

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023	
NAME OF PROVIDER OR SUPPLIER EVERGREEN VILLAGE AT FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 12523 AUBURN ROAD, FORT WAYNE, , 46845					
(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 IN00405996. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00405996 - State deficiencies related to the allegations are cited at R0029. Survey dates: May 10 and 11, 2023 Facility number: 014512 Residential Census: 122 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 12, 2023	R 0000	May 25, 2023 RE: Survey Event ID W23911 To Whom It May Concern: On May 10 and 11, 2023, a Complaint (IN00405996) with a Residential Covid-19 Quality Assurance Wal Through Survey was conducted at our community Evergreen Village at Fort Wayne by the Division of Long-term Care, Indiana Department of Health, to determine if the facility was in compliance with state requirements for health facilities found in 410.IAC 16.2. Complaint IN00405996 resulted				

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			in a citation under R0029 Resident Rights pertaining to the perception that residents were not treated with consideration, respect, and dignity. Attached you will find a Plan of Correction relating to the alleged citation but does not validate the complaint or citation. Evergreen Village at Fort Wayne is asking for a desk review on this plan of correction. If you have any questions, I can be reached at 260-637-2830 or emailed at execdir@evergreenvillage-fortwayne.com. Sincerely, Laura Etter Executive Director	
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.	R 0029	It is the policy and practice that all residents are treated with consideration, respect, and recognition of their dignity and individuality.	06/09/2023

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Based on observation and interviews, the facility failed to ensure residents were treated with consideration, respect, and dignity for 7 of 9 residents reviewed (Resident P, Resident Q, Resident R, Resident T, Resident U, Resident V, and Resident X).

Findings include:

On 5/10/23 at 10:15 A.M., during an interview, the Area Ombudsman indicated she had received numerous concerns from residents of the facility regarding being disrespected.

1. On 5/10/23 at 11:17 A.M., Resident P, identified by the facility as interviewable, was interviewed. She was observed seated in a wheelchair too small for her large frame. The resident indicated staff repeatedly told her, she "asked" for too much help therefore, she was going to be discharged from the facility. Staff would tell her she needed to help herself when she was trying to, but was now afraid to ask for help because she didn't want to leave the facility. She indicated staff told her she was spending too much money and hadn't understood why that was any of their business; it made her feel like a child. She was currently trying to purchase a larger wheelchair so she wouldn't fall from the small one

In this citation it is stated Ombudsman received numerous concerns from residents being disrespected but in actuality only brought it to community attention twice for two residents.

At no other time did the Ombudsman alert or tell the community even anonymously on behalf of resident that there was a concern. In both instances the Ombudsman brought it to the attention of the community these resident concerns were followed up on and resolved per verbal response and conversation with community staff and resident.

Community does have a grievance process and follows it. When we are alerted of issues and concerns then we do an investigation and attempt to address them to the best of our ability.

This plan of correction is in request to your citation but does not acknowledge an admission of wrongdoing on behalf of community. The community was told this citation is due to a perception but not due to actual wrongdoing.

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she used.

2. On 5/10/23 at 12:19 P.M., Resident R, identified as interviewable, was interviewed. She indicated some staff were disrespectful and ignored her concerns about activities, qualification of the cook, transportation driver, and issues with patio furniture. She indicated, approximately 2 months ago, 25-30 residents tried to meet with staff members to discuss the issues but staff initially refused to speak with the residents. When the staff met with the residents, it was a very unproductive meeting. The meeting left she and others angry, resentful, and disrespected. Resident R indicated she no longer participated in any community activities and just stayed in her room.

3. On 5/10/23 at 2:10 P.M., Resident Q, identified as interviewable, was interviewed. She had several concerns which she alleged had not been followed up on. She believed the facility misled her about the services provided and use of amenities. She indicated the residents were unable to use the Bistro. She indicated a new dining program had been put into place. She indicated the residents felt discriminated against. All residents ate in the main dining room. The new

What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident P

- resident has three wheelchairs, one borrowed, one purchased, and then an electric scooter the one bought wheelchair was adjusted over 4 weeks ago when brought to community of a need resident refuses to use new wheelchair that fits her frame.

- Resident was not told she asked for too much help resident had a decline in her mobility and ability to assist in her care to point of total care which is beyond the scope of care assisted living can provide per regulation care was still being provided but this decline was what was discussed with resident, family, and ombudsman that we may have to look at alternate placement because the care she required was outside the scope of what

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dining program called Enhanced Nutrition Program (ENP), was available to those residents who paid extra. Residents were given dining cards; those paying for the ENP were given blue cards and residents without ENP were given a white card. When something was requested, staff would come to the table and ask for their card and if they had a white card, would be told they couldn't have any extra items because they hadn't paid for it. Resident Q had asked for a cup of ice cream because her tablemate had gotten one. She indicated she was embarrassed and belittled when told she couldn't have one because she didn't have a blue card. She believed it was discriminatory and the situation made her feel very disrespected. She recounted a meeting had been attempted with management staff, with group of 25 residents, but it had not gone well. She indicated residents were afraid to say anything because they hadn't wanted to get in trouble and be asked to leave the facility.

4. On 5/10/23 at 2:49 P.M., Resident T, identified as interviewable, was interviewed. She indicated, approximately 2 weeks ago, she was asked to come to the Administrators office. She indicated her POA had been called and was told the resident needed to be under

we could provide resident was already on therapy and home health but still was not progressing it is our responsibility to look at the welfare of the individual and ensure we provide the right services and if a higher level of care is needed then it is our responsibility to address that

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Staff was attempting to motivate resident to assist and get stronger due to the decline in participation and mobility in ADLs staff will be educated by 6-2-23 regarding approach and how to speak to residents even when it is regarding motivation acknowledging each resident's individuality and perception of a conversation.

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Staff is not aware of what money a resident may have we as a community do not interfere or handle any resident funds at our level all resident funds are handle by the resident or POA resident resides in studio and had a lot of items in there brother came in during a care conference and wanted to clear some of it

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control and toe the line or she would have to find another place to live. The resident indicated she felt scolded, embarrassed, and disrespected because her son, who was her POA, was contacted as if she were a child. During the interview, the resident called her son who verified this event had occurred. He indicated the call had surprised him as his mother was responsible for herself and her own actions.

5. On 5/11/23 at 9:16 A.M., Resident X who served as the Resident Council President (RCP) was interviewed. He indicated the council meets every month to discuss concerns. The Resident Council meeting was followed by a food committee meeting. Around 2 months ago, a group of about 25 residents had gathered and asked to speak with the Administrator. She initially refused to meet with the group but then did so. He indicated the meeting was unproductive, loud at times with yelling and cursing, further no one believed anything had been resolved. The residents present during the meeting had expressed anger, feelings of being unheard, disrespected, and feeling no control over their home. He indicated one of his concerns, regarding times of meals, had been addressed although not to his or other resident's total

out because it was over crowded causing a safety concern this was between brother and resident has been on waiting list for a 1 bedroom to accommodate this and will remain on waiting list till one opens up that will meet her needs

Resident R

- community has a grievance process and residents are educated on this process meeting held was regarding dietary service and the new process residents did not like it meeting was unproductive because there was no order to it and there was profanity, yelling, and cursing staff were present this was not a scheduled meeting so staff was not prepared and did not know it was going to occur issues and concerns were noted and resolved dining service was returned to its old process immediately and residents were satisfied

- all staff are trained for their department and their duties in that department there is no

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satisfaction. He and other residents had requested a total of 2 hours be designated for each meal however, the Administrator indicated a cost and labor issue was involved and compromised by scheduling breakfast for 1 hour and lunch and dinner for 1 and a half hours. Since the meeting, the RCP indicated a general feeling of apathy by residents and lack of desire to further attempt to improve their living conditions.

6. On 5/11/23 at 2:16 P.M., Resident U, identified as interviewable was interviewed in her apartment. She indicated she was hard of hearing and staff would, at times, mumble when speaking to her and she couldn't hear them. When she would ask for clarification, staff would get angry and either ignore her or tell her to stop yelling at them. She gave the following example: the nurse had brought in her pills. She keeps track of her medication and counts due to past issues with not receiving the correct medication. Resident U asked if the nurse had her nasal spray but the nurse walked out her door. The resident got up, went to the door and yelled out to the nurse going down the hall, and asked if she was bringing back her nasal spray. The nurse ignored her and kept walking. Resident U indicated she didn't know why staff didn't like her

requirement for qualification of dietary staff except for one to be serve safe certified which we do have

- concern regarding activities and transportation was regarding a staff member expecting this also was addressed as we can't discriminate against an employee expecting and if employee felt there was a concern, they would bring it to us resident did not feel staff member should be driving

- patio furniture was address and there is patio furniture present and has been present for over a year there is no regulatory to provide front porch patio furniture, but it is present, and all residents use it and enjoy it

- resident does participate in community activities and community events resident runs the community store weekly as well as an activity of preference

Resident Q

and didn't know what she had done to them to be treated with such dislike and disrespect. She shared other instances and kept repeating she didn't know what she had done to make staff not like her. While being interviewed, there was a knock on the door followed by a housekeeper unlocking the door and walking in. She indicated she was just there to clean her bathroom and walked to the room. The resident continued to talk and looked hesitantly at times towards the bathroom. When asked if she wanted the housekeeper to leave while the interview continued, she indicated she hadn't known she was allowed to do that, was afraid to get in trouble, and didn't want to make staff mad and dislike her further.

7. On 5/11/23 at 2:31 P.M., Resident V, identified as interviewable, was interviewed. She had numerous concerns involving medications, nursing, and laundry services. She indicated she had in the past, completed grievance forms but never received any word back on her concerns so she quit submitting them. She indicated feeling if she complained, there was a implied threat of retaliation so it wasn't worth the time filling them out. She denied any direct threats, just what she felt. She indicated she felt very disrespected by staff, her

- Residents was educated upon admission regarding amenities and what community could and could not do however there have been some changes since admission due to other concerns that affected community. Community will initiate systematic changes as necessary for the common good of all residents and these changes were communicated to residents prior to implementing them.

- Residents are allowed to use bistro this is not a closed area and open 24 hours a day 7 days per week and attached to the dining area.

- Enhanced Nutrition Plan is an elective service that residents pay for the cards are used to identify a resident on the plan and is only the anytime menu that they order off of all residents if wanted can be assessed for the elective service if they choose and want to be on it. This service was explained to resident prior to and at admission resident

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opinions and experiences hadn't mattered. She had previously been a nursing assistant, was very familiar with care of elderly persons and how assisted living facilities were run but felt like her opinions and knowledge were ignored.

During a confidential staff interview, Staff 3 indicated there were issues between staff and residents with feelings of disrespect and distrust. Staff 3 would not provide examples or further information due to possible retaliation.

On 5/11/23 at 3:45 P.M., the Administrator was interviewed. She indicated there were issues with some residents who wanted things a certain way however, as the Administrator, she was responsible for the care of the entire community and had to do what was best for all. She indicated a need for further education with staff regarding customer service, showing respect for residents and their individual needs, ensuring dignity, and conflict resolution.

A current policy, titled "Residents' Personal Rights", was provided on 5/11/23 at 1:54 P.M., and stated: "4. Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality...."

waived the service.

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Residents at meeting did have opportunity to state their grievances and most did rebuttal was not given at time of meeting because community needed time to look into the concern and address appropriately which was done within 24 hours of the meeting after meeting residents were ok with resolution and told administration that they were happy with the resolution which was addressed quickly.

Resident T

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Resident was not asked to administrator's office resident came there to file a grievance administrator listened to grievance but resident became verbally aggressive and started to have behaviors in the office administrator was assisted by other staff to re-direct resident to therapy to diffuse resident anger and aggressiveness family was called due to behaviors and

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This State Residential Finding relates to Complaint IN00405996.

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Findings include:

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1. On 5/10/23 at 11:17 A.M., Resident P, identified by the facility as interviewable, was interviewed. She was observed seated in a wheelchair too small for her large frame. The resident indicated staff repeatedly told her, she "asked" for too much help therefore, she was going to be discharged from the facility. Staff would tell her she needed to help herself when she was trying to, but was now afraid to ask for help because she didn't want to leave the facility. She indicated staff told her she was spending too much money and hadn't understood why that was any of their business; it made her feel like a child. She was

other behaviors that were reported earlier that day with other staff members it is the responsibility of the community to notify families of medical or psychosocial concerns such as this in speaking with son there was more information given as to residents background and diagnosis that could trigger this type of behavior and it was explained that resident has a history of aggressive verbal behavior towards others interventions were discussed and family was going to call resident to check on her

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All residents have a responsible person or POA on file as part of their medical records for contact in case of instances like this or medical concerns this is not a new thing in health care to contact families and discuss things with them this family is on the resident's notification list as well

Resident X

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Meeting was not a planned

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currently trying to purchase a larger wheelchair so she wouldn't fall from the small one she used.

2. On 5/10/23 at 12:19 P.M., Resident R, identified as interviewable, was interviewed. She indicated some staff were disrespectful and ignored her concerns about activities, qualification of the cook, transportation driver, and issues with patio furniture. She indicated, approximately 2 months ago, 25-30 residents tried to meet with staff members to discuss the issues but staff initially refused to speak with the residents. When the staff met with the residents, it was a very unproductive meeting. The meeting left she and others angry, resentful, and disrespected. Resident R indicated she no longer participated in any community activities and just stayed in her room.

3. On 5/10/23 at 2:10 P.M., Resident Q, identified as interviewable, was interviewed. She had several concerns which she alleged had not been followed up on. She believed the facility misled her about the services provided and use of amenities. She indicated the residents were unable to use the Bistro. She indicated a new dining program had been put into place. She indicated the

meeting it was a group of disgruntled residents sitting in the front lobby of the community yelling, using profanity, and calling administrator derogatory names with other staff present as witnesses administrator has a right to walk away and protect self if feels attacked and resume conversations later at a time that is more appropriate

- Concerns regarding meal service were addressed and resolved no other resident has verbalized a complaint regarding mealtimes. Mealtimes have not changed except into an open mealtime so resident can choose when they want to come down. No concern has been brought up during food council or resident council that residents are concerned about this. Visually watching the dining room residents seem very content and enjoy the more residents in there for socialization. Dining times have not changed due to labor and cost but due to resident request and dining satisfaction

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residents felt discriminated against. All residents ate in the main dining room. The new dining program called Enhanced Nutrition Program (ENP), was available to those residents who paid extra. Residents were given dining cards; those paying for the ENP were given blue cards and residents without ENP were given a white card. When something was requested, staff would come to the table and ask for their card and if they had a white card, would be told they couldn't have any extra items because they hadn't paid for it. Resident Q had asked for a cup of ice cream because her tablemate had gotten one. She indicated she was embarrassed and belittled when told she couldn't have one because she didn't have a blue card. She believed it was discriminatory and the situation made her feel very disrespected. She recounted a meeting had been attempted with management staff, with group of 25 residents, but it had not gone well. She indicated residents were afraid to say anything because they hadn't wanted to get in trouble and be asked to leave the facility.

4. On 5/10/23 at 2:49 P.M., Resident T, identified as interviewable, was interviewed. She indicated, approximately 2 weeks ago, she was asked to come to the Administrators

Resident has been out and about in community, gardens, does activities, and has not shown any signs of feeling apathy conditions of community are clean and organized all resident council concerns are addressed timely and resolved to the best of the ability of the community within the regulatory statutes provided by the Indiana State Department of Health resident has never filed a complaint with community of with family a feeling always states he is happy and enjoys living here

Resident U

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Resident had a care conference with POA, administrator and DON regarding issues and concerns. All concerns at that time were addressed. Staff will be educated on resident's issue when it comes to be able to hear and how to speak directly to resident so she understands by 6-2-23.

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Staff will be educated on

office. She indicated her POA had been called and was told the resident needed to be under control and toe the line or she would have to find another place to live. The resident indicated she felt scolded, embarrassed, and disrespected because her son, who was her POA, was contacted as if she were a child. During the interview, the resident called her son who verified this event had occurred. He indicated the call had surprised him as his mother was responsible for herself and her own actions.

5. On 5/11/23 at 9:16 A.M., Resident X who served as the Resident Council President (RCP) was interviewed. He indicated the council meets every month to discuss concerns. The Resident Council meeting was followed by a food committee meeting. Around 2 months ago, a group of about 25 residents had gathered and asked to speak with the Administrator. She initially refused to meet with the group but then did so. He indicated the meeting was unproductive, loud at times with yelling and cursing, further no one believed anything had been resolved. The residents present during the meeting had expressed anger, feelings of being unheard, disrespected, and feeling no control over their home. He indicated one of his concerns,

residents rights in regards to knowing about their medications pills and taking time to speak with resident in a dignified manner

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Staff will be educated on appropriately knocking on resident's doors, waiting to be let in and acknowledging resident in their home prior to starting their duties.

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Residents are allowed to ask staff to leave their apartment at any time. Resident will be educated to this practice and how to file a grievance or report administrator or designee concerns needing addressed.

Resident V

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Community has a grievance process and all grievances are addressed to resident satisfaction. Sometimes a grievance may come up again and have to be reported again and investigated. A grievance binder is kept in the

regarding times of meals, had been addressed although not to his or other resident's total satisfaction. He and other residents had requested a total of 2 hours be designated for each meal however, the Administrator indicated a cost and labor issue was involved and compromised by scheduling breakfast for 1 hour and lunch and dinner for 1 and a half hours. Since the meeting, the RCP indicated a general feeling of apathy by residents and lack of desire to further attempt to improve their living conditions.

6. On 5/11/23 at 2:16 P.M., Resident U, identified as interviewable was interviewed in her apartment. She indicated she was hard of hearing and staff would, at times, mumble when speaking to her and she couldn't hear them. When she would ask for clarification, staff would get angry and either ignore her or tell her to stop yelling at them. She gave the following example: the nurse had brought in her pills. She keeps track of her medication and counts due to past issues with not receiving the correct medication. Resident U asked if the nurse had her nasal spray but the nurse walked out her door. The resident got up, went to the door and yelled out to the nurse going down the hall, and asked if she was bringing back her nasal spray. The nurse

administrator's office and grievances are tracked on the morning meeting form until resolved by appropriate parties.

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Resident opinions are acknowledged when presented and there is no retaliation when a resident presents a concern it is addressed by appropriate staff and followed up on as well as documented the follow up

Staff Member

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Education of staff will be provided that all staff are responsible to report issues and concerns on behalf of a resident so these concerns can be addressed appropriately concerns and grievances of this nature are taken very seriously, and each resident has the right to be treated with dignity and respect by
6-2-23

ignored her and kept walking. Resident U indicated she didn't know why staff didn't like her and didn't know what she had done to them to be treated with such dislike and disrespect. She shared other instances and kept repeating she didn't know what she had done to make staff not like her. While being interviewed, there was a knock on the door followed by a housekeeper unlocking the door and walking in. She indicated she was just there to clean her bathroom and walked to the room. The resident continued to talk and looked hesitantly at times towards the bathroom. When asked if she wanted the housekeeper to leave while the interview continued, she indicated she hadn't known she was allowed to do that, was afraid to get in trouble, and didn't want to make staff mad and dislike her further.

7. On 5/11/23 at 2:31 P.M., Resident V, identified as interviewable, was interviewed. She had numerous concerns involving medications, nursing, and laundry services. She indicated she had in the past, completed grievance forms but never received any word back on her concerns so she quit submitting them. She indicated feeling if she complained, there was a implied threat of retaliation so it wasn't worth the time filling them out. She denied

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

No other residents were affected by this alleged deficient practice. Residents have interviews quarterly by management for quality assurance to ensure they are happy within the community and things are going ok. Over the last quarter no grievances were noted regarding respect and dignity.

What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur?

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any direct threats, just what she felt. She indicated she felt very disrespected by staff, her opinions and experiences hadn't mattered. She had previously been a nursing assistant, was very familiar with care of elderly persons and how assisted living facilities were run but felt like her opinions and knowledge were ignored.

During a confidential staff interview, Staff 3 indicated there were issues between staff and residents with feelings of disrespect and distrust. Staff 3 would not provide examples or further information due to possible retaliation.

On 5/11/23 at 3:45 P.M., the Administrator was interviewed. She indicated there were issues with some residents who wanted things a certain way however, as the Administrator, she was responsible for the care of the entire community and had to do what was best for all. She indicated a need for further education with staff regarding customer service, showing respect for residents and their individual needs, ensuring dignity, and conflict resolution.

A current policy, titled "Residents' Personal Rights", was provided on 5/11/23 at 1:54 P.M., and stated: "4. Residents have the right to be treated with consideration, respect, and

The community will continue to do quarterly resident interviews over the next six months to ensure residents are ok and being treated with dignity and respect. Issues and concerns will be brought to the administrator or designee for follow up and resolution.

A notice for residents was placed by the grievance forms on how to file a grievance or an anonymous grievance on 5-24-23

The community instituted an adopt a resident program with all residents that are listed in the complaint to have follow up and communication to ensure they are not having further concerns. This program will be ongoing and discussed weekly over the next six months. Residents can be placed on list for multiple reasons or taken off list if QA Committee determines that is appropriate.

How will the corrective action(s) be monitored to ensure the deficiency practice will not recur, i.e., what

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recognition of their dignity and individuality...."

This State Residential Finding relates to Complaint IN00405996.

quality assurance program will be put in place?

Quarterly interviews will be conducted for QA Committee to review and resolve any concerns. Concerns will be forwarded to QAPI Team for follow up and resolution. QAPI team will monitor all residents and grievances over the next six months to ensure residents feel comfortable bringing grievances up.

Date of Compliance:
June 9, 2023

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
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