STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR RESIDENCES OF LAFAYETTE	250 SHENANDOAH DRIVE, LAFAYETTE, , 47905

(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 Complaints IN00362767, IN00364403 and IN00362449. This visit included a Quality Assurance Walk Through Survey. Complaint IN00362767 - Substantiated. State Residential Findings related to the allegations are cited at R036 and R0117. Complaint IN00364403 - Substantiated. No State Residential Findings related to the allegations were cited. Complaint IN00362449 - Substantiated. State Residential Findings related to the allegations are cited at R0117. Survey dates: October 18 and 19, 2021 Facility number: 014015 Residential Census: 45 These State Residential	R 0000		

	Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 22, 2021.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify the physician and family of a change in condition for 1 of 3 residents reviewed for notification. (Resident B). Finding includes: During an interview, on 10/19/21 at 2:13 p.m., a family member indicated Resident B had a problem with her colon and the facility did not notify the doctor or the family of the problem. The record for Resident B was	R 0036	R036 410 IAC 16.2-5-1.2(k)(1-2) Resident Rights The facility must immediately consult the resident's physician and the resident's legal representative when the facility has noticed: . A significant decline in the resident's physical, mental or psychosocial status . A need to alter treatment significantly, that is a need to discontinue and existing form of treatment due to adverse consequences or to commence a new form of treatment To meet this rule the facility will train all care staff what change of condition means, documentation of change of condition, notification of physician and responsible /legal	12/03/2021

	reviewed on 10/18/21 at 2:32 p.m. Diagnoses included, but were not limited to, osteoarthritis, malignant neoplasm of the colon, hypertension, osteoporosis and C-difficile (inflammation of the colon often from antibiotics which can cause severe damage to the colon and can be fatal). A Nursing Progress Note, dated 7/27/21 at 3:30 p.m., indicated the resident had received the last dose of antibiotic therapy and had no loose stools. The resident reported she had a formed stool. A Nursing Progress Note, dated 8/7/21 at 8:40 a.m., indicated the resident had complaints of diarrhea and nausea. She reported she had diarrhea throughout the night and vomited one time at night. The resident was questioned about seeing the physician and declined. The resident remained in bed.		representative. All team members will have review and understanding of Resident Condition Changes that require Physician Notification Guidelines	

	A Nursing Progress Note, dated 8/7/21 at 9:45 a.m., indicated staff was called to resident's room, she voiced an episode of diarrhea. The stool was left in the commode and was not formed, brown with a wet powder look. The resident was encouraged to drink fluids and denied evaluation at the Emergency Room. A Nursing Progress Note, dated 8/7/21 at 3:15 p.m., indicated the residents daughter was at the facility and reported the resident had diarrhea again, her blood pressure was 83/55. The daughter was concerned due to the resident's history of colon cancer and the resident did want to go to the Emergency Room. An Emergency Department Physician Progress note, dated 8/7/21 at 4:41 p.m., indicated Lactated Ringers (a solution to replace fluids and electrolytes in those who have low blood volume or low blood pressure) 1000 ml (milliliter) was given IV (intravenously), isolation for C-diff and outpatient labs for C-diff and stool culture. During an interview, on 10/19/21 at 1:53 p.m., the Director of Resident Care indicated the staff should document in the nursing progress notes when the physician and family had been notified of any changes.			

	There was no documentation in the record of notification to the physician and no faxes for 8/7/21. A current facility policy, titled "Resident Condition Changes that Require Physician Notification Guidelines," effective 9/1/18 and received from the Executive Director on 10/19/21 at 12:35 p.m., indicated "...This policy provides guidelines for recognizing changes in residents' condition that require physician notification...Clinical policies and procedures serve as clinical guidelines to assist in clinical staff decision-making, staff education/training, and evaluation of employee performance...In the event of any doubt, the physician is notified...A situation/condition that warrants immediate physician notification and intervention [if the physician response is not immediate, determine if the resident should be sent to the emergency room]. Such conditions include, but are not limited to the following...Severe gastrointestinal symptoms...Any change [or suspected change] in the resident's infection status [i.e. MRSA, VRE, C-diff, positive PPD]...Urgent: A situation/condition that requires physician notification and a physician response within 2-4 hours. Such conditions include,			

	but are not limited to the following...Persistent nausea/vomiting or headache...Licensed nurses [staff and management] are expected to recognize resident situations/conditions that require physician notification. The nurse completes an assessment of the condition, including level of urgency. The nurse implements appropriate interventions and has accurate information available when contacting the physician...Documentation of the resident condition change and proper notification is the responsibility of the nurse who observes and assesses the change...The licensed nurse also notifies the ...Unit/Nurse Manager or Nursing Supervisor...Resident and/or family...." This State Tag relates to Complaint IN00362767. Based on interview and record review, the facility failed to notify the physician and family of a change in condition for 1 of 3 residents reviewed for notification. (Resident B). Finding includes: During an interview, on 10/19/21 at 2:13 p.m., a family member indicated Resident B had a problem with her colon and the facility did not notify the doctor or the family of the problem.			

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	urgency. The nurse implements appropriate interventions and has accurate information available when contacting the physician...Documentation of the resident condition change and proper notification is the responsibility of the nurse who observes and assesses the change...The licensed nurse also notifies the ...Unit/Nurse Manager or Nursing Supervisor...Resident and/or family...." This State Tag relates to Complaint IN00362767.			
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 person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly	R 0117	R117 410 lAC 16.2 5-1(b) Personnel Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty –four hour schedule 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 awake staff person, with	12/03/2021

	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 interview and record review, the facility failed to ensure enough staff were available to provide dining services for the residents and to ensure substitute and menu foods were available which had the potential to affect 45 of 45 residents who resided in the facility. Finding includes: During an interview, on 10/18/21 at 3:40 p.m., Resident B indicated the facility had a shortage of dining staff and sometimes the residents did not always get the food they ordered on their meal ticket. During an interview, on 10/18/21 at 3:45 p.m., the Executive Director (ED) indicated she started working on 9/25/21 and the dining room had been shut down due to being short staffed. The residents were happy the dining room had opened back up. During an interview, on 10/18/21		current CPR and first aid certificates, shall be on site at all times. If fifty or more residents of the facility regularly receive residential nursing services or administration of medication, or both at least one nursing staff person shall be on site at all times. Residential facilities with over 100 residents regularly receiving residential nursing services or administration of medication or both shall have at least one additional nursing staff person awake and on duty at all times for every 50 residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions The dining room will remain open and serve resident meals according to menus with substitutions as needed due to product demand with supplier. Facility will continue to work on	

at 3:22 p.m., Dietary staff 2 indicated the facility had a new dietary manager. A few months back the facility lost a lot of dietary staff. The residents were given a choice of hot dog, grilled cheese or a peanut butter sandwich if they did not like the menu options. The facility would run out of quite a few things and at times would not have hot dogs or the grilled cheese or peanut butter. The facility was recently out of whipped cream and tomato juice and one resident liked tomato juice with each meal. The facility was out of the menu item brussel sprouts and had to serve broccoli today. There had also been a huge turnover in the dietary staff in the last 2-3 weeks.

During an interview, on 10/18/21 at 3:35 p.m., Dietary staff 3 indicated there had been four dietary staff who had quit including the manager and the staff did not get replaced right away. The previous ED had to order the food and sometimes substitutions had to be made to the menu due to being out of food items. During the summer time for about 6 weeks, the dining room was closed because the facility was short staffed and this was not due to covid. Some of the residents complained about the dining room being closed.

During an interview, on 10/19/21 at 10:33 a.m., Resident D indicated the facility was having issues in the dining room because they did not have enough dietary staff. The dining room had been closed several times and they had to eat in their rooms because there was not enough staff in the dining room to serve meals.

During an interview, on 10/19/21 at 1:33 p.m., the ED indicated she had provided wrong information and the dining room was closed in September due to a Covid positive staff.

During an interview, on 10/19/21 at 2:13 p.m., an anonymous family member indicated the dining room had been closed for about 4-6 weeks and had opened back up a couple of weeks ago. The reason given for the closure of the dining room was staffing concerns. The staff had been exposed to Covid-19 and other times the facility was having difficulty getting staff hired. The resident had ordered a hot dog and did not get it because the facility was out of hot dogs. Another time the resident got a cold grilled cheese sandwich because the regular menu item was not available.

A [name of facility] letter sent to residents, families and Team members on August 30, 2021,

indicated "...I'm reaching out to provide you with an update of what is occurring and taking place...We have had a team member test positive for Covid on Friday August 27...Our team member is quarantining outside of the community...The dining room is now closed until further notice. All meals will be delivered to the resident's apartment...."

A list of dietary staff who left the facility, provided by the ED on 10/19/21 at 2:30 pm., indicated one dietary aide quit on 7/7/21, one cook and one food service director quit on 7/20/21, two dietary aides quit on 7/21/21, one dietary aide quit on 7/30/21 and one dietary aide quit on 8/12/21.

The Resident Handbook, revised on 12/7/2019 and received from the ED on 4/19/21 at 2:30 p.m., indicated "..Dining Services...Snacks, Breakfast, Lunch and Dinner are served daily in the dining room located in the back center of the building. We do not observe an assigned seating policy...Lunch and dinner menus offer a selection of meals with daily specials being offered in addition to regular favorites. Menus are posted on a monthly basis at the bulletin board near the dining hall...

This State Tag relates to

Complaint IN00362449 and IN00362767.

Based on interview and record review, the facility failed to ensure enough staff were available to provide dining services for the residents and to ensure substitute and menu foods were available which had the potential to affect 45 of 45 residents who resided in the facility.

Finding includes:

During an interview, on 10/18/21 at 3:40 p.m., Resident B indicated the facility had a shortage of dining staff and sometimes the residents did not always get the food they ordered on their meal ticket.

During an interview, on 10/18/21 at 3:45 p.m., the Executive Director (ED) indicated she started working on 9/25/21 and the dining room had been shut down due to being short staffed. The residents were happy the dining room had opened back up.

During an interview, on 10/18/21 at 3:22 p.m., Dietary staff 2 indicated the facility had a new dietary manager. A few months back the facility lost a lot of dietary staff. The residents were given a choice of hot dog, grilled cheese or a peanut butter sandwich if they did not like the menu options. The facility would

run out of quite a few things and at times would not have hot dogs or the grilled cheese or peanut butter. The facility was recently out of whipped cream and tomato juice and one resident liked tomato juice with each meal. The facility was out of the menu item brussel sprouts and had to serve broccoli today. There had also been a huge turnover in the dietary staff in the last 2-3 weeks.

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This State Tag relates to Complaint IN00362449 and IN00362767.

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