health and Wellness Director will contact the Resident and or Family of transfer 3. If the discharge is involuntary, the resident will be offered a hearing to discuss reasons for request. The Ombudsman will be contacted and family or POA will be notified. 4. HWD or Nurse in Charge will sign documentation and place a copy in their chart. 5. All transfers will be audited by the Executive Director/designee weekly and documented for the next 6 months, then monthly indefinitely.	

	(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health			

	facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to ensure complete and accurate			

	documentation was completed for transfers and discharges from the facility for 2 of 2 residents reviewed (Resident 50 and Resident 70). Findings include: 1. Resident 50's record was reviewed on 2/21/25 at 9:35 AM. Diagnoses included diabetes, chronic kidney disease, congestive heart failure. Resident 50's Service Description, dated 8/29/24, indicated the resident was oriented to person, place and time. Resident 50 was independent with dining, dressing, ambulation and toileting. Resident 50 required minimal assistance with bathing. Resident 50 required assistance with medication administration. A Hospital/Facility Transfer Form, dated 10/9/24 at 9:00 AM, indicated Resident 50 had been transferred to the hospital due to a fall. A Notice of Transfer or Discharge, dated 10/9/24, indicated Resident 50 had been transferred to the hospital due to the resident's needs could not be met at the facility.			

	An undated Notice of Transfer or Discharge Request for Hearing, indicated Resident 50 had received a bed hold policy. A Hospital/Facility Transfer Form, dated 10/11/24, indicated Resident 50 had been transferred to the hospital due to confusion and elopement from the facility. An Incident Report, dated 2/11/25 at 3:50 AM, indicated Resident 50 had been exit seeking. Resident 50 had displayed confusion and was delusional. Resident 50 had been incontinent of urine and been partially unclothed. A resident service note, dated 2/11/25 at 10:15 AM, indicated Resident 50 had been transferred to the hospital due to elopement from the facility and delusional behaviors. Resident 50's daughter had been made aware of the need for placement at a different facility upon hospital discharge. A resident service note, dated 2/11/25 at 12:35 PM, indicated Resident 50 had returned from the hospital with a diagnosis of a urinary tract infection. A resident service note, dated 2/13/25 at 8:00 AM, indicated Resident 50 had been accepted at a skilled nursing facility. A resident service note, dated			

	2/13/25 at 11:00 AM, indicated Resident 50 had left the facility with their daughter in a private vehicle to a skilled nursing facility. A Notice of Transfer or Discharge, dated 2/13/25, indicated Resident 50 had been transferred to another nursing facility. A Notice of Transfer or Discharge Request for Hearing, was blank. The form did not indicate it had been offered to the residnet or their family. An undated document, titled Discovery Senior Living-Internal Use Only, indicated Resident 50 had been transferred to a memory care unit on 2/15/25. The document did not have a signature. 2. Resident 70's record was reviewed on 2/21/25 at 10:35 AM. Diagnoses included atrial fibrillation, (irregular heartbeat) congestive heart failure, emphysema and kidney disease. Resident 70's Service Description, dated 9/27/24, indicated the resident had occasional confusion. Resident 70 was independent with dining. Resident 70 required assistance with bathing, dressing, grooming, toileting and medication administration. Resident 70 required assistance			

	for wheelchair mobility such as staff pushing the wheelchair. An Incident Report, dated 10/9/24 at 6:30 PM, indicated Resident 70 had a fall. Resident 70 had been transferred to the hospital. A resident service note, dated 10/9/24 at 9:30 PM, indicated Resident 70 had been transferred to the hospital. Resident 70's record did not include a transfer form, a request for hearing or a bed hold policy dated October 8, 9 or 10, 2024. A Hospital/Facility Transfer, dated 10/12/24 at 1:45 PM, indicated Resident 70 had been transferred to the hospital after having an unwitnessed fall. An Incident Report, dated 10/12/24 at 1:20 PM, indicated Resident 70 had a fall in their bathroom. A Notice of Transfer or Discharge, dated 10/12/24, indicated Resident 70 had been transferred to the hospital due to their needs were not able to be met at the facility. An undated Notice of Transfer or Discharge Request for Hearing, indicated Resident 50 had received a bed hold policy. The form did not include Resident 70's Representative's			

phone number or address.

In an interview, on 2/21/25 at 11:25 AM, Licensed Practical Nurse (LPN) 4 indicated a transfer form should be used for every transfer out of the facility. LPN 4 indicated documentation related to a transfer should be included in a nurse note.

A current facility policy, dated 6/10/24, provided by the Administrator on 2/21/25 at 2:05 PM, indicated the facility would evaluate residents before and after transport. The policy indicated the facility must use a form prescribed by the department to inform the residents of the reasons for transfer or discharge. The policy indicated the facility must place a copy of the form in the resident's clinical record. The policy indicated the facility must provide a copy of the form to the resident, family, legal representative, the long-term care ombudsman and the agency responsible for the resident's care.

Based on interview and record review, the facility failed to ensure complete and accurate documentation was completed for transfers and discharges from the facility for 2 of 2 residents reviewed (Resident 50 and Resident 70).

Findings include:

	1. Resident 50's record was reviewed on 2/21/25 at 9:35 AM. Diagnoses included diabetes, chronic kidney disease, congestive heart failure. Resident 50's Service Description, dated 8/29/24, indicated the resident was oriented to person, place and time. Resident 50 was independent with dining, dressing, ambulation and toileting. Resident 50 required minimal assistance with bathing. Resident 50 required assistance with medication administration. A Hospital/Facility Transfer Form, dated 10/9/24 at 9:00 AM, indicated Resident 50 had been transferred to the hospital due to a fall. A Notice of Transfer or Discharge, dated 10/9/24, indicated Resident 50 had been transferred to the hospital due to the resident's needs could not be met at the facility. An undated Notice of Transfer or Discharge Request for Hearing, indicated Resident 50 had received a bed hold policy. A Hospital/Facility Transfer Form, dated 10/11/24, indicated Resident 50 had been transferred to the hospital due to confusion and elopement from the facility.			

	An Incident Report, dated 2/11/25 at 3:50 AM, indicated Resident 50 had been exit seeking. Resident 50 had displayed confusion and was delusional. Resident 50 had been incontinent of urine and been partially unclothed. A resident service note, dated 2/11/25 at 10:15 AM, indicated Resident 50 had been transferred to the hospital due to elopement from the facility and delusional behaviors. Resident 50's daughter had been made aware of the need for placement at a different facility upon hospital discharge. A resident service note, dated 2/11/25 at 12:35 PM, indicated Resident 50 had returned from the hospital with a diagnosis of a urinary tract infection. A resident service note, dated 2/13/25 at 8:00 AM, indicated Resident 50 had been accepted at a skilled nursing facility. A resident service note, dated 2/13/25 at 11:00 AM, indicated Resident 50 had left the facility with their daughter in a private vehicle to a skilled nursing facility. A Notice of Transfer or Discharge, dated 2/13/25, indicated Resident 50 had been transferred to another nursing facility.			

	A Notice of Transfer or Discharge Request for Hearing, was blank. The form did not indicate it had been offered to the residnet or their family. An undated document, titled Discovery Senior Living-Internal Use Only, indicated Resident 50 had been transferred to a memory care unit on 2/15/25. The document did not have a signature. 2. Resident 70's record was reviewed on 2/21/25 at 10:35 AM. Diagnoses included atrial fibrillation, (irregular heartbeat) congestive heart failure, emphysema and kidney disease. Resident 70's Service Description, dated 9/27/24, indicated the resident had occasional confusion. Resident 70 was independent with dining. Resident 70 required assistance with bathing, dressing, grooming, toileting and medication administration. Resident 70 required assistance for wheelchair mobility such as staff pushing the wheelchair. An Incident Report, dated 10/9/24 at 6:30 PM, indicated Resident 70 had a fall. Resident 70 had been transferred to the hospital. A resident service note, dated 10/9/24 at 9:30 PM, indicated Resident 70 had been			

transferred to the hospital.

Resident 70's record did not include a transfer form, a request for hearing or a bed hold policy dated October 8, 9 or 10, 2024.

A Hospital/Facility Transfer, dated 10/12/24 at 1:45 PM, indicated Resident 70 had been transferred to the hospital after having an unwitnessed fall.

An Incident Report, dated 10/12/24 at 1:20 PM, indicated Resident 70 had a fall in their bathroom.

A Notice of Transfer or Discharge, dated 10/12/24, indicated Resident 70 had been transferred to the hospital due to their needs were not able to be met at the facility.

An undated Notice of Transfer or Discharge Request for Hearing, indicated Resident 50 had received a bed hold policy. The form did not include Resident 70's Representative's phone number or address.

In an interview, on 2/21/25 at 11:25 AM, Licensed Practical Nurse (LPN) 4 indicated a transfer form should be used for every transfer out of the facility. LPN 4 indicated documentation related to a transfer should be included in a nurse note.

A current facility policy, dated

	6/10/24, provided by the Administrator on 2/21/25 at 2:05 PM, indicated the facility would evaluate residents before and after transport. The policy indicated the facility must use a form prescribed by the department to inform the residents of the reasons for transfer or discharge. The policy indicated the facility must place a copy of the form in the resident's clinical record. The policy indicated the facility must provide a copy of the form to the resident, family, legal representative, the long-term care ombudsman and the agency responsible for the resident's care.			
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 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	R 0117	1. All staff will be audited for up-to-date CPR and First Aid certification by the HWD/ED. 2. Any staff that are without the proper certifications will be scheduled for class within the next 30 days. They will also not be allowed to work a shift unless scheduled with another employee that has both certifications. 3. A binder will be created by March 7, 2025, to hold all license certifications based on their expiration dates. The HWD/ED will check the binder 30 days ahead to ensure that we do not allow employees' certifications to expire. This will be done each month indefinitely. 4. Scheduler will cross reference employees to ensure that we have	03/31/2025

	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 interviews, the facility failed to ensure one staff person, with current first aid certification was on site at all times for 4 of 21 shifts reviewed. Findings include: A review of hours worked dated 2/14/25-2/20/25 indicated staff were not certified for first aid during the first shift of 2/14/25, first shift of 2/17/25, first shift of 2/19/25, and third shift of 2/19/25. In an interview, on 2/21/25 at 11:15 AM, the Administrator indicated there were no further First Aid certifications for review. The administrator indicated there should be first aid certified staff on site at all times. Based on record review and interviews, the facility failed to ensure one staff person, with current first aid certification was		a fully certified staff member in the community for both CPR and First Aid. 5. Executive Director or designee to audit schedule for compliance weekly x6 weeks, then monthly indefinitely.	

	on site at all times for 4 of 21 shifts reviewed. Findings include: A review of hours worked dated 2/14/25-2/20/25 indicated staff were not certified for first aid during the first shift of 2/14/25, first shift of 2/17/25, first shift of 2/19/25, and third shift of 2/19/25. In an interview, on 2/21/25 at 11:15 AM, the Administrator indicated there were no further First Aid certifications for review. The administrator indicated there should be first aid certified staff on site at all times.			
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: (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	R 0120	1. The Executive Director will audit assigned Relias courses from Discovery Senior Living to ensure all employees are meeting the annual training requirements. Audits will be completed each December for the upcoming year. This will be done indefinitely. If found deficient, ED will contact the Corporate Office to request they assign any missing training. 2. For 2025, ED will complete the audit by the end of March 2025 to ensure all training is scheduled correctly for the current year for all staff members.	03/31/2025

	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 annual training was completed for Preventing, Recognizing, and Reporting Abuse for 1 of 5 employees reviewed.		3. The deficient employee has been assigned the missing 2024 module to be completed by March 31, 2025. ED or Designee will audit employee to ensure that the module is complete. 4. Employee that was missing 1 module, had changed positions and is now corrected in the Relias system so that she will be assigned proper training going forward.	

Findings include:

In an interview, on 2/21/25 at 11:15 AM, the Administrator indicated annual Abuse, Dementia, and Resident Rights training had changed to computer-based modules, she indicated the training was completed yearly.

In a record review, on 2/21/25 at 11:45 AM, the record of computer-based training for CNA 5 indicated the last completed Preventing, Recognizing, and Reporting Abuse was completed on 12/4/2023.

Based on interview and record review the facility failed to ensure annual training was completed for Preventing, Recognizing, and Reporting Abuse for 1 of 5 employees reviewed.

Findings include:

In an interview, on 2/21/25 at 11:15 AM, the Administrator indicated annual Abuse, Dementia, and Resident Rights training had changed to computer-based modules, she indicated the training was completed yearly.

In a record review, on 2/21/25 at 11:45 AM, the record of computer-based training for CNA 5 indicated the last completed Preventing,

	Recognizing, and Reporting Abuse was completed on 12/4/2023.			
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 interview and record review, the facility failed to ensure 1 of 5 pets living with residents in the facility had their required immunizations. Findings include: In an interview, on 2/21/25 at 9:05 AM, the Administrator indicated Veterinary documents contained veterinary visit and vaccination records for each pet residing in the facility. During a review of veterinary records, a cat belonging to Resident 80 received a rabies vaccine on 11/28/22. The record indicated the rabies vaccine should be repeated annually. No additional records for Resident 80's cat were available for review. During an interview, on 2/21/25 at 9:50 AM, the Admininstrator indicated she spoke to Resident 80 and her family. She indicated	R 0151	1 The Executive Director or designee will audit all documentation any residents that have pets to ensure 100% compliance Audit will be completed monthly for 6 months, then quarterly thereafter for 1 year, to ensure compliance. 2. The Executive Director will track all new move ins with pets and conduct audits on those resident files quarterly for 1 year. 3. Pet missing vaccination has been taken to the vet and vaccinated with 3-yr Rabies. Vaccination will expire 2/24/28.	03/04/2025

	there were no further vaccination records were available. She indicated she had performed an audit on pet vaccinations and failed to place this pet on the audit list. She indicated the cat residing with Resident 80 should have had a current rabies vaccine. A current policy, titled Pet Agreement, dated 9/2016, indicated residents in the facility who had pets residing in their residence were required to present current vaccination documentation at the time of the signed pet agreement and annually thereafter. Based on interview and record review, the facility failed to ensure 1 of 5 pets living with residents in the facility had their required immunizations. Findings include: In an interview, on 2/21/25 at 9:05 AM, the Administrator indicated Veterinary documents contained veterinary visit and vaccination records for each pet residing in the facility.			

	During a review of veterinary records, a cat belonging to Resident 80 received a rabies vaccine on 11/28/22. The record indicated the rabies vaccine should be repeated annually. No additional records for Resident 80's cat were available for review. During an interview, on 2/21/25 at 9:50 AM, the Admininstrator indicated she spoke to Resident 80 and her family. She indicated there were no further vaccination records were available. She indicated she had performed an audit on pet vaccinations and failed to place this pet on the audit list. She indicated the cat residing with Resident 80 should have had a current rabies vaccine. A current policy, titled Pet Agreement, dated 9/2016, indicated residents in the facility who had pets residing in their residence were required to present current vaccination documentation at the time of the signed pet agreement and annually thereafter.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the	R 0216	1. All residents' assessments will be reviewed by the Executive Director or designee to determine if any additional signatures were missed by the previous DHW. 2. The audit will be completed by March 30, 2025. All unsigned assessments will be completed by	03/30/2025

	following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review the facility failed to ensure semi-annual evaluations were completed for 3 of 5 residents reviewed (Resident 20, Resident 30, and Resident 60). Findings include: 1. Resident 20's record was reviewed on 2/20/25 at 1:22 PM. Diagnoses included hypertension, osteoporosis, and neuropathy. A document, titled Service Description, dated 12/3/24 included assessments for mobility risk, elopement risk, self-administration of medications, orientation, behavior, communication, assistance needed with activities of daily living and		our new HWD for accuracy and be signed and entered correctly. 3. The Executive Director will audit all assessments done that month every month for the next 6 months, then 5 random assessments quarterly thereafter to ensure the process is completed. 4. All residents will be assessed prior to admission, 30 days after they move-in and every six months or if there is a significant change.	

	memory testing. The document did not include any signatures, dates, or indication the assessments were updated and completed in any of the assessment areas. In an interview, on 2/21/25 at 10:40 AM, the Administrator indicated the assessment areas were not completed. 2. Resident 30's record was reviewed on 2/20/25 at 1:38 PM. Diagnoses included hypertension, Parkinson's disease and depression. A document, titled Service Description dated 12/1/24 included assessments for mobility risk, elopement risk, self-administration of medications, orientation, behavior, communication, assistance needed with activities of daily living and memory testing. The document did not include any signatures, dates, or indication the assessments were updated and completed in any of the assessment areas. In an interview, on 2/21/25 at 10:40 AM, the Administrator indicated the assessment areas were not completed. 3. Resident 60's record was reviewed on 2/21/25 at 10:10 AM. Diagnoses included atrial fibrillation, sick sinus syndrome, and non-ischemic			

cardiomyopathy.

A document, titled Service Description dated 12/22/24, included assessments for mobility risk, elopement risk, self-administration of medications, orientation, behavior, communication, assistance needed with activities of daily living and memory testing. The document did not include any signatures, dates, or indication the assessments were updated and completed in any of the assessment areas.

During an interview, on 2/21/25 at 10:47 AM, the Administrator indicated Resident 60's semi-annual evaluation was not filled out. She indicated the form should have been completed, signed and dated. She indicated she recently became aware of nursing tasks not being completed and was in the process of making personnel changes.

A current policy titled Resident Assessments, dated 6/10/24, provided by the Administrator on 2/21/25 at 10:47 AM indicated the resident assessment should be completed or updated prior to moving in, 30 days after moving in, every six months, and upon a significant change in the resident's status.

Based on interview and record

review the facility failed to ensure semi-annual evaluations were completed for 3 of 5 residents reviewed (Resident 20, Resident 30, and Resident 60).

Findings include:

1. Resident 20's record was reviewed on 2/20/25 at 1:22 PM. Diagnoses included hypertension, osteoporosis, and neuropathy.

A document, titled Service Description, dated 12/3/24 included assessments for mobility risk, elopement risk, self-administration of medications, orientation, behavior, communication, assistance needed with activities of daily living and memory testing. The document did not include any signatures, dates, or indication the assessments were updated and completed in any of the assessment areas.

In an interview, on 2/21/25 at 10:40 AM, the Administrator indicated the assessment areas were not completed.

2. Resident 30's record was reviewed on 2/20/25 at 1:38 PM. Diagnoses included hypertension, Parkinson's disease and depression.

A document, titled Service Description dated 12/1/24

	included assessments for mobility risk, elopement risk, self-administration of medications, orientation, behavior, communication, assistance needed with activities of daily living and memory testing. The document did not include any signatures, dates, or indication the assessments were updated and completed in any of the assessment areas. In an interview, on 2/21/25 at 10:40 AM, the Administrator indicated the assessment areas were not completed. 3. Resident 60's record was reviewed on 2/21/25 at 10:10 AM. Diagnoses included atrial fibrillation, sick sinus syndrome, and non-ischemic cardiomyopathy. A document, titled Service Description dated 12/22/24, included assessments for mobility risk, elopement risk, self-administration of medications, orientation, behavior, communication, assistance needed with activities of daily living and memory testing. The document did not include any signatures, dates, or indication the assessments were updated and completed in any of the assessment areas. During an interview, on 2/21/25			

	at 10:47 AM, the Administrator indicated Resident 60's semi-annual evaluation was not filled out. She indicated the form should have been completed, signed and dated. She indicated she recently became aware of nursing tasks not being completed and was in the process of making personnel changes. A current policy titled Resident Assessments, dated 6/10/24, provided by the Administrator on 2/21/25 at 10:47 AM indicated the resident assessment should be completed or updated prior to moving in, 30 days after moving in, every six months, and upon a significant change in the resident's status.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and	R 0217	1. Service plans should be completed upon admission, 30 days after admission, every six months and upon significant change. Executive Director or designee will audit all residents for current Service Plans and insure they are signed by both the HWD and the Resident or Family member. 2. Continued audits will be conducted every month for 6 months, then quarterly thereafter.	03/31/2025

(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 interview and record review the facility failed to ensure a current, signed service plan was completed for 1 of 5 residents reviewed (Resident 60).

Findings include:

Resident 60's record was reviewed on 2/21/25 at 10:10 AM. Diagnoses included atrial fibrillation, sick sinus syndrome,

and non-ischemic cardiomyopathy.

Resident 60's current service plan, last revised 2/12/24, did not contain resident or representative signatures.

Documentation of any review of the service plan with Resident 60 or his representative was not available for review.

During an interview, on 2/21/25 at 10:47 AM, the Administrator indicated a current service plan for Resident 60 had not been signed by the resident or staff. She indicated staff should review the service plan with the resident, then both parties should sign and date the form.

A current policy titled Service Plans dated 6/10/24 provided by the Administrator on 2/21/25 at 10:47 AM indicated Service Plans should be completed upon admission, 30 days after admission, every 6 months thereafter, and upon a significant condition change. The policy indicated a current service plan should be reviewed and signed by staff and the resident or their representative.

Based on interview and record review the facility failed to ensure a current, signed service plan was completed for 1 of 5 residents reviewed (Resident 60).

	Findings include: Resident 60's record was reviewed on 2/21/25 at 10:10 AM. Diagnoses included atrial fibrillation, sick sinus syndrome, and non-ischemic cardiomyopathy. Resident 60's current service plan, last revised 2/12/24, did not contain resident or representative signatures. Documentation of any review of the service plan with Resident 60 or his representative was not available for review. During an interview, on 2/21/25 at 10:47 AM, the Administrator indicated a current service plan for Resident 60 had not been signed by the resident or staff. She indicated staff should review the service plan with the resident, then both parties should sign and date the form. A current policy titled Service Plans dated 6/10/24 provided by the Administrator on 2/21/25 at 10:47 AM indicated Service Plans should be completed upon admission, 30 days after admission, every 6 months thereafter, and upon a significant condition change. The policy indicated a current service plan should be reviewed and signed by staff and the resident or their representative.			

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. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review the facility failed to ensure complete and accurate emergency files were maintained for 1 of 5 residents	R 0356	1. Emergency files will be audited by the Executive Director. All Resident information, photo and contact information will be inspected and updated no later than March 30, 2025. 2. The Executive Director will add new Resident’s information sheet and photo to the binder as they move in. The audits will continue monthly as part of our safety committee ongoing agenda. 3. The affected resident's emergency sheets where updated and added to the emergency binder on February 21, 2025.	03/31/2025

reviewed (Resident 40).

Findings include:

Resident 40's record was reviewed on 2/21/25 at 11:10 AM. Diagnoses included asthma and hypertension. Resident 40's record indicated Resident 40 used Nurse Practitioner (NP) 2 as her primary healthcare provider. A telephone number was listed to contact NP 2.

The facility emergency file book was reviewed on 2/21/25 at 11:15 AM. Resident 40's emergency file did not include a photo for her identification. Resident 40's emergency file identified NP 3 as her primary provider. No phone number for NP 3 was provided in the emergency file.

During an interview, on 2/21/25 at 11:29 AM, the Administrator indicated Resident 40 had switched providers and the facility failed to update the emergency file. She indicated resident emergency files should include a photo of the resident and an accurate name and phone number for the primary healthcare provider. She indicated the resident's form should have been updated to include these items and was likely missed when the facility changed ownership. She indicated the Maintenance supervisor was responsible for

auditing the emergency files and ensuring they were updated and complete.

During an interview, on 2/21/25 at 2:22 PM, the Administrator indicated a policy pertaining to emergency files was not available for review.

Based on interview and record review the facility failed to ensure complete and accurate emergency files were maintained for 1 of 5 residents reviewed (Resident 40).

Findings include:

Resident 40's record was reviewed on 2/21/25 at 11:10 AM. Diagnoses included asthma and hypertension. Resident 40's record indicated Resident 40 used Nurse Practitioner (NP) 2 as her primary healthcare provider. A telephone number was listed to contact NP 2.

The facility emergency file book was reviewed on 2/21/25 at 11:15 AM. Resident 40's emergency file did not include a photo for her identification. Resident 40's emergency file identified NP 3 as her primary provider. No phone number for NP 3 was provided in the emergency file.

During an interview, on 2/21/25 at 11:29 AM, the Administrator indicated Resident 40 had switched providers and the

	facility failed to update the emergency file. She indicated resident emergency files should include a photo of the resident and an accurate name and phone number for the primary healthcare provider. She indicated the resident's form should have been updated to include these items and was likely missed when the facility changed ownership. She indicated the Maintenance supervisor was responsible for auditing the emergency files and ensuring they were updated and complete. During an interview, on 2/21/25 at 2:22 PM, the Administrator indicated a policy pertaining to emergency files was not available for review.			

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