STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF EDISON LAKES	1025 PARK PLACE MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00408343, IN00396008, and IN00407567. Complaint IN00408343 - No deficiencies related to the allegation are cited. Complaint IN00407567 - No deficiencies related to the allegations are cited. Complaint IN00396008 - State defiencies related to the allegations are cited at R0090 Survey dates: May 8, 9, and 10, 2023 Facility number: 013331 Residential census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 5/22/2023.	R 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.**	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Brinkman	Executive Director	06/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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. (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	R 0090	**R090-Administration and**	07/03/2023

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	failed to report an elopement to State Agency for 1 of 3 residents reviewed for elopement. (Resident B) Finding includes: A record review was completed on 5/8/23 at 9:56 A.M., Resident B's diagnoses included, but were not limited to: Hypertension, prostate cancer, atrial fibrillation, cerebrovascular accident, expressive aphasia, hyperlipidemia, mild depression, anxiety, irritable bowel syndrome and pulmonary embolism. Resident B was moderately cognitively impaired. A clinical progress note, dated 11/2/22 indicated Resident B had walked almost 4 miles to a local club to attend an auction. Resident B returned to the facility after an employee from the facility located him at the auction. During an interview, on 5/9/23 at 10:52 A.M., the Director of Nursing indicated Resident B wanted to attend an auction but the facility bus was out at the time and unable to take him. Resident B left the building and walked 4 miles to an auction. The facility notified law enforcement and also initiated their own search. Resident B was located at the auction and returned to the facility. During an interview, on 5/9/23 at 12:24 P.M., the Executive Director indicated the elopement was not reported and should have been reported immediately. On 5/10/23 at 10:04 A.M., the Director of Nursing provided the policy titled, "Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation", dated 3/14/2022, and indicated the		**Management** It is the practice of this facility to report unusual occurrences to the ISDH within 24 hours. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B no longer resides in the community. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The new Executive Director and new Director of Wellness services will call the Regional Nurse to discuss any possible events that are or could be unusual occurrence for reporting to ISDH. No residents were affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director and Director of Wellness services will be in-serviced on reporting unusual occurrences within 24 hours to ISDH by the Regional Nurse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	policy was the one currently used by the facility. The policy indicated"...1. Immediately notify your state agency and appropriate law enforcement agencies as indicated...." A "Long-Term Care Abuse and Incident Reporting Policy", with an effective date of 12/8/2022, indicated "...C. Types of Incidents reportable under state rules...3. Elopement: Elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown...." This state residential finding relates to complaint IN00396008.		Residents will be discussed at the weekly ROAR (Resident Opportunity at Risk) meeting. This will help with early identification of residents at risk and trigger the necessary assessments to be completed. This meeting will be held weekly by the Executive Director or designee.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency			

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	procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure general orientation and job specific orientation documentation was available for 4 of 5 employees whose records were reviewed. (QMA 4, CNA 9, Server11, and Server 13) Findings include: 1.An employee record review was completed, on 5/10/2023 at 11:40 A.M., for QMA (Qualified Medication Aide) 4. The record lacked the documentation indicating the completion of general orientation or specific orientation upon hire. 2.An employee record review was completed, on 5/10/2023 at 11:48 A.M., for CNA (Certified Nursing Assistant) 9. The record lacked the documentation indicating the completion of the general orientation or specific orientation upon hire. 3.An employee record review was completed, on 5/10/2023 at 11:50 A.M., for Server 11. The record lacked the documentation indicating the completion of general orientation or specific	R 0119	**R119 – Personnel** It is the practice of this facility to provide new orientation for new employees. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The community will complete an audit of all employee files to make sure general orientation and job specific orientation have been completed. The current	07/03/2023

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	orientation upon hire. 4. An employee record review was completed, on 5/10/2023 at 11:55 A.M., for Server 13. The record lacked the documentation indicating the completion of general orientation or specific orientation upon hire. During an interview, on 5/10/2023 at 9:15 A.M., the Executive Director indicated that the employee files were incomplete and would not be able to provide any of the missing records, but indicated employee files should contain all required documents. On 5/10/2023 at 3:03 P.M., the Regional Nurse indicated the facility did not have a policy for general orientation or specific orientation.		employees that do not have the general or job specific orientation complete will do so. The Business Office Manager and the other department managers will be in-serviced on what needs to be completed for all new employees. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will conduct an audit of new employee files weekly for the first month, monthly for three months, and quarterly thereafter to assure compliance.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing			

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	personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure the required 3 hours of annual dementia in-services were completed for 4 of 10 employees reviewed for in-services. (QMA 5, QMA 7, LPN 10, and LPN 12) Findings include: 1. An employee record was review was completed, on 5/10/2023 at 11:10 A.M., The employee file for QMA (Qualified Medication Aide) 5 lacked the documentation to show completion of the required 3 hours of dementia training. 2. An employee record was review was completed, on 5/10/2023 at 11:15 A.M., The employee file for QMA (Qualified Medication Aide) 7 lacked the documentation to show completion of the required 3 hours of dementia training.	R 0120	**R120-Personnel** It is the practice of this facility to provide three hours of dementia training annually for all employees. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by the deficient practice. **What measures will be put into place or what systemic**	07/03/2023

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	3. An employee record was review was completed, on 5/10/2023 at 11:18 A.M., The employee file for LPN (Licensed Practical Nurse) 10 lacked the documentation to show completion of the required 3 hours of dementia training. 4. An employee record was review was completed, on 5/10/2023 at 11:22 A.M., The employee file for LPN (Licensed Practical Nurse) 12 lacked the documentation to show completion of the required 3 hours of dementia training. During an interview, on 5/10/2023 at 9:15 A.M., the Executive Director indicated that the employee files were incomplete and would not be able to provide any of the missing records. The Executive Director indicated employee files should contain all required documents. On 5/10/2023 at 3:03 P.M., the Regional Nurse indicated the facility did not have a policy for in-services.		**changes will be made to ensure that the deficient practice does not recur:** The community will complete an audit of all employee files to make sure dementia training has been completed. The current employees that do not have the three hours of dementia training will have it scheduled and completed. The Business Office Manager and the other department managers will be in-serviced on what needs to be completed for all new employees. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will conduct an audit of new employee files weekly for the first month, monthly for three months, and quarterly thereafter to assure compliance.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:			

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	(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure a 1st and 2nd step TB (Tuberculin) skin test was completed for 1 newly hired employee and failed to ensure an Annual Risk Assessment for tuberculosis was completed for 2 of 10 employees whose files were reviewed. (Server 11, QMA 5, and QMA 8) Findings include:	R 0121	**R121-Personnel** It is the practice of this facility to complete a TB skin test for new employees and annual risk assessment for employees. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	07/03/2023

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	1. An employee record review was completed, on 5/10/2023 at 11:30 A.M. The employee file for Server 11 lacked the documentation to show that a 1st and 2nd step TB skin test had been completed prior to hire. 2. An employee record review was completed, on 5/10/2023 at 11:35 A.M. The employee file for QMA (Qualified Medication Aide) 5 lacked the documentation to show that an Annual Risk Assessment for tuberculosis was completed for the current year. 3. An employee record review was completed, on 5/10/2023 at 11:35 A.M. The employee file for QMA (Qualified Medication Aide) 8 lacked the documentation to show that an Annual Risk Assessment for tuberculosis was completed for the current year. During an interview, on 5/10/2023 at 9:15 A.M., the Executive Director indicated that the employee files were incomplete and would not be able to provide any of the missing records, but indicated employee files should contain all required documents. On 5/10/2023 at 3:03 P.M., the Regional Nurse indicated the facility did not have a policy for tuberculosis testing and annual screenings.		No residents were affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The community will complete an audit of all employee files to make sure TB skin tests were completed or annual risk assessments completed. The current employees that do not have TB skin tests or annual risk assessment completed will have them completed. The Business Office Manager and the other department managers will be in-serviced on what needs to be completed for all new employees. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will conduct an audit of new employee files weekly for the first month, monthly for three months, and quarterly thereafter to assure compliance.	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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; 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 ensure service plans were completed and signed by the resident or their representative for 1 of 8 residents reviewed for service plans. (Residents D) Finding includes:	R 0217	**R217-Evaluation** It is the practice of this facility to have evaluations or service plans signed by resident/family and staff. **What corrective action(s) will be accomplished for those residents found to have been**	07/03/2023

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	A record review was completed on 5/10/2023 at 11:45 A.M. Resident D's diagnoses included, but were not limited to diabetes, depression, anxiety, heart failure, and Wernicks's disease. A Service Plan, dated 4/11/2022, lacked the resident/responsible party, facility staff signatures and dates. The record lacked any further Service Plans or semi evaluations for Resident D. During an interview, on 5/9/2023 at 12:15 P.M., the Corporate Nurse indicated there were no other service plans and or evaluations completed for the resident and there should have been. On 5/20/2023 at 10:24 A.M., the Director of Nursing provided the policy titled," Individualized Service Plan Policy and Procedures", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... 4. If the Resident experiences a significant change of condition or preferences or service needs change, the Individualized Service Plan will be updated and reviewed with the Resident and/or Resident's Authorized Signer. 5. Each Individualized Service Plan will address the appropriateness of the Resident's current Level of Care, be reviewed, and updated when a change in the Resident's Level of Care is warranted...."		**affected by the deficient practice:** Resident D will have a new service plan completed and reviewed with the resident and family along with the necessary signatures. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** An audit will be completed of all residents to make sure all service plans have signatures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The regional nurse has in-serviced the Director of Wellness regarding service plans and obtaining signatures. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Wellness or designee will conduct an audit of resident's service plans for signature weekly for the first month, monthly for three months, and quarterly thereafter to assure compliance.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by			

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	a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure a PRN (as needed) medication administered by a QMA (Qualified Medication Aide) were approved by a licensed nurse for 1 of 8 residents reviewed for medications. (Resident E) Finding includes: A record review was completed on 5/9/2023 at 2:45 P.M. Resident E's diagnoses included, but were not limited to: bradycardia, osteoarthritis, osteoporosis and coronary artery disease. A MAR (Medication Administration Record), dated February 2023, indicated a PRN (as needed) Hydrocodone(narcotic) had been administered on 2/12023 at 4:37 P.M., by QMA (Qualified Medication Aide) 7 without documentation of a licensed nurse approving the administration of the narcotic. During an interview, on 5/10/2023 at 12:15 P.M., the Director of Nursing indicated the QMA should have documented in the record the nurse's approval was received. On 5/10/2023 at 12:17 P.M., a policy for QMA's administering PRN medications was requested. On 5/10/2023 at 1:53 P.M. the Director of Nursing indicated she had no policy for administering PRN	R 0246	**R246 – Health Service** It is the practice of this facility that each resident receives PRN medication by a QMA only upon authorization by a licensed nurse. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E receiving the PRN medication had no adverse effects. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with PRN medication orders have the potential to be affected by this finding. A facility audit will be conducted by the Director of Wellness to identify all residents with PRN medication orders. Any residents with PRN medications will be identified by a list for the QMA's to review before the shift. **What measures will be put into place or what systemic changes will be made to**	07/03/2023

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	medications by a QMA.		**ensure that the deficient practice does not recur:** All QMA's will be in-serviced on or before 7/3/23. This in-service will be conducted by the Director of Wellness and will include why PRN's have to be authorized by a nurse and where to document PRN's given by the QMA. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the Quality Assurance Performance Improvement audit tools labeled "PRN Medications" weekly for a month and then monthly thereafter. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:			

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	(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to assess and document the residents condition following a hospital stay for 1 of 3 residents reviewed for hospitalization. (Resident 6) Finding includes: A record review was completed on 5/10/2023 at 2:38 P.M. Resident 6's diagnoses included, but were not limited to hypertension, open-angle glaucoma and muscle weakness. A Note, dated 2/27/2023 at 6:00 P.M., indicated the resident had transitioned out to the hospital due to shortness of breath. A Note, dated 2/27/2023 at 6:45 P.M., indicated Resident 6 had been admitted to the hospital due to a low biox (low blood oxygen level). A Note, dated 3/2/2023 at 6:21 P.M., indicated the resident returned to the facility. The note lacked any assessment of the resident following the hospital stay. A Note, dated 3/3/2023 at 6:07 P.M., indicated the resident remained on isolation for covid. The note lacked any assessment of the resident following her return to the facility. A Note, dated 3/4/2023 at 12:26 P.M., indicated the resident was taken off isolation today and after the resident showered, the bandage to the left leg was replaced.	R 0349	**R349– Clinical Records** It is the practice of this facility to assess and document resident condition after a hospital stay or a change in condition. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 6 had no adverse effects from deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No adverse effects were identified for any residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nurses and QMA's will be in-serviced on or before 7/3/23 by the Director of Wellness. This in-service will be over documentation after a resident return from a stay at a hospital, skilled facility or a change in condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	07/03/2023

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	The record lacked any further notes and or assessment of the resident upon returning to the facility. During an interview, on 5/10/2023 at 11:58 A.M., the Director of Nursing indicated the resident should have been assessed and charted on for 72 hours after being in th hospital. On 5/10/2023 at 4:00 P.M., the Director of Nursing provided the policy titled, "Alert Charting", dated 3/14/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Alert charting will be implemented for each Resident as specified in the procedure that follows. A Certified Med Aide, the Director of Wellness, Licensed Nurse or Executive Director can place a resident on an alert status, and until the resident will be evaluated and documented in Caremerge notes for 72 hours or until a licensed nurse discontinues the alert status. ...Unless otherwise directed by the Licensed Nurse or Director of Wellness, conditions or events that need charting include, but are not limited to: c. Infections... 4. Transfers/return from Emergency Departments or hospital stay...."		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the Quality Assurance Performance Improvement audit tool labeled “Alert Charting” weekly for the first month and then monthly thereafter. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.			

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	(4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure infections were being monitored and tracked from September 2022 to May 2023. Finding includes: An Infection Control Log book was provided by the Director of Nursing on 5/10/2023 at 4:05 P.M. The log book will filled with completed log sheets for 8 months of 2022. The Infection Control book lacked any documentation to indicate which residents had an infection, when the infection started, what type of infection, how had the infection been treated, and what was the outcome after treatment. During an interview, on 5/10/2023 at 4:10 P.M., the Director of Nursing indicated the previous Director was responsible for the Infection Control book. She indicated the infections had not been tracked since the previous Director had left, and there should have been updated and current log sheets for the infections. On 5/10/2023 at 4:15 P.M., a policy was requested for the facilities Infection Control Program, but one was not provided prior to the survey exit.	R 0407	**R407– Infection Control** It is the practice of this facility that infections are monitored and tracked. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No adverse effects were identified for any residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Wellness will be in-serviced on or before 7/3/23. This in-service will be conducted by the Regional Nurse and will include infections to be monitored and tracked. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality	07/03/2023

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			Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the Quality Assurance Performance Improvement audit tool labeled "Infection Control Log" weekly for a month and then monthly thereafter. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure an annual health statement from the physician was obtained on admission and yearly thereafter for 1 of 7 residents whose clinical records were reviewed. (Resident F) Finding includes: A record review was completed on 5/9/2023 at 2:15 P.M. Resident F's diagnoses included, but were not limited to Parkinson's disease, hypertension and hyperlipidemia. Resident F was admitted on 12/15/2022. The residents record lacked the documentation of an annual health statement to indicate Resident F being free from tuberculosis in an infectious state	R 0409	**R409– Infection Control** It is the practice of this facility that an annual health statement from a physician upon admission and yearly thereafter to show no evidence of TB. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident F had no adverse effects for deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	07/03/2023

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	upon admission and yearly thereafter. During an interview, on 5/9/2023 at 2:08 P.M., the Director of Nursing indicated there should have been an annual health statement on the admission orders and on the orders thereafter. On 5/10/2023 at 3:02 P.M., a request for the policy of Physician orders was requested , but one was not provided prior to the survey exit.		**action(s) will be taken:** No adverse effects were identified for any residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Wellness will be in-serviced on or before 7/3/23. This in-service will be conducted by the Regional Nurse and will include health assessment upon admission and yearly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the Quality Assurance Performance Improvement audit tool labeled “Health Assessment” weekly for a month and then monthly thereafter. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	