PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED		
AND I LANGI CORRECTION IDENTIFICATION NOMBER		B. WING			05/14/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ARK PLACE DR		
PARK PL	ACE II, LLC			FORT V	VAYNE, IN 46845		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
R 0000	REGULATORT OR	LEC IDENTIFTING INFORMATION	IAG				DATE
Bldg. 00	This visit was for a State Residential Licensure Survey.			R 0000			
	Survey dates: May	13 and 14, 2024					
	Facility number: 01	12582					
	Residential Census:	143					
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 15, 2024						
R 0273	410 IAC 16.2-5-5.1(f)						1
Bldg. 00		nal Services - Deficiency					
Diag. 00		ation and serving areas n residents ' units) are					
	` •	ordance with state and					
		d safe food handling					
	standards, includir	ng 410 IAC 7-24. on, interview and record	R 0273		What carrective actions will	ha	06/14/2024
		failed to ensure steam table	K 02	2/3	What corrective actions will laccomplished for those	oe	06/14/2024
	-	a sanitary manner. 143 of 143			residents found to have beer	1	
	_	the facility ate food prepared			affected by the finding:		
	in the facility kitche	en.			N		
	Findings include:				No negative outcomes found from the finding.		
	During a tour of the kitchen on 5/13/24 beginning at 9:25 AM the Dietary Manager (DM 20) separated 3 stacks of stored pans. The inside of 7 pans were observed to be wet. The inside of 2 pans were observed to contain green chunks of unknown debris.				How will you identify other residents having the potentia be affected by the same find and what corrective action whe taken:	ing	
	In an interview on 5/13/24 at 9:40 AM DM 20				All residents had the potential	to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Kristin Townsley Executive Director 05/24/2024

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.

State Form Event ID: 0J3411 Facility ID: 012582 If continuation sheet Page 1 of 6

PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 05/14/2024				
NAME OF PROVIDER OR SUPPLIER PARK PLACE II, LLC			STREET ADDRESS, CITY, STATE, ZIP COD 4411 PARK PLACE DR FORT WAYNE, IN 46845					
(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 CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE			
	indicated the pans s before being stacke	hould have been air dried d for storage.		be affected by the finding. I				
	A current facility policy dated 9/1/21 provided by the Executive Administrator on 5/14/24 at 10:43 AM indicated all dishware would be air dried and properly stored.			What measures will be purplace or what systemic clithe facility will make to enthat the deficient practice not recur: Staff were in-serviced the control survey. Staff will be in-serviced proper washing and drying dishes upon hire and routin verify knowledge of proper washing/drying.	changes change			
				How the corrective action be monitored to ensure the finding will not recur:	` '			
				Culinary Director or Design audit dishes 1/day to verify dishes have been washed dried correctly for 1 month, for 3 months and 1/month finonths.	that all and 1/week			
R 0349	410 IAC 16.2-5-8. Clinical Records -							
Bldg. 00	(a) The facility mu on each resident. maintained under employee of the fa	st maintain clinical records These records must be the supervision of an acility designated with that records must be as cumented. sible.						

State Form Event ID: 0J3411 Facility ID: 012582 If continuation sheet Page 2 of 6

PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING				
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD ARK PLACE DR		
	ACEILLIC						
PARKPL	ACE II, LLC			FURT	WAYNE, IN 46845		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on interview	and record review, the facility	R 0	349 What corrective actions will		be (06/07/2024
		ccurate records related to			accomplished for those residents found to have been		
		code status for 2 of 9 residents					
	reviewed (Resident	4 and Resident 7).			affected by the finding:		
	Findings include:				No negative outcomes found f	from	
					the finding.		
	· ·	ord was reviewed on 5/13/24 at					
		s included diabetes,					
	unspecified dement	ia and adult failure to thrive.			How will you identify other		
					residents having the potential		
	Resident 4's demographic record indicated their emergency medical code status was Do Not				be affected by the same find	- 1	
					and what corrective action w	vill	
	Resuscitate (DNR).				be taken:		
	A physician order dated 8/3/23 indicated Resident 4's emergency code status was Cardiopulmonary Resuscitation (CPR). A Code Status Directive dated 7/21/23 indicated						
					Two residents had the potential		
					be affected by the finding. But		
					none were adversely affected.		
		ency medical code status was					
	Full Code, Full Res	_			What massures will be put in	.	
	Tun Code, Tun Kes	uscitation.			What measures will be put in place or what systemic chan		
	A Traditions Manag	gement document dated			the facility will make to ensu	_	
		y the Executive Director (ED)			that the deficient practice do		
		AM indicated Resident 4's			not recur:	,63	
		code status was No Code, Do			, , , , , , , , , , , , , , , , , , ,		
		e document was signed by			Staff were in-serviced the day	of	
		of Attorney (POA). The			survey where to find the corre		
		ed by Licensed Practical Nurse			code status document. And		
	6.				on-going in-servicing will be		
					completed as well.		
	A State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order (DNR) dated 12/7/23 23 provided by the Executive Director (ED) on 5/14/24 at 10:50 AM indicated Resident 4's emergency medical code status was DNR. The DNR was signed by Resident 4's POA. The DNR				· .		
					How the corrective action(s)	will	
					be monitored to ensure the		
					finding will not recur:		
	witness signature ar	rea was blank. The DNR			Wellness Director or designee	will	
	physician signature	area was blank.			audit all code status forms for		
					completion, accuracy and veri	fy	

State Form Event ID: 0J3411 Facility ID: 012582 If continuation sheet Page 3 of 6

PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

	B. WING		COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER PARK PLACE II, LLC	STREET ADDRES 4411 PARK F FORT WAYN		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX CRC TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
In an interview on 5/14/24 at 10:25 AM Qualified Medication Aide (QMA) 21 indicated emergency medical code status could be found either in paper charts or physicisn orders and should be the same so staff knew what to do.2) Resident 7's record was reviewed on 5/13/24 at 2:39 PM. Diagnoses included dementia, history of breast cancer, thyroid disease, arthritis, osteoporosis, depression, and anxiety. Resident 7's current service plan, dated 4/22/24, indicated the resident's code status was DNR. Resident 7's face sheet indicated the resident's code status was DNR. A Doctor's progress note dated 2/18/24 at 7:01 AM, 1/12/24 at 8:29 AM, and 1/1/24 at 10:23 AM by the Nurse Practitioner indicated the resident's code status was DNR. Resident 7's document titled "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order", signed 10/20/23 by the resident's POA indicated the resident's code status was DNR. Resident 7's current physician orders dated 8/19/22 indicated the resident's code status was Full Code. In an interview 5/14/24 at 11:56 AM, the ED indicated Resident 7's code status changed to DNR once she went on hospice; her ancillary orders under Physician Order Report indicated Full Code. In an interview on 5/14/24 at 11:56 AM the ED indicated the facility did not need a physician order for an emergency medical code status change. The ED indicated physician orders were	they orga audi	r are readily accessible and anized. Code status will be ited upon move in and mor 3 months, 1/month for 9	d

State Form Event ID: 0J3411 Facility ID: 012582 If continuation sheet Page 4 of 6

PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	E CONSTRUCTION	î ´	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	<u>00</u>	•	COMPLETED 05/14/2024	
			B. WING		05/12	1/2024
NAME OF PROVIDER OR SUPPLIER PARK PLACE II, LLC		441	ET ADDRESS, CITY, STATE, ZIP COI 1 PARK PLACE DR RT WAYNE, IN 46845)		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHOTE)		(X5)
TAG	· ·	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
	not believe a full or orders and a DNR record could lead to the staff did not recode status. The Elementary binder emergency binder emergency medical Status form. A current policy to 6/14, provided by 5/14/24 at 10:43 A have a code status admission, if not the full code. The policy resident/representary DNR a Do Not Recompleted, given to and faxed to the phypolicy indicated we resident/representate be placed in the resident/representate be placed in the resident/representate be placed in the resident of Services Provide direction for locate a resident's of Services Provide by the Executive Dindicated the facility of Services policy did not provide staff where to local status.	tive chose a code status of suscitate form would be to the Resident Clinical Director, pysician for signature. The then the form was signed by the tive and the physician it would sident's chart under the resection. The policy did not for nursing and/or staff where to current code status. The "Maintenance of Records red", revised 6/15/23, provided birector on 5/14/24 at 1:05 PM, the would follow all State and concerning maintenance of provided to its residents. The ride direction for nursing and/or the a resident's current code				
		te a resident's current code				

State Form Event ID: 0J3411 Facility ID: 012582 If continuation sheet Page 5 of 6

PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-039

OND NO. 0000 007							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			05/14/2024	
NAME OF PROVIDER OR SUPPLIER PARK PLACE II, LLC			STREET ADDRESS, CITY, STATE, ZIP COD 4411 PARK PLACE DR FORT WAYNE, IN 46845				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION
TAG	REGULATORY OF	REGULATORY OR LSC IDENTIFYING INFORMATION			DEFICIENCY)	DATE	
	status was provided	by the facility by survey exit.					

State Form Event ID: 0J3411 Facility ID: 012582 If continuation sheet Page 6 of 6