PRINTED:	05/11/2021
FORM API	PROVED
OMB NO. (0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES
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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		î î	JILDING	00	(X3) DATE SURVEY COMPLETED 04/13/2021	
NAME OF I	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG R 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOLL D RE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	This visit was for a Survey. Survey dates: Apr	a State Residential Licensure il 12 and 13, 2021	R 0	000			
	accordance with 4	s: 28 ential Findings are cited in 10 IAC 16.2-5.					
R 0054 Bldg. 00	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/19/21. 410 IAC 16.2-5-1.2(x) Residents' Rights - Deficiency (x) Residents have the right to confidentiality of all personal and clinical records. Information from these sources shall not be released without the resident 's consent, except when the resident is transferred to another health facility, when required by law, or under a third party payment contract. The resident 's records shall be made immediately available to the resident for inspection, and the resident may receive a copy within five (5) working days, at the resident 's expense. Based on record review and interview, the facility failed to provide access to a resident's clinical record within five working days of a written request for 1 of 7 residents reviewed. (Resident 7) Finding includes:		R 0	054	Submission of this response a Plan of Correction is NOT a le admission that a deficiency e> or, that this Statement of Deficiency was correctly cited and is also NOT to be constru as an admission against intere by the facility, or any employe	egal , , led est	
		ident 7 was reviewed on n. The diagnoses included, but			agents, or other individuals wildrafted or may be discussed i	ho	
LABORATOR	AY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURI	E	TITLE	(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	EDICARE & MEDIC				OMB NO. 0938-0391
	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	·	X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/13/2021
NAME OF PRO	VIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				/IRGINIA ST	
VIRGINIA F	LACE		MERR	ILLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
v	vere not limited to	, dementia and hypertension.		the Response and Plan of Correction. In addition,	
A	An Authorization f	for Release of Clinical Records		preparation and submission of	
f	orm, dated 3/1/21	and signed by Resident 7's		this Plan of Correction does NC	ОТ
		of attorney (POA), requested a		constitute an admission or	
	-	's medical record.		agreement of any kind by the	
				facility of the truth of any facts	
I	nterview with the	Care Service Manager (CSM)		alleged or the correctness of ar	ıy
		a.m. indicated the resident's		conclusions set forth in this	
		d a written request for copies		allegation by the survey agency	/.
		ord on $3/1/21$. She sent the			
-		required information to			
		21 she was contacted by the			
	•	had been contacted by the		1.Resident records were	
		quiring about the copies of the		provided to Resident 7's POA o	n
		e had not received anything yet.		4/8/2021.	-
		tacted corporate to inquire		2.An audit of current resident	
		the record request. They had		records in reference to medical records requests in the past 30	
		mation re-sent to them and then		days will be completed by	
		est. She called the resident's		5/7/2021 by the Care Services	
				Manager and any issues identif	ied
		et her know the copies were		will be corrected.	
		The resident's POA picked up		3.The Regional Care Speciali	sts
	-	1. She indicated there seemed		will provide re-education to the	
		munication with corporate		Care Service Manager or	
		cal record request and the		designee on the proper process	6
C	opies had not been	n provided timely.		for obtaining residents records	
				5/7/2021	-
				4.The Care Services Manage	r is
				responsible for sustained	
			compliance. The Care Services Manager, or designee, will audit		;
				resident records for requests for	r
				clinical records weekly for four	
				weeks, bi-weekly for four weeks	S,
				then monthly for one month.	
				Results of the audit will be	
				discussed in the monthly QI	
				meetings. The QI committee wi	
				determine if continued auditing	is
				necessary based on 3	

State Form

Event ID: 2GDI11

Facility ID: 010887

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PRINTED: 05/11/2021 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	04/13/2021
	A PLACE			/IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOLILD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				consecutive months of compliance. Monitoring will be ongoing.	9
R 0116	410 IAC 16.2-5-1 Personnel - Nono				
Bldg. 00	 (a) Each facility s procedures writte screening of pros Appropriate inqui prospective empl have a personne references and a accordance with Based on record re failed to ensure ref for employees priot facility, for 3 of 5 of 1, Housekeeper 1, Findings include: The employee files 12:50 p.m. 1. LPN 1's start da no reference check employment. 2. Housekeeper 1's There were no refet to employment. 3. HHA 1's start da 	hall have specific n and implemented for the pective employees. ries shall be made for oyees. The facility shall policy that considers ny convictions in IC 16-28-13-3. view and interview, the facility erence checks were obtained r to starting employment at the employee files reviewed. (LPN	R 0116	Submission of this response a Plan of Correction is NOT a le admission that a deficiency et or, that this Statement of Deficiency was correctly cited and is also NOT to be constru- as an admission against inter by the facility, or any employe agents, or other individuals w drafted or may be discussed the Response and Plan of Correction. In addition, preparation and submission or this Plan of Correction does N constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of conclusions set forth in this allegation by the survey agen	egal xists I, ied est ess, ho in of NOT S any cy.
				1.Reference checks for LPN	N 1.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	B. WING		e survey pleted 3/2021
	PROVIDER OR SUPPLIE	ER	8253 V	ADDRESS, CITY, STATE, ZIP (/IRGINIA ST	CODE	
VIRGINI	A PLACE		MERR	RILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COL (FACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOLLD BE	(X5) COMPLETIO DATE
	and Regional Care	Regional Executive Director Specialist on 4/13/21 at 2:34 reference checks had not been		Housekeeper 1, and H initiated on 4/14/2021 Executive Director and 2.An audit of current files was initiated on 4 the Executive Director designee to ensure re checks were obtained employees prior to sta employment at the con and any issues identific corrected. 3.The Executive Dire provide re-education to Services Manager on process for employee by 5/7/2021. 4.The Executive Dire responsible for sustain compliance. The Exec Director, or designee, newly hired employee proper documentation references weekly for biweekly for four week monthly for one month the audit will be discus monthly QI meeting. T Committee will determ continued auditing is r based on 3 consecutiv of compliance. Monito ongoing.	by the d designee. t employee's ./14/2021 by r and ference for arting mmunity ied will be ector will o Care the proper new hires ector is ned cutive will audit files for of four weeks, (s, then n. Results of ssed in the rhe QI nine if necessary ve months	
R 0117 Bldg. 00	410 IAC 16.2-5-1 Personnel - Defic	. ,				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 04/13/2021	
	PROVIDER OR SUPPLIE	R	8253	T ADDRESS, CITY, STATE, ZIP CODE VIRGINIA ST RILLVILLE, IN 46410	•	
	1					(37.5)
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETIO DATE
	 with applicable si the twenty-four (2 unscheduled near services provided qualifications, and depend on skills specific needs of of one (1) awake CPR and first aid site at all times. I of the facility regunaring services medication, or box staff person shall Residential faciliti (100) residents renursing services medication, or box (1) additional nur on duty at all times (50) residents. Proonly those duties to perform. Empl with written job d Based on record refailed to ensure the a current first aid or shifts reviewed. Finding includes: Facility staffing services the schedules indimembers who wer following dates and Midnight shift on the schedules indimembers who mere following dates and Midnight shift on the schedules indimembers who were following dates and the schedules indimembers who were following dates and Midnight shift on the schedules indimembers who were following dates and the schedules indimem	d training of staff shall required to provide for the the residents. A minimum staff person, with current certificates, shall be on f fifty (50) or more residents ularly receive residential or administration of oth, at least one (1) nursing be on site at all times. ies with over one hundred egularly receiving residential or administration of oth, shall have at least one sing staff person awake and es for every additional fifty ersonnel shall be assigned for which they are trained oyee duties shall conform escriptions. eview and interview, the facility ere was one staff member with certificate scheduled for 6 of 21	R 0117	Submission of this response a Plan of Correction is NOT a le admission that a deficiency ex or, that this Statement of Deficiency was correctly cited and is also NOT to be constru as an admission against intera by the facility, or any employe agents, or other individuals wh drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission o this Plan of Correction does N constitute an admission or agreement of any kind by the facility of the truth of any facts	rgal xists ed est es, no n f IOT	05/13/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	date survey completed)4/13/2021
NAME OF PROVIDER OR SUPPLIER VIRGINIA PLACE		8253 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, IN 46410	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOLILD RE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
and Regional Care p.m. indicated the	Interview with the Regional Executive Director and Regional Care Specialist on 4/13/21 at 2:34 p.m. indicated there was no staff with current first aid certification working the above shifts.		alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
			 An audit of current employee files was initiated on 4/14/2021 by the Executive Director and designee to identify staff with current first aid certification. Direct care employees identified as needing first aid certification will have first aid certification obtained by 5/7/2021. On 4/28/2021 the Executive Director provided education to the Care Services Manager on the requirement to have minimum of one staff member with a current first aid certification scheduled for each shift. The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will audit employee files and work schedule to ensure one employee with current first aid certification is scheduled for each shift for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed in the monthly QI meeting. The QI committee will determine if continued auditing is 	

State Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 2GDI11

Facility ID: 010887

ongoing.

If continuation sheet

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FORM APPROVED

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/13/2021	
	PROVIDER OR SUPPLIE	R	8253 V	ADDRESS, CITY, STATE, ZIP IRGINIA ST LLVILLE, IN 46410	CODE	
	1					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (FACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
R 0121 Bldg. 00	employee of a fa contact. The scre tuberculin skin te method (5 TU, P positive reaction result shall be re induration with th by whom adminis assure the follow (1) At the time of (1) month prior to annually thereaft personnel of faci tuberculosis. The must be read prior work. For health had a documente test result during months, the base should employ th first step is negati be performed on after the first step testing will deper with tuberculosis (2) All employees reaction to the sk have a chest x-ra laboratory exami a diagnosis. (3) The facility sk	compliance en shall be required for each cility prior to resident een shall include a st, using the Mantoux PD), unless a previously can be documented. The corded in millimeters of e date given, date read, and stered. The facility must ing: employment, or within one o employment, or within one o employment, and at least er, employees and nonpaid lities shall be screened for e first tuberculin skin test or to the employee starting care workers who have not ed negative tuberculin skin the preceding twelve (12) eline tuberculin skin testing te two-step method. If the tive, a second test should e (1) to three (3) weeks b. The frequency of repeat ad on the risk of infection s who have a positive tin test shall be required to ay and other physical and nations in order to complete all maintain a health record				
	employment-rela (4) An employee active disease, (s	e that includes reports of all ted health screenings. with symptoms or signs of symptoms suggestive of is, including, but not limited				

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	î î	LDING	00	· /	PLETED
			B. WIN	lG		04/1	3/2021
NAME OF I	PROVIDER OR SUPPLIE	ÎR.		STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
	A PLACE				'IRGINIA ST ILLVILLE, IN 46410		
_					ILLVILLE, IN 40410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	F	PREFIX TAG	(FACH CORRECTIVE ACTION SHOLILD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	COMPLETIO DATE
	to, cough, fever, loss) shall not be tuberculosis is ru Based on record re failed to ensure en a first and second s tuberculosis) and h 5 employee files re Finding includes: Employee files we p.m. Housekeeper 1 wa not had any health completed. Interview with the and Regional Care	night sweats, and weight e permitted to work until led out. eview and interview, the facility poloyees of the facility received step Mantoux test (test for nealth screen upon hire for 1 of eviewed. (Housekeeper 1) eviewed on 4/13/21 at 12:50 s hired on 12/28/20. She had screen or Mantoux testing Regional Executive Director e Specialist on 4/13/21 at 2:34 health screen and Mantoux	R 01		Submission of this response Plan of Correction is NOT a admission that a deficiency or, that this Statement of Deficiency was correctly cit and is also NOT to be cons as an admission against int by the facility, or any emplo agents, or other individuals drafted or may be discusse the Response and Plan of Correction. In addition, preparation and submission this Plan of Correction does constitute an admission or agreement of any kind by th facility of the truth of any fac alleged or the correctness of conclusions set forth in this allegation by the survey age 1.A Health Screen for Housekeeper 1 will be initia prior to employee returning FMLA. 2.An audit of current emp files was initiated on 4/14/2 the Executive Director and designee to ensure employ received a first and second Mantoux test and health scr upon hire and any issues identified will be corrected. 3.The Executive Director	legal exists ed, trued erest yees, who d in of NOT e cts f any ency. ted from oyee 021 by ees een	05/13/202
					received a first and second Mantoux test and health scr upon hire and any issues identified will be corrected.	een will e	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/13/2021	
	PROVIDER OR SUPPLIE A PLACE	R	8253	ET ADDRESS, CITY, STATE, ZIP CO 3 VIRGINIA ST 2 RILLVILLE, IN 46410	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (FAC'H CORRECTIVE ACTION SHU CROSS-REFERENCED TO THE AF DEFICIENCY)	DUILD BE	(X5) COMPLETION DATE	
				receive a first and secon Mantoux test and health upon hire by 5/7/2021. 4. The Executive Direct responsible for sustained compliance. The Execut Director, or designee, we newly hired employee fit proper documentation of second step Mantoux a Screens completion upon weekly for four weeks, the for four weeks, then mo one month. Results of the will be discussed in the QI meeting. The QI com determine if continued a necessary based on 3 consecutive months of compliance. Monitoring ongoing.	n screen ctor is ed tive vill audit les for of first and nd Health on hires piweekly inthly for he audit monthly nmittee will auditing is		
R 0273 Bldg. 00	(f) All food prepa (excluding areas maintained in acc local sanitation a standards, includ Based on observat interview, the facil stored under safe a to open and unlabe potential to affect	nal Services - Deficiency ration and serving areas in residents ' units) are cordance with state and nd safe food handling ing 410 IAC 7-24. ion, record review and ity failed to ensure food was nd sanitary conditions related eled foods. This had the the 28 residents who resided in re served food from the	R 0273	Submission of this resp Plan of Correction is NC admission that a deficie or, that this Statement of Deficiency was correctly and is also NOT to be of as an admission agains by the facility, or any en agents, or other individu	DT a legal ency exists of y cited, construed t interest nployees,	05/13/202	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED B. WING 04/13/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8253 VIRGINIA ST **VIRGINIA PLACE** MERRILLVILLE. IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: drafted or may be discussed in the Response and Plan of Correction. In addition, Upon initial tour of the Kitchen with the Assistant preparation and submission of Chef on 4/12/21 at 9:45 a.m., the following was this Plan of Correction does NOT observed: constitute an admission or agreement of any kind by the 1. In the freezer: facility of the truth of any facts - A plastic bag of hamburger patties open to air alleged or the correctness of any and undated. conclusions set forth in this - A plastic bin on the bottom shelf with multiple allegation by the survey agency. plastic bags of food that were open to air and undated. Some of the items were not identifiable and were not labeled. Interview with the Assistant Chef at the time of the observation 1.Identified food open to air, identified some of the items as chicken and undated and/or unlabeled was sausage. She indicated she just "knows what discarded by Assistant Chef on everything is." 4/12/2021. 2.An audit of the refrigerator, freezer and dry storage was 2. In the dry storage area: completed by the Chef on - Two bags of potato chips open to air and 4/27/2021 to ensure food stored undated. under safe and sanitary - A plastic bag of powdered sugar open to air and conditions. Any unlabeled or undated. undated food was discarded. 3. The Regional Executive Interview with the Assistant Chef on 4/12/21 at Director will provide re-education 10:00 a.m. indicated all of the items should be to the Chef and Assistant Chef on closed and labeled with an open date. food preparation and serving areas being mainlined in A facility policy titled, "Storage of Products," accordance with state and local received as current, indicated " Once opened, sanitation and safe food handling items should be dated and sealed/covered standards by 5/7/2021. appropriately for storage." 4. The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will audit the refrigerator, freezer and dry storage weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure food is stored under safe and

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If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING O B. WING		CO:	(X3) DATE SURVEY COMPLETED 04/13/2021	
	PROVIDER OR SUPPLIE	R		8253 V	ADDRESS, CITY, STATE, ZIP COI IRGINIA ST	DE	
VIRGINI	A PLACE			MERRI	LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PI AN OF CORRE (FACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	C REGULATORY OR LSC IDENTIFYING INFORMATION				sanitary conditions. The the audit will be discusse monthly QI meeting. The Committee will determine continued auditing is nee based on 3 consecutive of compliance. Monitorin ongoing.	ed in the QI e if cessary months	
R 0349 Bldg. 00	on each resident, maintained under employee of the f responsibility. Th follows: (1) Complete. (2) Accurately do (3) Readily access (4) Systematically Based on record re failed to ensure the complete and accu documentation tha completed for 2 of 8 & 5) Findings include: 1. Record review f on 4/12/21 at 10:3 were not limited to dementia. The Physician's On	- Noncompliance ust maintain clinical records These records must be the supervision of an facility designated with that e records must be as cumented.	R 03	349	Submission of this respo Plan of Correction is NO admission that a deficier or, that this Statement of Deficiency was correctly and is also NOT to be co as an admission against by the facility, or any em agents, or other individua drafted or may be discus the Response and Plan of Correction. In addition, preparation and submiss this Plan of Correction de constitute an admission agreement of any kind by facility of the truth of any	T a legal icy exists cited, onstrued interest ployees, als who sed in of cion of oes NOT or y the	05/13/202

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	construction ((X3) DATE SURVEY COMPLETED	
			B. WING		04/13/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
VIRGINI	A PLACE			RILLVILLE, IN 46410		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	sugar checks three	e times a day before meals.		alleged or the correctness of ar	ıy	
				conclusions set forth in this		
		e Monitoring Sheet, dated		allegation by the survey agency	<i>y</i> .	
	March 2021, indic	ated the resident's blood sugars				
	were not documen	ted on the following dates and				
	times:					
				1.Residents 5 and 8 suffered	no	
	- 3/2/21, before di	nner		negative outcomes related to		
	- 3/15/21, before b	preakfast		these findings.	,	
	- 3/19/21, before d	linner		2.An audit of current resident	S	
	- 3/28/21, before d	linner		with orders for blood glucose		
	- 3/30/31, before d			testing will be completed by		
	,			5/7/2021 by the Care Services		
	The resident's reco	ord lacked any documentation		Manager to ensure clinical records are complete and		
		vere documented on the above		accurate related to documentat	tion	
	dates and times.			of order blood glucose test and		
				any issues identified will be		
	Interview with the	Care Services Manager on		reviewed with resident's		
		n., indicated she was unable to		physician.		
		nentation the blood glucose		3.The Care Services Manage	er	
		ompleted on the above dates and		will provide re-education to the		
	times.			licensed nurses on the proper		
				process to document blood		
	2 Record review	for Resident 5 was completed		glucose monitoring by 5/7/2021		
		p.m. Diagnoses included, but		4.The Care Services Manage	⊧r is	
		o diabetes mellitus, and		responsible for sustained		
	hypertension.	una		compliance. The Care Services		
	ing percension.			Manager, or designee, will audi		
	The POS dated A	pril 2021, indicated the		residents records with orders for		
	following orders:	prir 2021, indicated the		blood glucose monitoring week		
	ionowing orders.			for four weeks, biweekly for fou	ſ	
	- check blood sug	ar at HS (at bedtime)		weeks, then monthly for one month to ensure records reflect	۰ I	
	- Lantus (insulin)			complete and accurate		
				documentation. Results of the		
	The Blood Glucos	e Monitoring Sheet, dated		audit will be discussed in the		
		ated the resident's blood sugars		monthly QI meeting. The QI		
		ited on the following dates and		Committee will determine if		
	times:	and on the following dates and		continued auditing is necessary	/	
	unies.			based on 3 consecutive months		
				of compliance. Monitoring will b		

State Form

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/13/2021	
NAME OF	PROVIDER OR SUPPLIE	BR		ADDRESS, CITY, STATE, ZIP CODE /IRGINIA ST		
VIRGINI	A PLACE		MERR	ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOILD R CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETIC DATE
	 - 3/11/21, at HS - 3/12/21, at HS - 3/13/21, at HS - 3/13/21, at HS - 3/14/21, at HS - 3/15/21, at HS - 3/16/21, at HS - 3/19/21, at HS - 3/23/21, at HS - 3/29/21, at HS - 3/30/21, at HS - 3/30/21, at HS The resident's record the blood sugars we dates and times. Interview with the 4/13/21 at 11:30 a provide any documents 	ord lacked any documentation vere documented on the above Care Services Manager on .m., indicated she was unable to nentation the blood glucose ompleted on the above dates and		ongoing. 1.Residents 5 and 8 suffer negative outcomes related to these findings. 2.An audit of current reside with orders for blood glucose testing will be completed by 5/7/2021 by the Care Service Manager to ensure clinical records are complete and accurate related to documer of order blood glucose test a any issues identified will be reviewed with resident's physician. 3.The Care Services Mana will provide re-education to t licensed nurses on the prope process to document blood glucose monitoring by 5/7/20 4.The Care Services Mana responsible for sustained compliance. The Care Servi Manager, or designee, will a residents records with order blood glucose monitoring we for four weeks, biweekly for weeks, then monthly for one month to ensure records refl complete and accurate documentation. Results of th audit will be discussed in the monthly QI meeting. The QI Committee will deter	ent's ent's es es ntation and ager he er 021. ager is ces nudit 5 s for eekly four elect he es	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		00	COMPLETED 04/13/2021		
				STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF	PROVIDER OR SUPPLIE	R			IRGINIA ST			
VIRGINI	A PLACE				LLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(FACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP	F	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					of compliance. Monitoring w ongoing.	ill be		
R 0354	410 IAC 16.2-5-8 Clinical Records	- Noncompliance						
Bldg. 00	following: (1) Identification (2) Name of the t (3) Name of the t of transfer. (4) Resident 's p transferred to an (5) Nurses ' note (A) functional abi limitations; (B) nursing care; (C) medications; (D) treatment; an (E) current diet a (6) Diagnosis. (7) Date of chest tuberculosis.	ransferring institution. eceiving institution and date ersonal property when acute care facility. s relating to the resident ' s: lities and physical d nd condition on transfer. x-ray and skin test for						
	failed to complete transfer form for 1 (Resident 2) Finding includes: The closed record on 4/12/21 at 11:10	view and interview, the facility a discharge summary and of 7 clinical records reviewed. for Resident 2 was reviewed) a.m. The resident was	R 0	354	Submission of this response Plan of Correction is NOT a admission that a deficiency or, that this Statement of Deficiency was correctly cite and is also NOT to be const as an admission against inte by the facility, or any employ agents, or other individuals drafted or may be discussed	legal exists ed, rued erest yees, who	05/13/202	
	3/13/21. There we forms completed in note was entered of	nsferred to another facility on re no transfer or discharge n the record The last progress n 3/12/21 and indicated the ed his COVID vaccine.			the Response and Plan of Correction. In addition, preparation and submission this Plan of Correction does constitute an admission or	of		

NTERS FOR	MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
and Plan of correction identification number:		A. BUILDING B. WING	00	04/13/2021	
			_		04/13/2021
NAME OF P	ROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE VIRGINIA ST	
VIRGINIA	A PLACE			RILLVILLE, IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	(FACH CORRECTIVE ACTION SHOULD P CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	agreement of any kind by th	DATE
	Interview with the	Regional Nurse on 4/12/21 at		facility of the truth of any fac	
		d there should be a progress		alleged or the correctness o	
	-	the details of the resident's		conclusions set forth in this	
	discharge.			allegation by the survey age	ency.
	8				
	Interview with the	Care Service Manager on			
	4/13/21 at 1:30 p.m	n., indicated the resident had		1 Decident 0 v - lav v	-idea
	transferred to anoth	her facility. She was unable to		1.Resident 2 no longer res	sides
	locate a copy of the	e resident's transfer form and		in the community. 2.An audit of resident's real	corde
	indicated there wer	e no progress notes regarding		transferred from community	
	his discharge.			past 30 days will be comple	
				5/7/2021 by the Care Service	
				Manager to ensure a discha	
				summary and transfer form	-
				completed. Results of audit	will be
				reviewed with Executive Dir	
				3.The Care Services Man	-
				will provide re-education to	
				licensed nurses on the prop	
				documentation requirements	
				resident's who transfer from community by 5/7/2021.	
				4.The Care Services Man	ager is
				responsible for sustained	
				compliance. The Care Servi	ces
				Manager, or designee, will a	audit
				transferred residents' record	
				weekly for four weeks, biwe	
				for four weeks, then monthly	
				one month to ensure record	-
				reflect discharge summary a transfer form. Results of the	
				will be discussed in the mor	
				QI meeting. The QI Commit	
				will determine if continued a	
				is necessary based on all 3	
				consecutive months of	
				compliance. Monitoring will	be
				ongoing.	

State Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 2GDI11 Fa

Facility ID: 010887

887 If continua

If continuation sheet Pa

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FORM APPROVED

PRINTED: 05/11/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES					OMB NO. 0938-0391	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			LETED	
			B. WING			04/13/2021		
	NAME OF PROVIDER OR SUPPLIER			STREET A 8253 VI MERRI				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT		T	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX TAG		(FACH CORRECTIVE ACTION SHOTT D BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION					DATE	

State Form	Event ID:	2GDI11	Facility ID:	010887	If continuation sheet	Page 16 of 16	