STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1019 SENIOR LIVING VERMILLION PLACE	449 MAIN ST, ANDERSON, , 46016

(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 the Investigation of Complaint IN00371295. Complaint IN00371295 - Substantiated. State deficiencies related to the allegations are cited at R0090, R0214 and R0217. Unrelated deficiencies are cited. Survey date: February 1, 2022 Facility number: 011970 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 3, 2022.	R 0000	Preparation and/or execution of this Plan of Correction in general or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Vermillion Place of the facts alleged or the conclusions set forth in the statement of deficiencies The Plan of Correction and the specific corrective actions are prepared and/or executed solely because of provisions of state laws. Vermillion Place desires this Plan	

			of Correction to be considered the facility's Allegation of Compliance. Compliance is effective February 24, 2022. This building respectfully requests consideration for paper compliance from this Plan of Correction.	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings;	R 0090	1. Resident B was discharged on 12/10/2021 at 2:15 AM. 2. All other residents with cognitive impairment have the potential to be at risk for elopement and the potential to have the elopement reported later than 24 hours after the occurance and potentially without a complete investigation. Any potential alleged elopements that occur, per the ISDH Regulations, will be thouroughly investigated and reported within 24 hours, by the Administrator, or their designee. The Administrator has reviewed the ISDH regulation regarding resident elopement. 3. All current residents will have a current Elopement Risk Assessment completed within 31 days. These will be completed by the Director of Nursing or their designee. Staff has been instructed to notify the Executive Director, or their designee, of any elopement of a resident. The Executive Director,	03/18/2022

	(C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available		or their designee, has been instructed to begin the investigation of and report any resident elopement to the Administrator, or their designee. The Administrator, or their designee, will continue the investigation and report the elopement to the ISDH per regulations. All prospective residents will be evaluated to ensure they are not an elopement risk. If they are found to be an elopement risk, they will not be admitted. Current residents will have elopement risk assessments completed with their 6-month evaluation. Staff will do routine rounds of residents during the night time hours to ensure any cognitively impaired residents are not near any doors that are not easily viewed. Cognitively impaired residents will be observed for any unusual behaviors that might signify possible risk of elopement. The Director of Nursing, or their designee will instruct their staff on the procedures. The monitoring will be ongoing as long as there is a resident with a cognitive impairment. 4. All resident elopements, the investigations and the reporting of the elopements to the ISDH will be monitored by the Administrator, or their designee. biweekly for 6 months, then monthly for 6 months. Any issues noted in the elopements, the investigations, or in the reporting will be evaluated by the Administrator, or their designee, the Executive Director, or their designee, and the Director of Nursing, or their designee, to determine what actions need to be taken to correct the issue.	

for inspection to any member of the public upon request

Based on interview and record review, the facility failed to conduct a thorough investigation of an elopement of a cognitively impaired resident (Resident B).

Findings include:

Review of an Indiana Department of Health (IDOH) reportable, provided by the Administrator on 2/1/22 at 1:15 p.m. The report was dated 1/17/21 and indicated the elopement occurred 12/10/21.

The closed clinical record for Resident B was reviewed on 2/1/22 at 11:09 a.m. Diagnoses included, but were not limited to, dementia without behaviors, anxiety, chronic kidney disease, hemiplegia and hemiparesis.

Resident B was admitted to the facility on 6/19/19.

An Evaluation of Needs/ Service Plan, dated 6/1/21, indicated the resident was alert, oriented and able to make sound decisions. The resident was able to ambulate independently.

A service plan, dated 6/1/21, was signed by Resident B and indicated a level 3 care service.

A progress note, dated 10/8/21 at 8:00 p.m., indicated Resident

B she could not find her daughter and began to cry.

A progress note, dated 10/26/21 at 12:00 a.m., indicated the resident had been up and down all evening waiting on her family to pick her up. Resident became tearful and was anxious all night.

A new order was received on 10/28/21 for divaloprox (to treat manic phase of bipolar disorder) 500 mg daily.

A progress note, dated 12/10/21 at 12:25 a.m., indicated a QMA was outside the front doors when she saw Resident B walking from around the side of the building. The resident was last seen in bed at 8:45 p.m. The resident indicated she was looking for her daughters and everyone had left her. The QMA asked the resident how she exited the building because she had been near the front doors since 10:00 p.m. Resident B indicated she went out the back doors.

A progress note indicated QMA 1 notified the former Director of Nursing (DON) on 12/10/21 at 12:35 a.m. The DON advised her to notify Director 1.

A progress note on 12/10/21 at 12:50 a.m., indicated Director 1 was notified the resident was found outside. Director 1 advised her to contact the family

	and ask them to stay with the resident until other arrangements could be made. An unsigned service plan, dated 1/5/22, indicated the resident needed more reassurance, increase in mobility needs and an increase in disturbances and emotion state. During an interview on 2/1/22 at 1:15 p.m., indicated the Administrator indicated she did not have any statements from staff and/or residents. The only documented information was what the QMA documented in the progress notes. She indicated the facility follows the IDOH guidelines for reporting. During an interview on 2/1/22 at 2:58 p.m., the Administrator indicated Director 1 was informed of the elopement and failed to inform her for a couple days and then developed Covid-19. The Administrator was having trouble with submitting the report and her corporate support was supposed to submit the information and failed to do so. She eventually used his access into the system and submitted the information. She indicated she did not have any statements from staff or other residents and stated the investigation may have not been complete.			

	During an interview on 2/1/22 at 3:30 p.m., the Administrator was unable to find any elopement risk assessments or semi-annual evaluation of needs for Resident B. This State tag relates to Complaint IN00371295. Based on interview and record review, the facility failed to conduct a thorough investigation of an elopement of a cognitively impaired resident (Resident B). Findings include: Review of an Indiana Department of Health (IDOH) reportable, provided by the Administrator on 2/1/22 at 1:15 p.m. The report was dated 1/17/21 and indicated the elopement occurred 12/10/21. The closed clinical record for Resident B was reviewed on 2/1/22 at 11:09 a.m. Diagnoses included, but were not limited to, dementia without behaviors, anxiety, chronic kidney disease, hemiplegia and hemiparesis. Resident B was admitted to the facility on 6/19/19.			

	An Evaluation of Needs/ Service Plan, dated 6/1/21, indicated the resident was alert, oriented and able to make sound decisions. The resident was able to ambulate independently. A service plan, dated 6/1/21, was signed by Resident B and indicated a level 3 care service. A progress note, dated 10/8/21 at 8:00 p.m., indicated Resident B she could not find her daughter and began to cry. A progress note, dated 10/26/21 at 12:00 a.m., indicated the resident had been up and down all evening waiting on her family to pick her up. Resident became tearful and was anxious all night. A new order was received on 10/28/21 for divaloprox (to treat manic phase of bipolar disorder) 500 mg daily. A progress note, dated 12/10/21 at 12:25 a.m., indicated a QMA was outside the front doors when she saw Resident B walking from around the side of the building. The resident was last seen in bed at 8:45 p.m. The resident indicated she was looking for her daughters and everyone had left her. The QMA asked the resident how she exited the building because she had been near the front doors since 10:00 p.m. Resident B indicated she went out the back			

doors.

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A progress note on 12/10/21 at 12:50 a.m., indicated Director 1 was notified the resident was found outside. Director 1 advised her to contact the family and ask them to stay with the resident until other arrangements could be made.

An unsigned service plan, dated 1/5/22, indicated the resident needed more reassurance, increase in mobility needs and an increase in disturbances and emotion state.

During an interview on 2/1/22 at 1:15 p.m., indicated the Administrator indicated she did not have any statements from staff and/or residents. The only documented information was what the QMA documented in the progress notes. She indicated the facility follows the IDOH guidelines for reporting.

During an interview on 2/1/22 at 2:58 p.m., the Administrator indicated Director 1 was informed of the elopement and failed to inform her for a couple days and then developed Covid-19. The Administrator was having trouble with submitting the report and her

	corporate support was supposed to submit the information and failed to do so. She eventually used his access into the system and submitted the information. She indicated she did not have any statements from staff or other residents and stated the investigation may have not been complete. During an interview on 2/1/22 at 3:30 p.m., the Administrator was unable to find any elopement risk assessments or semi-annual evaluation of needs for Resident B. This State tag relates to Complaint IN00371295.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to obtain a pre-admission evaluation and/or semi-annual evaluation of resident's individual needs for 4 of 4	R 0214	1. Resident B was discharged on 2/10/2021 at 2:15. Residents C, D, E, cannot have an evaluation done prior to admission since they have already been admitted. Residents C, D, and E shall all have an evaluation of their needs done by the Director of Nursing, or their designee, by 03/03/2022. Residents C, D, and E shall have their evaluation of the individual needs updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request, by the Director of Nursing, or their designee. 2. All other residents in the facility have the potential to be affected, by this alleged deficiency. All other	03/17/2022

	residents reviewed for evaluations. (Resident B, C, D and E) Findings include: 1. The clinical record for Resident B was reviewed on 2/1/22 at 11:09 a.m. Diagnoses included, but were not limited to, dementia without behaviors, anxiety, chronic kidney disease, hemiplegia and hemiparesis. Resident B was admitted to the facility on 6/19/19. During an interview on 2/1/22 at 3:30 p.m., the Administrator indicated they were unable to find any semi-annual evaluation of needs for Resident B. 2. The clinical record for Resident C was reviewed on 2/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anxiety and chronic obstructive pulmonary disease. Resident C was admitted to the facility on 1/5/22 after being evicted from another facility. An Evaluation of Needs/Service Plan was completed on 1/5/22. The evaluation indicated Resident C was unsure of where her glucometer was and had been sitting at a dining room table where she had become attached to another resident who had dementia. No		residents shall have their charts audited by the Director of Nursing, or their designee, to insure they have had a preadmission evaluation. If they have not had a pre-admission evaluation done by a licensed nurse. it cannot be done at this time as they have already been admitted. All other residents shall have their charts audited by the Director of Nursing or their designee, to ensure their semi-annual evaluation of their needs have been done timely. Any resident who is found to not have a current semi-annual evaluation completed and signed by the resident or their family and the nurse who completed it will have one done by the Director of Nursing, or their designee, by 03/17/2022. 3. The Director of Nursing, or their designee, will audit all new admissions to ensure each resident has an evaluation initiated prior to admission and updated at least semi-annually and upon a known substantial change in the resident's condition or more often at the resident or the facility's request. These audits will be done every 2 weeks for 3 months, then every month for 3 months. Randon audits will be ongoing. 4. The Director of Nursing, or their designee, will report the findings of their audits to the Executive Director, or their designee. If there are corrections that need to be done or other issues, the Executive Director, or their designee, will report these findings to the Administrator, or their designee, for assistance in the correction.	

supportive services were noted.

3. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure.

A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility.

An Evaluation of Needs/Service Plan was completed on 1/24/22. The evaluation indicated Resident D may require incontinent pads and had a fear of falling.

4. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension.

Resident E was admitted to the facility on 11/26/21 from another facility.

A pre-admission evaluation was completed by Director 1 on 11/26/21.

A Nursing Admission Assessment for resident needs was completed on 1/27/21.

Review of a current facility

	policy, titled "Evaluation and Service Plan", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following; "An evaluation of the individual needs of each resident shall be done: prior to admission upon admission at lease semiannually upon a known substantial change in a resident's condition At the request of the resident or their family. ...The service plan shall be reviewed and revised as appropriate and discussed...." This State tag relates to Complaint IN00371295 Based on interview and record review, the facility failed to obtain a pre-admission evaluation and/or semi-annual evaluation of resident's individual needs for 4 of 4 residents reviewed for evaluations. (Resident B, C, D and E) Findings include: 1. The clinical record for Resident B was reviewed on 2/1/22 at 11:09 a.m. Diagnoses			

included, but were not limited to, dementia without behaviors, anxiety, chronic kidney disease, hemiplegia and hemiparesis.

Resident B was admitted to the facility on 6/19/19.

During an interview on 2/1/22 at 3:30 p.m., the Administrator indicated they were unable to find any semi-annual evaluation of needs for Resident B.

2. The clinical record for Resident C was reviewed on 2/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anxiety and chronic obstructive pulmonary disease.

Resident C was admitted to the facility on 1/5/22 after being evicted from another facility.

An Evaluation of Needs/Service Plan was completed on 1/5/22. The evaluation indicated Resident C was unsure of where her glucometer was and had been sitting at a dining room table where she had become attached to another resident who had dementia. No supportive services were noted.

3. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart

	failure. A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility. An Evaluation of Needs/Service Plan was completed on 1/24/22. The evaluation indicated Resident D may require incontinent pads and had a fear of falling. 4. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension. Resident E was admitted to the facility on 11/26/21 from another facility. A pre-admission evaluation was completed by Director 1 on 11/26/21. A Nursing Admission Assessment for resident needs was completed on 1/27/21. Review of a current facility policy, titled "Evaluation and Service Plan", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following;			

	"An evaluation of the individual needs of each resident shall be done: prior to admission upon admission at lease semiannually upon a known substantial change in a resident's condition At the request of the resident or their family. ...The service plan shall be reviewed and revised as appropriate and discussed...." This State tag relates to Complaint IN00371295			
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 (D) preference;	R 0217	1. Resident B was discharged from the facility on 12/10/2021 at 2;15AM. Residents C, D, and E will have a new a new semi-annual service plan completed by the Director of Nursing, or their designee, which will be signed by the resident or their family member. 2. All other residents have the potential the be affected by the alleged deficiency.All other residents shall have their charts audited by the Director of Nursing, or their designee, to insure they have had their semi-annual service plans completed and signed by the resident or their family. Any resident who is found to not have a current semi-annual evaluation completed and signed by the	03/17/2022

	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 have the agreed upon service plans signed by the resident for 4 of 4 residents reviewed for signed service plans. (Residents B, C, D and E) 1. The clinical record for Resident B was reviewed on 2/1/22 at 11:09 a.m. Diagnoses included, but were not limited to, dementia without behaviors, anxiety, chronic kidney disease,		resident or their family and the nurse who completed it, will have one done by the Director of Nursing, or their designee, by 03/17/2022. and signed by the resident or their family. 3. All resident charts will be audited by the Director of Nursing, or their designee, to ensure all semi-annual service plans have been signed by the resident or their family. The audits will be done bi-weekly for 3 months, then monthly for 3 months. Random audits will be ongoing. 4. If any residents are found to not have a current semi-annual service plan signed by the resident or their family, the Director of Nursing, or their designee, will report any service plans not signed by the resident or their family or other issues to the Executive Director for correction. The Executive Director, or their designee, shall report any finding that they need assistance in correcting to the Administrator, or their designee, for correction.	

	hemiplegia and hemiparesis. Resident B was admitted to the facility on 6/19/19. An Evaluation of Needs/ Service Plan, dated 6/1/21, indicated the resident was alert, oriented and able to make sound decisions. The resident was able to ambulate independently. A service plan, dated 6/1/21, was signed by Resident B and indicated a level 3 care service. Resident B eloped from the facility on 12/10/21. An unsigned service plan, dated 1/5/22, indicated the resident needed more reassurance, increase in mobility needs and an increase in disturbances and emotion state. 2. The clinical record for Resident C was reviewed on 2/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anxiety and chronic obstructive pulmonary disease. Resident C was admitted to the facility on 1/5/22 after being evicted from another facility. An Evaluation of Needs/Service Plan was completed on 1/5/22. The agreed upon services were not signed by Resident C and/or a family member.			

	3. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure. A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility. An Evaluation of Needs/Service Plan was completed on 1/24/22. The agreed upon services were not signed by Resident D and/or a family member. 4. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension. Resident E was admitted to the facility on 11/26/21 from another facility. A pre-admission evaluation was completed by Director 1 on 11/26/21. A Nursing Admission Assessment for resident needs was completed on 1/27/21. A service plan was completed on 11/29/21 by the former Director of Nursing, but the agreed upon services were not			

	signed by Resident E and/or a family member. Review of a current facility policy, titled "Evaluation and Service Plan", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following; "An evaluation of the individual needs of each resident shall be done: prior to admission upon admission at lease semiannually upon a known substantial change in a resident's condition At the request of the resident or their family. ...The service plan shall be reviewed and revised as appropriate and discussed...." This State tag relates to Complaint IN00371295 Based on record review and interview, the facility failed to have the agreed upon service plans signed by the resident for 4 of 4 residents reviewed for signed service plans. (Residents B, C, D and E) 1. The clinical record for Resident B was reviewed on 2/1/22 at 11:09 a.m. Diagnoses			

included, but were not limited to, dementia without behaviors, anxiety, chronic kidney disease, hemiplegia and hemiparesis.

Resident B was admitted to the facility on 6/19/19.

An Evaluation of Needs/ Service Plan, dated 6/1/21, indicated the resident was alert, oriented and able to make sound decisions. The resident was able to ambulate independently.

A service plan, dated 6/1/21, was signed by Resident B and indicated a level 3 care service.

Resident B eloped from the facility on 12/10/21.

An unsigned service plan, dated 1/5/22, indicated the resident needed more reassurance, increase in mobility needs and an increase in disturbances and emotion state.

2. The clinical record for Resident C was reviewed on 2/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anxiety and chronic obstructive pulmonary disease.

Resident C was admitted to the facility on 1/5/22 after being evicted from another facility.

An Evaluation of Needs/Service Plan was completed on 1/5/22. The agreed upon services were

not signed by Resident C and/or a family member.

3. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure.

A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility.

An Evaluation of Needs/Service Plan was completed on 1/24/22. The agreed upon services were not signed by Resident D and/or a family member.

4. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension.

Resident E was admitted to the facility on 11/26/21 from another facility.

A pre-admission evaluation was completed by Director 1 on 11/26/21.

A Nursing Admission Assessment for resident needs was completed on 1/27/21.

A service plan was completed

	on 11/29/21 by the former Director of Nursing, but the agreed upon services were not signed by Resident E and/or a family member. Review of a current facility policy, titled "Evaluation and Service Plan", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following; "An evaluation of the individual needs of each resident shall be done: prior to admission upon admission at lease semiannually upon a known substantial change in a resident's condition At the request of the resident or their family. ...The service plan shall be reviewed and revised as appropriate and discussed...." This State tag relates to Complaint IN00371295			

R 0237	Health Services - Deficiency 410 IAC 16.2-5-4(a) (a) Each resident shall have a primary care physician selected by the resident Based on interview and record review, the facility failed to obtain physician order's prior to admission for 2 of 4 residents reviewed for physician orders. (Resident D and E) Findings include: 1. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure. A pre-admission evaluation was completed by Director 1 on 1/10/22. A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility. A service plan, dated 1/24/22, indicated the resident needed daily support and reassurance with changes and implementation of changes. A progress note, dated 1/31/22 at 2:00 p.m., indicated Director 2 was "searching for a new	R 0237	1. Residents D and E will have a primary care physician, selected by them, by 02/28/2022. 2. Any new admission, after 02/01/2022, have the potential to be affected by this alleged deficiency. All new admissions after 02/01/2022, will not be admitted until they have a primary care physician selected by them. 3. All new admissions after 02/01/2022 will not be admitted without a current physician who will follow the resident at the facility. This will be audited by the Assistant Executive Director, or their designee. All new admissions will be audited biweekly for 3 months, then monthly for 3 months to ensure all residents have a primary care physician selected by them. Random audits will be ongoing. 4. The Assistant Executive Director, or their designee, will report the findings of their audits to the Executive Director, or their designee. for correction. If the Executive Director, or their designee, has any issues she cannot correct she will notify the Administrator, or their designee, for their assistant in correction the issue.	02/28/2022

physician for resident."

Review of the current orders for Resident D, the facility was using the previous orders from the discharging facility.

During an interview 2/1/22 at 12:09 p.m., Director 1 indicated the resident admitted from another facility and the physician there was not going to follow her at this facility. She indicated the resident currently did not have a physician.

2. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension.

Resident E was admitted to the facility on 11/26/21 from another facility.

A pre-admission evaluation was completed by Director 1 on 11/26/21.

A resident information form, dated 11/26/21, indicated another person was the primary physician.

Review of the November physician orders, the physicians name from the discharging facility was crossed out and another name was wrote on the physician line. The clinical record lacked a physician's

signature.

Review of the December physician orders, the physician from the discharging facility remained on the orders. The clinical record lacked a physician's signature.

Review of the January physician orders, the physician from the discharging facility remained on the orders. The physician orders were signed by the primary on 1/4/22.

Review of the February physician orders, the physician from the discharging facility remained on the orders.

During an interview on 2/1/22 at 2:22 p.m., the Director of Nursing indicated Resident E discharged from another facility and the Medical Director at that facility would not continue to remain with Resident E. The resident was later seen by the current, but she was unsure of the date, but she was without a physician for a while.

Review of a current facility policy, titled "ADMISSION POLICY", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following;

"It is the policy of....

...4. The resident will require a history and physical, chest

x-ray, physician's orders including medications...."

Based on interview and record review, the facility failed to obtain physician order's prior to admission for 2 of 4 residents reviewed for physician orders. (Resident D and E)

Findings include:

1. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure.

A pre-admission evaluation was completed by Director 1 on 1/10/22.

A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility.

A service plan, dated 1/24/22, indicated the resident needed daily support and reassurance with changes and implementation of changes.

A progress note, dated 1/31/22 at 2:00 p.m., indicated Director 2 was "searching for a new physician for resident."

Review of the current orders for Resident D, the facility was using the previous orders from

	the discharging facility. During an interview 2/1/22 at 12:09 p.m., Director 1 indicated the resident admitted from another facility and the physician there was not going to follow her at this facility. She indicated the resident currently did not have a physician. 2. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension. Resident E was admitted to the facility on 11/26/21 from another facility. A pre-admission evaluation was completed by Director 1 on 11/26/21. A resident information form, dated 11/26/21, indicated another person was the primary physician. Review of the November physician orders, the physicians name from the discharging facility was crossed out and another name was wrote on the physician line. The clinical record lacked a physician's signature. Review of the December physician orders, the physician from the discharging facility			

	remained on the orders. The clinical record lacked a physician's signature. Review of the January physician orders, the physician from the discharging facility remained on the orders. The physician orders were signed by the primary on 1/4/22. Review of the February physician orders, the physician from the discharging facility remained on the orders. During an interview on 2/1/22 at 2:22 p.m., the Director of Nursing indicated Resident E discharged from another facility and the Medical Director at that facility would not continue to remain with Resident E. The resident was later seen by the current, but she was unsure of the date, but she was without a physician for a while. Review of a current facility policy, titled "ADMISSION POLICY", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following; "It is the policy of.... ...4. The resident will require a history and physical, chest x-ray, physician's orders including medications...."			

R 0408	Infection Control - Noncompliance 410 IAC 16.2-5-12(c) (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure residents received a chest radiograph prior to admission for 3 of 4 sampled residents. (Residents C, D and E). Findings include: 1. The clinical record for Resident C was reviewed on 2/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anxiety and chronic obstructive pulmonary disease. Resident C was admitted to the facility on 1/5/22 after being evicted from another facility. The clinical record lacked a chest x-ray completed prior to admission. 2. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure.	R 0408	1. Residents C, D, and E are current residents and cannot obtain a diagnostic chest xray completed no more than 6 months prior to admission. Residents C, D, and E will obtain a diagnostic chest xray before 03/07/2022. 2. All other residents have the potential to be affected by the alleged deficiency. All other residents will have their charts audited by the Executive Director's Assistant, or their designee, to see if the resident has a diagnostic chest xray completed no more than 6 months prior to their admission. Any resident who did not have a diagnostic chest xray completed no more than 6 months prior to their admission and who have not had a diagnostic chest xray completed since their admission will have a diagnostic chest xray completed by 03/17/2022. 3. All potential admissions will have their pre-admission paperwork audited by the Executive Director's Assistant, or their designee prior to admission, to ensure a diagnostic chest xray has been completed no more than 6 months prior to admission. No residents will be admitted without a diagnostic chest xray completed no more than 6 months prior to admission. All admissions will be randomly audited ongoing. Facility Policy and Procedure regarding new admissions has been reviewed by the Administrator, Executive Director, Executive Directors, Assistant, and the Director of Nursing to ensure policy is being followed. 4. The Executive Director's	03/17/2022

	A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility. The clinical record lacked a chest x-ray completed prior to admission. 3. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension. Resident E was admitted to the facility on 11/26/21 from another facility. On 2/1/22 at 12:45 p.m., Director 2 indicated she thought the chest x-rays could be done the day of admission. During an interview on 2/1/22 at 3:30 p.m., the Administrator indicated she was unable to find any chest x-rays done prior to admission for Resident C, D or E. Review of a current facility policy, titled "ADMISSION POLICY", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following; "It is the policy of.... ...4. The resident will require a history and physical, chest		Assistant, or their designee, will audit all new admissions charts within 24 hours of admission to ensure all new admissions received a diagnostic chest xray no more than 6 months prior to admission. If any new admission has occurred before the resident received a diagnostic chest xray, a diagnostic chest xray will be immediately obtained and the issue reported to the Administrator for evaluation of the possible deficient practice and correction to avoid further issues.	

x-ray, physician's orders including medications...."

Based on interview and record review, the facility failed to ensure residents received a chest radiograph prior to admission for 3 of 4 sampled residents. (Residents C, D and E).

Findings include:

1. The clinical record for Resident C was reviewed on 2/1/22 at 10:30 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anxiety and chronic obstructive pulmonary disease.

Resident C was admitted to the facility on 1/5/22 after being evicted from another facility.

The clinical record lacked a chest x-ray completed prior to admission.

2. The clinical record for Resident D was reviewed on 2/1/22 at 12:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, chronic kidney disease, diabetes mellitus and heart failure.

A progress note, dated 1/21/22, indicated the resident admitted to the facility from another facility.

The clinical record lacked a

chest x-ray completed prior to admission.

3. The clinical record for Resident E was reviewed on 2/1/22 at 1:32 p.m. Diagnoses included, but were not limited to, major depression, acute kidney disease, diabetes mellitus and hypertension.

Resident E was admitted to the facility on 11/26/21 from another facility.

On 2/1/22 at 12:45 p.m., Director 2 indicated she thought the chest x-rays could be done the day of admission.

During an interview on 2/1/22 at 3:30 p.m., the Administrator indicated she was unable to find any chest x-rays done prior to admission for Resident C, D or E.

Review of a current facility policy, titled "ADMISSION POLICY", which was provided by the Administrator on 2/1/22 at 3:45 p.m., indicated the following;

"It is the policy of....

...4. The resident will require a history and physical, chest x-ray, physician's orders including medications...."

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE