CENTERS FOR	MEDICARE & MEDIC.	_			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		155522	B. WING	05/12/2023		/2023
			 _			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				ARKVIEW LN		
ELWOOD	HEALTH AND LIV	/ING	ELWO	OD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROUDERIG TV . V OF CORRES		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IÉ	DATE
F 0000			1110			
. 0000						
Bldg. 00						
5.4g. 00	This visit was for a	Recertification and State	F 0000	Submission of this plan of		
		nd Investigation of Complaint	L 0000	Submission of this plan of	or	
	_	visit included a State		correction shall not constitute		
				be construed as an admission	•	
	Residential Licensu	re Survey.		Elwood Health and Living that		
	G 11 - B70040	5002 N 1 6 1 1 1 1 1		allegations int he survey repor		
	_	5083 - No deficiencies related to		accurate or reflect accurately		
	the allegations are c	eited.		provisions of care and service		
		0 0 10 11 112 2022		the residents at Elwood Health	-	
	Survey dates: May	8, 9, 10, 11, and 12, 2023		and Living. The facility reques		
		20272		the following plan of correction	n be	
	Facility number: 00			considered its allegations of		
	Provider number: 1			compliance.		
	AIM number: 100289060					
	G F 17					
	Census Bed Type:					
	SNF/NF: 59					
	Residential: 16					
	Total: 75					
	G 5 5					
	Census Payor Type:	:				
	Medicare: 7					
	Medicaid: 42					
	Other: 10					
	Total: 59					
		reflect State Findings cited in				
	accordance with 41	0 IAC 16.2-3.1.				
	Quality review com	pleted May 22, 2023.				
F 0637	483.20(b)(2)(ii)					
SS=D	-	ssessment After Signifcant				
Bldg. 00	Chg					
	. , , , , ,	Within 14 days after the				
	facility determines					
		here has been a significant				
	change in the resi	dent's physical or mental				

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

TITLE (X6) DATE

Penny Broshar Administrator 05/26/2023

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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<i>'</i>		X1) PROVIDER/SUPPLIER/CLIA	· '		(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		_ 			COMPLETED	
		155522	B. W	ING		/2023		
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING			2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN DD, IN 46036				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE NAME CONDECT			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
TAG	condition. (For pu "significant chang or improvement in will not normally reintervention by sta standard disease-interventions, that than one area of than one	rpose of this section, a e" means a major decline the resident's status that esolve itself without further aff or by implementing related clinical thas an impact on more the resident's health status, disciplinary review or the plan, or both.) view and interview, the facility gnificant change in a resident's in a MDS (Minimum Data Set) 12 residents reviewed for MDS and 31).	F 00		What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? All residents had the potential be affected by this deficient practice. All residents current on hospice services were revie by corporate nurse to ensure significant change MDS was completed. MDS will be audite weekly by the corporate RN tin 2 weeks or until 100% complia is reached. BOM or designeer communicate all hospice payer changes to MDS and will be audited monthly by corporate consultant times 2 months or a 100% compliance is reached. BOM or designee to communicall hospice payer changes to MDS and will be audited monthly by corporate RN consultant quarterly times for a quarter or until 100% compliance is reached. Once this has been completed, we will bring to QA to discuss discontinuation of audit. MDS coordinator was educated on the guidelines for significant change MDS.	nts y the to ty ewed ed mes ance to er RN until cate MDS one nce n	05/25/2023	

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PRINTED: 06/01/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2023		
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING				2300 F	ADDRESS, CITY, STATE, ZIP COD PARKVIEW LN OD, IN 46036	
		SUMMARY (EACH DEFICIEN REGULATORY OF change MDS assess services had started A current care plan, resident received he colon cancer diagno During an interview Clinical Support Nu not admit with hosp change MDS assess completed. During an interview MDS Coordinator it Assessment Instrum reference for complete of the "Lon Assessment Instrum version 1.17.1, date SCSA as a Significat Assessment and ind SCSA is required to	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Sment to reflect hospice . dated 6/20/22, indicated the espice services related to essis. 7, on 5/12/23 at 2:04 p.m., the earse indicated the resident did exice services and a significant			al to er tor the or ched. icate MDS y s 2 ncce to er by terly this oring the ge
					will be made to ensure that deficient practice does not red The Business Office Manager designee will inform the MDS coordinator daily (Monday-Fri of any payor source changes	cur? or day)

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2023			
	PROVIDER OR SUPPLIER D HEALTH AND LIV		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036				
(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 APPROPRIAT DEFICIENCY) census email. The BOM or designee will communicate all	DATE		
				hospice payers changes to the MDS coordinator and will be audited weekly by the corporat RN consultant times 2 weeks ountil 100% compliance is reach BOM or designee to communic all hospice payer changes to Mand will be audited monthly by corporate RN consultant times months or until 100% compliar is reached. BOM or designee to communicate all hospice payer changes to MDS and audited to corporate RN consultant quarter for one quarter or until 100% compliance is reached. Once 100% compliance is reached. Once 100% compliance is noted, will bring to QAPI to discuss discontinuation of audit. How the corrective action(s) we monitored to ensure the deficite practice will not recur IE what quality assurance program will put into place? Audits will be reviewed at the monthly focused QAPI for one year to ensure that this deficited practice does not reoccur.	te or ned. cate MDS 2 nce co r oy erly I lill be ent be		
F 0641 SS=D Bldg. 00	The assessment resident's status. Based on record rev	essments acy of Assessments. The facility and interview, the facility complete a resident	F 0641	What corrective action(s) will be accomplished for those reside			

assessment in the MDS (Minimum Data Set) for 1

found to have been affected by the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/12/2023			
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING			STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR of 2 residents review (Resident 65). Findings include: During a closed rec 3:28 p.m., Resident and discharged on 3 assessment dated 3/ "Discharged - Retur Instructions dated 3 discharged to home	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION wed for MDS assessment ord review, on 5/12/2023 at 65 was admitted on 2/23/2023 8/15/2023. Resident 65's MDS 15/2023 was coded as rn Anticipated". Discharge /14/2023 indicated Resident 65 , with continued therapy	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) deficient practice? All residents had the potentia be affected by this deficient practice. All discharge MDS ff 5-24-23, will be reviewed by corporate RN to ensure accur coding. How other residents having th potential to be affected by the same deficient practice will be identified and what corrective	DATE I to rom rate ne e		
	indicated "May discontinuated" During an interview MDS Coordinator is have been coded as Anticipated." Review of the "Lon Assessment Instrum Version 1.17.1, data following: "Legal accuracy with the p	ian's order, dated 3/14/23, sharge to home on 3/15/2023." on 5/12/2023 at 11:35 a.m., the indicated Resident 65 should "Discharge - Return Not g-Term Care Facility Resident thent 3.0 User's Manual," and October 2019, indicated the ly, it is an attestation of rimary responsibility for its erson selecting the MDS item		action(s) will be taken? All resident's have the potent be affected by this deficient practice, All discharge MDS f 5-24-23 will be reviewed by corporate RN to ensure accur coding times 12 months. What measures will be put interplace and what systemic chain will be made to ensure that deficient practice does not read to deficiency is found during auch the corporate RN will address immediately with MDS coording and correct. How the corrective action(s) with monitored to ensure the deficiency practice will not recur IE what quality assurance program with put into place? Audits will be reviewed at the monthly focused QAPI for one year to ensure that this deficient	rate to onges cur? dit, sonator vill be ient il be		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING 00		ľ ´	X3) DATE SURVEY COMPLETED	
155522			B. WING		05/12/2023		
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER		2300 PARKVIEW LN				
ELWOOD	HEALTH AND LIV	'ING		ELWOO	DD, IN 46036		
(X4) ID	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG							COMPLETION DATE
TAG	REGULATORT OR	LESC IDENTIFY FING INFORMATION		IAG	practice does not reoccur.		DATE
F 0812 SS=F Bldg. 00	§483.60(i) Food so The facility must - §483.60(i)(1) - Pro approved or consifederal, state or log (i) This may included in applicable State a regulations. (ii) This provision of facilities from using gardens, subject to applicable safe graphicable safe graphic	does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not preclude residents bods not procured by the ore, prepare, distribute and ordance with professional service safety. On, record review, and ty failed to ensure the shwasher was tested daily for and sanitation levels. Of the ts, this deficient practice had ct 58 residents who received	F 08	12	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice? All residents had the potential be affected by this deficient practice. All dietary staff was is serviced on the proper policy a procedures for the dish machine Temperature Log daily (M-F)	nts y the to n and	05/25/2023
	_	e low-temperature dishwasher			during normal business hours	for	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522 NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed three times daily, and she regularly reminded staff A. BUILDING B. WING OD OD COMPLETED 05/12/2023 STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036 ID PROVIDERS PLAN OF CORRECTION (CACHON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY) OS/12/2023
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036 (X5) PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE Compliance. How other residents having the potential to be affected by the same deficient practice will be
ELWOOD HEALTH AND LIVING ELWOOD, IN 46036 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed 2300 PARKVIEW LN ELWOOD, IN 46036 (X5) PREFIX PREFIX PREFIX COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Compliance. Compliance. How other residents having the potential to be affected by the same deficient practice will be
ELWOOD HEALTH AND LIVING ELWOOD, IN 46036 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed 2300 PARKVIEW LN ELWOOD, IN 46036 (X5) PREFIX PREFIX PREFIX COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Compliance. Compliance. How other residents having the potential to be affected by the same deficient practice will be
ELWOOD, IN 46036 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed ELWOOD, IN 46036 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE How other residents having the potential to be affected by the same deficient practice will be
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed PREFIX PREFIX PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE Compliance. How other residents having the potential to be affected by the same deficient practice will be
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE How other residents having the potential to be affected by the same deficient practice will be
TAG REGULATORY OR LSC IDENTIFYING INFORMATION Was incomplete. Only the May 1, 2023 and May 2, 2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed TAG DEFICIENCY) Compliance. How other residents having the potential to be affected by the same deficient practice will be
2023 temperatures and sanitation levels were documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed How other residents having the potential to be affected by the same deficient practice will be
documented, and both were initialed by three different staff members. The Dietary Manager indicated the log was supposed to be completed How other residents having the potential to be affected by the same deficient practice will be
different staff members. The Dietary Manager potential to be affected by the indicated the log was supposed to be completed same deficient practice will be
indicated the log was supposed to be completed same deficient practice will be
three times daily, and she regularly reminded staff identified and what corrective
to keep log current. The Dietary Manager action(s) will be taken?
attempted to test the low-temperature dishwasher, All resident had the potential to be
but indicated she did not know how to perform affected by this deficient practice.
the test. She was unsure whether or not the strips All dietary staff was in serviced on
she used were the correct strips. She could not the proper policy and procedures
complete test and would need to get her regular for the dish machine. CDM will
staff member to perform the test at a later time. audit Dish machine Temperature
Log daily (M-F during normal
During an interview on 5/11/2023 at 11:00 a.m., business hours) for compliance.
Dishwasher 5 indicated she regularly tested the
low-temperature dishwasher, but she was not
consistent about logging the testing of the What measures will be put into
dishwasher for sanitation and temperature. place and what systemic changes
will be made to ensure that
On 5/11/2023 at 11:11 a.m., the Dietary Manager deficient practice does not recur?
indicated she relied on Dishwasher 5 to operate CDM will audit Dish machine
and test the low-temp dishwasher. They would Temperature Log daily (M-F during
also be relied upon to train new staff to operate normal business hours) for
and test the dishwasher. compliance for 2 weeks. When
100% compliance is reached,
Review of a current facility policy, titled "Dish audit will decrease to 3 times a
Machine Policy," dated January 1, 2022 and week for two weeks then weekly
provided by the Dietary Manager on 5/9/23 at times two weeks then taken to
10:30 a.m., indicated the following: "Objectives: QAPI and reviewed for
1) Understand high temperature vs low discontinuation. After audit is
temperature dish machines. 2) Understand how complete, CDM will review the
dishes are sanitized correctly. 3) Follow the Dishmachine Temperature log
manufacturer's instructions" daily on an ongoing basis.
3.1-21(i)(3)
How the corrective action(s) will be
monitored to ensure the deficient
practice will not recur IE what
quality assurance program will be

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T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
	155522	B. WING			05/12/2023		
OTREET ADDRESS CITY STATE ZID COD							
ROVIDER OR SUPPLIER	-						
	WN C						
HEALTH AND LIV	ING		ELWOC	DD, IN 46036			
SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
				normal business hours) for compliance for 2 weeks. Wher 100% compliance is reached, audit will decrease to 3 times a week for two weeks then week times two weeks then taken to QAPI and reviewed for discontinuation. After audit is complete, CDM will review the	a dy		
Survey. This visit in State Licensure Survey Complaint IN00406 the allegations are complaint Information IN00406 the allegations are complaint Information IN00406 the allegations are complaint IN00406 the allegations are c	ncluded a Recertification and vey and Investigation of 1083. 1083 - No deficiencies related to ited. 1083 - No deficiencies related to ited. 1084 - No deficiencies related to ited. 1085 - No deficiencies related to ited. 1086 - No deficiencies related to ited. 1087 - No deficiencies related to ited. 1088 - No deficiencies related to ited. 1099 - No defici	R 00	000	be construed as an admission Elwood Health and Living that allegations int he survey repor accurate or reflect accurately t provisions of care and services the residents at Elwood Health and Living. The facility request	by the t are the s to		
'	This visit was for a Survey. This visit is State Licensure Sur Complaint IN00406 the allegations are complaint Industry of Survey dates: May State Licensure Sur Complaint Industry of the allegations are complaint Industry of Survey dates: May State Licensure Survey dates: May State Licensure Survey dates: May State Licensure Survey dates: May State Residential Census: Elwood Health and compliance with 41 State Residential Licensure Description	OF CORRECTION IDENTIFICATION NUMBER	This visit was for a State Residential Licensure (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00406083. Complaint IN00406083 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10, 11, and 12, 2023. Facility number: 000372 Residential Census: 16 Elwood Health and Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00406083. Complaint IN00406083 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9, 10, 11, and 12, 2023. Facility number: 000372 Residential Censure: 10 PREFIX TAG R 0000 R 0000	ROYIDER OR SUPPLIER DIFFICATION NUMBER DIFFICATION	ROVIDER OR SUPPLIER D HEALTH AND LIVING SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DUBLISHED ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION DUI thit place? CDM will audit Dish machine Temperature Log daily (M-F during normal business hours) for compliance of 2 weeks. When 100% compliance for 2 weeks. When 100% compliance for 2 weeks. When 100% compliance for 2 weeks. When 100% compliance is reached, audit will decrease to 3 times a week for two weeks then taken to QAPI and reviewed for discontinuation. After audit is complete, CDM will review the Dishmachine Temperature log daily on an ongoing basis R 0000 Submission of this plan of correction shall not constitute or be construed as an admission by Elmood Health and Living that the allegations are cited. Survey dates: May 8, 9, 10, 11, and 12, 2023. Residential Census: 16 Elwood Health and Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	

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