STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 00 B. WING	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00399782. Complaint IN00399782 - No deficiencies related to the allegations were cited. Survey dates: August 1, 2, 3, 4 and 7, 2023 Facility number: 000549 Provider number: 155510 AIM number: 100267470 Census Bed Type: SNF/NF: 58 SNF: 5 Residential: 39 Total: 102 Census Payor Type: Medicare: 7 Medicaid: 36 Other: 20 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 11, 2023.	F 0000	Deficiency ID: F_0000 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: Allegation of Compliance Please accept the following plan of correction for the annual survey completed on August 7th, 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws. This facility appreciated the time and dedication of the surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Michael Gerig 09/05/2023

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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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure a resident had a physician's order for a dressing and to address a wound found on admission for 2 of 2 residents reviewed for non-pressure skin conditions. (Resident E and 362) Findings include: 1. During an observation, on 8/7/23 at 1:44 p.m., Certified Nursing Assistant (CNA) 5 and CNA 6 were providing incontinence care for Resident E. When CNA 6 removed the resident's pants, a dressing was noticed on the resident's left lower leg. The leg had a stretchy wrap from approximately four inches from the knee to the ankle. There was approximately one inch of a white pad sticking out of the top of the stretchy wrap. The record for Resident E was reviewed on 8/4/23 at 3:44 p.m. Diagnoses included, but were not limited to, dementia, macular degeneration, pain in thoracic spine, and repeated falls. During an interview, on 8/7/23 at 1:45 p.m., CNA 5 indicated she worked on 8/4/23 and did not remember the dressing on the resident's leg. During an interview, on 8/7/23 at 1:46 p.m., CNA 6 indicated she had no idea why she had the dressing and thought maybe it was from a fall over the weekend.	F 0684	Deficiency ID: F_0684 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: F-684 Quality of Care Affected Resident: Resident #362 and Resident E head to toe skin assessment completed. Findings reported to NP, Orders implemented as appropriate and care plan updated. Potential to be affected: All admissions and readmissions were reviewed for the last 60 days. Any identified skin issues were audited to ensure orders were implemented and care plans updated as appropriate. A skin sweep audit was completed to identify all current treatments and skin concerns. The medical provider was notified of the finding, orders were implemented, and care plans were updated accordingly. Systemic changes: Nursing management educated nursing staff on the expectation of timely completion of admission skin assessment and implementation of treatment orders as appropriate, and on the policy for dressing	08/26/2023

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	During an interview, on 8/7/23 at 1:50 p.m., the Director of Nursing (DON) indicated she did not know why the resident had the wrap and the resident needed to have an order for the dressing. During an interview, on 8/7/23 at 4:00 p.m., the DON had talked to the hospice agency and her nursing staff, and no one knew why the dressing was on the resident's leg. The CNAs working indicated the dressing was not there on 8/4/23 and there should have been an order on the Medication Administration Record (MAR) for any dressings.2. During an observation, on 8/1/23 at 1:55 p.m., Resident 362 was sitting up in a chair and had a red open area on her right shin without a dressing. During an observation, on 8/3/23 at 10:42 a.m., the resident was sitting up in a chair with a dressing to her right shin covering up the open area. The record for Resident 362 was reviewed on 8/3/23 at 10:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, and congestive heart failure. An admission nursing assessment, dated 7/25/23 at 2:30 p.m., indicated the nurse noted multiple wounds on the resident's legs and feet. The nurse who completed the assessment had put the wound notes in the comment section instead of the wounds section. A physician's order, dated 8/3/23, indicated the facility was to do wound care to both feet and legs every day and as needed. The resident went eight (8) days with no wound treatments to the open areas on the right shin.		changes including the expectation to notify the medical provider of any identifying skin concerns and implement any orders given, and the requirement to obtain Orders for skin treatments. The wound nurse will complete an audit if admission skin assessments and treatment orders following new admissions. Monitoring: A performance improvement tool was developed, wound nurse and/or designee will complete a follow-up admission skin audit daily M-F for 4 weeks, then weekly x 8 weeks, then monthly x3 months to ensure skin assessments are completed accurately, treatment orders implemented, and care plans updated as necessary, to monitor ongoing compliance with results being forwarded to QAPI committee for ant further recommendations and/or resolution. AOC 8/26/23	

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	During an interview, on 8/3/23 at 12:04 p.m., RN 4 indicated the resident admitted to the facility with wounds to her legs and feet. During an interview, on 8/7/23 at 11:18 a.m., the Wound Charge Nurse indicated the resident came into the facility with the wounds. The wound care was not triggered since the staff nurse put the admission wound information in the comment section and not the wound section. The facility should have notified the doctor when the initial skin assessment was completed to obtain orders for the wound treatment. A current policy, titled "Dressing Changes," dated 11/21/14 and received from the Clinical Support Nurse on 8/7/23 at 3:39 p.m., indicated "...Infection control practices regarding dressing changes is followed to assist in prevention of exposure to infectious situations by reducing the number of instances of individual exposure to harmful substances...the following general guidelines will be followed: Review the physicians order regarding dressing changes...Administer treatment as ordered by the physician...." A current policy for resident assessment was requested but was not provided by exit conference. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to notify the physician of a significant weight loss and to ensure the resident received nutritional interventions in a timely manner for 1 of 5 residents reviewed for nutrition. (Resident 45) Finding includes: The record for Resident 45 was reviewed on 8/3/23 at 12:06 p.m. Diagnoses included, but were not limited to malignant neoplasm of the left breast and mild cognitive impairment of an unknown cause. The resident had the following weights: 1. On 4/24/23, the weight was 95.2 pounds. 2. On 5/5/23, the weight was 89.5 pounds which was a significant weight loss of 5.99% in 9 days. A physician order, dated 5/13/23, indicated Remeron (an appetite stimulant) was ordered. The intervention was implemented 8 days after the	F 0692	Deficiency ID: F_0692 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: F 692 Affected Residents: Resident #45 was evaluated by medical provider including review of weights. Recommendations and orders implemented as advised. Potential to be affected: Residents with weight fluctuations have the potential to be affected by the alleged deficient practice. An audit was conducted by the nurse management team to identify all current residents with weight loss or weight gain over the last 6 months and reviews with medical provider. Recommendations and orders	08/26/2023

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	significant weight loss occurred. A physician notification of the significant weight loss was not noted in the Electronic Record from 4/24/23 to 5/13/23. During an interview, on 8/3/23 at 3:19 p.m., the Assistant Director of Nursing indicated the physician should be notified of a significant weight loss. The Nurse Practitioner (NP) was notified on 5/13/23 when the order for Remeron was received. The notification to the NP occurred 8 days after the significant weight loss occurred. A current policy, titled "Change in a Resident's Condition or Status," dated as revised February 2021 and received from the Director of Nursing on 87/23 at 3:43 p.m., indicated "...Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status...The nurse will notify the resident's attending physician or physician on call when there has been a...significant change in the resident's physical/emotional/mental condition...A 'significant change' of condition is a major decline or improvement in the resident's status that...will not normally resolve itself without intervention by staff or implementing stand disease-related clinical interventions...impacts more than one area of the resident's health status...." A current policy, titled "Significant Weight Loss," dated as revised 4/2021 and received from the Executive Director on 8/8/23 at 12:03 p.m., indicated "...The goal of medical nutrition therapy [MNT] is to identify underlying causes or factors contributing to the significant unplanned weight		implemented as advised. Systematic Changes: DON/ADON was educated by Vice President of Clinical Operations on the policy for change of condition and significant weight loss including the review of all weight changes discussed in weekly SNAR and the expectation of medical provider notification. Ongoing the ADON will review weekly weight expectations report and review in weekly SNAR with the medical provider. Monitoring: The Director of Nursing and/or designee will review weekly weight changes to ensure provider notification weekly for (4) weeks then biweekly for (8) weeks, then monthly for no less than (3) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality assurance/Performance Improvement committee meeting to validate 100% compliance and then on-going per routine QAPI reviews. Plan updated as indicated. AOC 8/26/23	

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	loss, and intervene as appropriate to resolve the problem and stabilize the weight...Appropriate members of the interdisciplinary team will...Identify individuals with significant weight losses...Weight loss...5% weight loss in 1 month...Assess whether or not the weight loss was desirable [avoidable or unavoidable], and document accordingly...Request/implement nutrition interventions based on the individual case...." 3.1-46(a)(1)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to assess and document the post dialysis and daily observation for 1 of 1 resident reviewed for dialysis. (Resident 22) Findings include: The record for Resident 22 was reviewed on 08/03/23 at 10:02 a.m. Diagnoses included, but were not limited to, dependence on renal dialysis, and stage 4 chronic kidney disease. A care plan, dated 7/15/23, indicated the resident needed hemodialysis related to ESRD (end stage renal disease). The interventions included, but were not limited to, emergency care of shunt: apply pressure and call 911, monitor vital signs (blood pressure, pulse, etc.), notify physician of	F 0698	Deficiency ID: F_0698 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: F698 Affected Resident: Resident #22 upon return from dialysis, resident was assessed, VS taken, and port site assessed. All assessed information is placed in residents' progress notes. Potential to be Affected: Dialysis patients have been reviewed and assessed upon return from every dialysis day from 8/7/23 to ensure assessment, VS, and port site assessment,	08/26/2023

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	significant abnormalities, monitor signs and symptoms of infection, monitor, document, and report symptoms of renal insufficiency (poor kidney function), bleeding, or worsening peripheral edema. A progress note, dated 6/19/23 at 11:15 a.m., indicated the resident was at dialysis. The resident left at 9:45 a.m. for dialysis appointment with Quality Care Transport. A progress note, dated 6/23/23 at 9:46 a.m., indicated the resident was transported to dialysis per Quality Care ambulance. A progress note, dated 8/2/23 at 9:45 a.m., indicated the resident was on leave of absence to dialysis. There were no post dialysis notes in the electronic medical record. During an interview, on 8/7/23 at 11:12 a.m., the Assistant Director of Nursing indicated the resident went to dialysis on Monday, Wednesday, and Friday. During an interview, on 8/7/23 at 1:31 p.m., the Director of Nursing indicated the resident did not have a shunt/graft, as indicated in the care plan, but had a line in the subclavian area. During an interview, on 8/7/23 at 2:50 p.m., the Director of Nursing indicated there was a sign off form in the dialysis binder when the resident was returned from dialysis, it was signed and verified by facility staff and remained in the binder. The form contained information sent to the dialysis unit and returned with information from dialysis. She did not have a post dialysis assessment.		progress notes were implemented. Systemic Changes: Nursing management educated staff on the expectation of charting when dialysis patient does LOA to dialysis and to chart when dialysis patient returns with an assessment, VS, and port assessment including documentation. DON or designee with continue to check leave, assessments, and return of resident documentation. Monitoring: Will review leave, and assessment on dialysis patient on dialysis days. DON and/or designee to audit weekly x30 days, then audit bi-weekly x60 days, then monthly x 90 days to ensure that documentation and assessment are documented on dialysis residents. To continue until 100% compliance. AOC 8/26/23	

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	A current policy, titled "Hemodialysis Access Care," with a revision date of 9/2010 and received from the Director of Nursing on 8/7/23 at 1:30 p.m., indicated "...the general medical nurse should document in the resident's medical record every shift as follows...location of catheter, condition of dressing (interventions if needed)...if dialysis was done during the shift...any part of report from dialysis nurse post-dialysis being given...observations post - dialysis...." 3.1-37(a)			
F 0851 SS=D Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements.			

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	The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on record review and interview, the facility failed to ensure the mandatory submission of staffing information, Payroll Based Journal (PBJ), was electronically submitted to the Centers for Medicare and Medicaid Services (CMS) in a	F 0851	Deficiency ID: F_0851 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text:	08/26/2023

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	timely manner for the 2nd Quarter of 2023. (1/1/2023-3/31/2023) Finding includes: Staffing information was reviewed on 8/1/23 at 1:40 p.m. During an interview with the Administrator, on 8/1/23 at 1:40 p.m., the Certification and Survey Provider Enhanced Reports 3 (CASPER 3) was given to the Administrator. He indicated he was checking on why all areas were triggered in the Payroll Based Journal (PBJ), he knew they turned it in so he will call Corporate. During an interview with the Administrator, on 8/1/23 at 4:40 p.m., he indicated he spoke with Corporate about the PBJ information. Corporate indicated they received the information on time from the facility but unfortunately it was not turned in on time. Corporate office staff had it on their desk and it was not turned in timely.		F-851 Payroll Based Journal Affected Area: Upon inspection of CASPER report at entry of annual ISDH survey, it was found to be incomplete. Further investigation, at corporate office showed the report had not been submitted by CMS deadline in 1st quarter 2023. Potential to be Affected: All residents have information in MDS, along with PBJ reporting of labor for resident population. Systematic Changes: ELC Corporate will incorporate a double check for PBJ reporting, Vice President of MDS and Director of Talent Acquisition will double verify submission of data 5 days prior to CMS deadline. Monitoring: The two mentioned Corporate Directors will e-mail confirmation of submission in time frame stated to Executive Director at facility each quarter, so E. D can communicate submission, if needed, to ISDH AOC 8/26/23	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

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CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

(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
	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure staff wore gloves when performing a blood glucose check for 1 of 5 residents reviewed for medication administration. (Resident 29) Finding includes: During an observation, on 8/2/23 at 12:12 p.m., RN 2 entered the dining room holding an accu check machine (to test blood sugar levels), an alcohol swab and a lancet. She approached the resident and bent down holding the accu check machine under the table. She began talking to the resident and cleaned the resident's finger with an alcohol	F 0880	Deficiency ID: F_0880 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: F 880 Affected Resident: Resident #29 was assessed by facility infection preventionist, no adverse effects noted related to incident. RN# 2 was provided immediate re-education on the policy for blood glucose monitoring and completed return demonstration of	08/26/2023

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	swab. The nurse did not have gloves on and took the lancet and stuck the resident's finger. She obtained the blood and finished the accu check. The record for Resident 29 was reviewed on 8/4/23 at 4:03 p.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic kidney disease, atrial fibrillation, dementia, and anxiety disorder. During an interview, on 8/2/23 at 12:15 p.m., RN 2 indicated she did not know what the facility policy said about accu checks and she should not have done a blood sugar check in the dining room without gloves. During an interview, on 8/2/23 at 12:30 p.m., the Director of Nursing (DON) indicated the facility policy was to wear gloves when doing an accu check and not to do one in the dining room. A current policy, titled "Blood Glucose Monitoring," dated 5/17/16 and received from the Director of Nursing on 8/2/23 at 12:30 p.m., indicated "...The nurse will assist the resident with blood glucose monitoring to obtain a quantitative measure of blood glucose as ordered by the physician...Assemble equipment and take to bedside/resident. Explain procedure and provide privacy. Wash hands & apply gloves...Remove gloves and wash hands...." A current policy, titled "Medication Administration," dated as revised on 4/2019 and received from the Director of Nursing on 8/7/23 at 3:40 p.m., indicated "...Medications are administered in a safe and timely manner...Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as		donning gloves following notification of incident. Potential to be Affected: All residents requiring blood glucose monitoring have the potential to be affected by the alleged deficient practice. Systemic Changes: Nursing manamgent educated nursing staff on the blood glucose monitoring policy and the expectation of providing privacy and the use of gloves for any procedure with potential exposure to bodily fluids. Monitoring: The Director of Nursing and/or designer will observe 5 random occurrences of blood glucose monitoring across all shifts weekly for 4 weeks then biweekly for 8 weeks, then monthly for no less than 3 additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/ Performance Improvement committee meeting to validate 100% compliance and then on-going per routine QUPI reviews. Plan to be updated as indicated. AOC 8/26/23	

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	applicable...." 3.1-18(b) 3.1-18(l)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-			

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	(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to ensure a resident received the pneumococcal immunization and/or notified the physician when the resident or resident's representative had questions or concerns for 1 of 5 residents reviewed for immunizations. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 8/7/23 at 9:59 a.m. The immunization record indicated the resident did not have a pneumococcal immunization. During an interview, on 8/7/23 at 3:36 p.m., the DON (Director of Nursing) indicated the family	F 0883	Deficiency ID: F_0883 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: F 883 Affected Resident: Resident #6's Pneumococcal vaccination records were reviewed by medical provider education provided, consent obtained and recommended dose offered. Potential to be Affected. All residents have the potential to be affected by the alleged deficient practice. An audit was conducted	08/26/2023

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	was concerned with getting the vaccination. The MD (Medical Doctor) had been notified of the situation and was waiting to hear back about a decision. During an interview, on 8/7/23 at 3:42 p.m., the ADON (Assistant Director of Nursing) provided a note, dated 8/7/23 at 8:36 a.m., which indicated the facility contacted the MD and was waiting for a call back about getting the health clearance for the vaccination. There was no documentation to support the facility contacted the MD in a timely manner about the family's concern since the resident was admitted on 4/26/23. A current policy, titled "Pneumococcal Vaccine," dated as revised in October 2019 and received from the DON at 1:00 p.m., indicated "...Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated...." 3.1-13(a)(1)		by the nurse management team to identify all current residents with recommended doses due. Education was provided, consent or declinations obtained, and vaccinations offered where appropriate. Systemic Changes: Nursing management staff were educated by the Vice President of Clinical Operations on the Pneumococcal vaccination policy and the use of CDC recommendations app for determining appropriate doses of Pneumococcal vaccination, and the requirement for providing education, obtaining consent or declination, administering doses and documentation. The infection preventionist will review all admission ongoing for current vaccination status and recommended doses. Education will be provided, consent or declination obtained, orders entered, and doses administered. Monitoring: The Director of Nursing and/or designee will review all new admissions weekly for 4 weeks then monthly for no less than 2 additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/ Performance Improvement committee meeting to validate 100% compliance and then on-going per routine QAPI	

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			reviews. Plan to be updated as indicated. AOC 8/26/23	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.This visit also included the Investigation of Nursing Home Complaint IN00399782. Complaint IN00399782 - No deficiencies related to the allegations were cited. Survey dates: August 1, 2, 3, 4 and 7, 2023 Facility number: 000549 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 11, 2023.	R 0000	Deficiency ID: F_0000 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: Allegation of Compliance Please accept the following plan of correction for the annual survey completed on August 7th, 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws. This facility appreciated the time and dedication of the surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
R 0117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency			

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Bldg. 00	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met the requirements of First Aid certified staffing for 4 of 42 shifts reviewed for First Aid coverage. (7/31/23, 8/1/23, 8/3/23 and 8/4/23) Finding includes: A record review, on 8/7/23 at 10:00 a.m., indicated multiple shifts from Monday 7/31/23 through Saturday 08/5/2023 were not staffed with First Aid certified staff. The dates and shifts included were: a. Monday, 7/31/23 - No First Aid coverage for the night shift. b. Tuesday, 8/1/23 - No First Aid coverage for half	R 0117	Deficiency ID: R_ 0117 Completion Date 8/26/23 12:00:00 AM Plan of Correction Text: R117 Affected Resident: there is a staff member that holds a current First Aide Certification at the facility 24 hours a day. Those identified as needing First Aide certification have completed or been scheduled for completion. Potential to be affected: All	08/26/2023

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	of the night shift. c. Thursday, 8/3/23 - No First Aid coverage for the night shift. d. Friday, 8/4/23 - No First Aid coverage for half of the night shift. During an interview, on 08/07/23 at 11:05 a.m., the Scheduler indicated she did not know why there was no First Aid coverage for the missing shifts. During an interview, on 08/07/23 at 3:40 p.m., the Corporate Nurse indicated the facility did not have a policy on Associates CPR and First Aid requirements.		residents in residential care have the potential to be affected by the deficient practice. Systemic changes: the nursing management team was provided education by the vice president of clinical operation on the residential care regulation requiring a staff member to have an active first aide certification 24 hours a day. Nursing staff will have first aid training to ensure there is 24-hour staff coverage as required. First aide certification will be scheduled for new staff as needed. Monitoring: The Director of Nursing and or Designee will audit the daily nursing schedule to verify there is a staff member with a current first aid certification 24-hours a day. This audit will continue daily for (4) weeks then weekly for no less than (2) months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the quality Assurance/ Performance improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated. AOC 8/26/23	