STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE, MERRILLVILLE, , 46410

(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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00404254 completed on 3/22/23. This visit was done in conjunction with the Investigation of Complaint IN00405363 Complaint IN00404254 - Not Corrected. Complaint IN00405363 - State deficiencies related to the allegations are cited at R0149. Survey date: May 17, 2023 Facility number: 014178 Residential Census: 123 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/19/23.	R 0000	Thisn Plan of Correction constitutes our written allegation of compliance for the deficiency cited, however, submission of this plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet the established state and federal law.	

	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00404254 completed on 3/22/23. This visit was done in conjunction with the Investigation of Complaint IN00405363 Complaint IN00404254 - Not Corrected. Complaint IN00405363 - State deficiencies related to the allegations are cited at R0149. Survey date: May 17, 2023 Facility number: 014178 Residential Census: 123 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/19/23.			
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	R 0090	Belvedere Senior Housing Facility #: 014178 Survey Date: 0 5/17/2023 Plan of Correction-Re-visit	06/13/2023

	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; (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.		**R – 090** **Administration and Management -Deficiency** **Corrective Action:** 1. No Residents were harmed by the alleged deficient practice. Nurse on duty was re-educated on 05/24/2023 regarding immediate reporting of any allegations of abuse to include allegations of mistreatment immediately to the Administrator per state regulations. 2. All residents have the potential to be affected by alleged deficiency. Staff will monitor for signs of changes in behaviors/conditions and report to the Administrator immediately for further assessment and/or investigation.	

	(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 for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure allegations of mistreatment were reported timely to the Administrator for 1 of 2 residents reviewed for abuse. (Resident F) Finding includes: The record for Resident F was reviewed on 5/17/23 at 12:36 p.m. Diagnoses included, but were not limited to, anxiety, bipolar disorder, depression, high cholesterol, and high blood pressure. A Nurses' Note, dated 5/8/23 at 6:44 p.m., indicated "Resident came to nurses station visibly upset, complaining of mistreatment by dietary employee. Resident was informed she can make a complaint with administrator,		3. Staff were rein-serviced on 5/23/2023 on the policy/procedure on ensuring any allegations of abuse to include mistreatment are reported immediately to the Administrator or designee. The Director of Nursing/Executive Director will review daily the 24 hour nursing communication log and/or CareMerge will also be utilized to assure allegations of abuse are reported timely. The facilty will conduct any interviews with staff, residents and family to ensure allegations have not been missed on the 24 hour report and reported timely to Administration.	

and informed me she would follow-up with management."

An incident report, dated 5/9/23, indicated the incident date and time was 5/8/23 at 5:01 p.m. The resident reported a dietary aide had allegedly mistreated her in the dining room while serving.

Interview with the Director of Nursing on 5/17/23 at 2:45 p.m., indicated the nurse did not inform the Administrator or herself on 5/8/23 after the resident reported the allegation. The nurse was inserviced regarding abuse and reporting on 3/25/23 as part of their plan of correction from the previous complaint survey.

This State Residential tag was cited on 3/22/23. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the facility failed to ensure allegations of mistreatment were reported timely to the Administrator for 1 of 2 residents reviewed for abuse. (Resident F)

Finding includes:

The record for Resident F was reviewed on 5/17/23 at 12:36 p.m. Diagnoses included, but were not limited to, anxiety, bipolar disorder, depression,

4.
A QA audit will be conducted by the DON/Executive
Director or designee to ensure allegations of abuse are reported to the
Administrator immediately and reported to IDOH per state regulations. Audits will be conducted daily X 2 weeks, weekly x 4 weeks and then monthly for 6 months.
Audits will be reviewed at the monthly QA meeting for 6 months and
recommendations will be presented for any need for continued auditing.

Completion Date:
6/13/2023

high cholesterol, and high blood pressure.

A Nurses' Note, dated 5/8/23 at 6:44 p.m., indicated "Resident came to nurses station visibly upset, complaining of mistreatment by dietary employee. Resident was informed she can make a complaint with administrator, and informed me she would follow-up with management."

An incident report, dated 5/9/23, indicated the incident date and time was 5/8/23 at 5:01 p.m. The resident reported a dietary aide had allegedly mistreated her in the dining room while serving.

Interview with the Director of Nursing on 5/17/23 at 2:45 p.m., indicated the nurse did not inform the Administrator or herself on 5/8/23 after the resident reported the allegation. The nurse was inserviced regarding abuse and reporting on 3/25/23 as part of their plan of correction from the previous complaint survey.

This State Residential tag was cited on 3/22/23. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the facility failed to ensure allegations of mistreatment were reported

	timely to the Administrator for 1 of 2 residents reviewed for abuse. (Resident F) Finding includes: The record for Resident F was reviewed on 5/17/23 at 12:36 p.m. Diagnoses included, but were not limited to, anxiety, bipolar disorder, depression, high cholesterol, and high blood pressure. A Nurses' Note, dated 5/8/23 at 6:44 p.m., indicated "Resident came to nurses station visibly upset, complaining of mistreatment by dietary employee. Resident was informed she can make a complaint with administrator, and informed me she would follow-up with management." An incident report, dated 5/9/23, indicated the incident date and time was 5/8/23 at 5:01 p.m. The resident reported a dietary aide had allegedly mistreated her in the dining room while serving.			

Interview with the Director of Nursing on 5/17/23 at 2:45 p.m., indicated the nurse did not inform the Administrator or herself on 5/8/23 after the resident reported the allegation. The nurse was inserviced regarding abuse and reporting on 3/25/23 as part of their plan of correction from the previous complaint survey.

This State Residential tag was cited on 3/22/23. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the facility failed to ensure allegations of mistreatment were reported timely to the Administrator for 1 of 2 residents reviewed for abuse. (Resident F)

Finding includes:

The record for Resident F was reviewed on 5/17/23 at 12:36 p.m. Diagnoses included, but were not limited to, anxiety, bipolar disorder, depression, high cholesterol, and high blood pressure.

A Nurses' Note, dated 5/8/23 at 6:44 p.m., indicated "Resident came to nurses station visibly upset, complaining of mistreatment by dietary employee. Resident was informed she can make a complaint with administrator,

	and informed me she would follow-up with management." An incident report, dated 5/9/23, indicated the incident date and time was 5/8/23 at 5:01 p.m. The resident reported a dietary aide had allegedly mistreated her in the dining room while serving. Interview with the Director of Nursing on 5/17/23 at 2:45 p.m., indicated the nurse did not inform the Administrator or herself on 5/8/23 after the resident reported the allegation. The nurse was inserviced regarding abuse and reporting on 3/25/23 as part of their plan of correction from the previous complaint survey. This State Residential tag was cited on 3/22/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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