STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155791	A. BUILDING 00 B. WING	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLAIR RIDGE HEALTH CAMPUS	269 MEADOWVIEW DR PERU, IN 46970

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 11, 12, 15, 16, & 17, 2024 Facility number: 012565 Provider number: 155791 AIM number: 201021970 Census Bed Type: SNF/NF: 27 SNF: 25 Residential: 26 Total: 78 Census Payor Type: Medicare: 15 Medicaid: 15 Other: 22 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 7/31/2024.	F 0000	R0000 The submission of this plan of correction does not indicate an admission by Blair Ridge Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided and the living environment provided to the residents of Blair Ridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economical and efficient manner. The facility hereby maintains it substantially complies with the participation requirements for skilled health care facilities. To this end, the plan of correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The			

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

Tamara Tinsley | Executive Director | 08/20/2024

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	facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;			

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	(ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility			

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	closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview, record review, and interview, the facility failed to provide a transfer and discharge form for 1 of 3 residents reviewed for hospitalizations. (Resident 36) Finding includes: During an interview, on 7/12/2024 at 9:33 A.M., Resident 36 indicated he had not been hospitalized since his admission to the facility, but had been at the facility 3 times. A record review was completed on 7/15/2024 at 10:59 A.M. Diagnoses included, but were not limited to: infection of the spinal internal fixation device, osteomyelitis, and MSSA (Methicillin Sensitive Staphylococcus Aureus). An Admission Minimum Data Set (MDS) assessment, dated 6/5/2024, indicated Resident 36 was cognitively intact. The medical record indicated Resident 36 was discharged to the Emergency Room on 6/19/2024 and returned to the facility on 6/20/2024. A Nurse's Note, dated 6/19/2024 at 12:49 P.M., indicated an order was obtained from Resident 36's surgeon to send to the Emergency Room due to his spinal surgical site dehiscence (reopening	F 0623	F623 1. Resident 36 was affected. Residents are without adverse effects. 2. All residents transferred from the facility have the potential to be affected. All nursing staff and social services were educated on completing, scanning, attaching, and sending notices of transfer and discharge to residents upon discharge from the campus. 3. As a measure of ongoing compliance, the ED or designee will audit 5 discharges, as available, for completion and scanning of notice of transfer and discharge weekly for one month, then every other week for two months, and finally monthly for three months. 4. As a quality measure, the ED or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	08/12/2024

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	of a surgical wound) with purulent (pus) drainage. On 6/20/2024 at 2:34 A.M., a Nurse's Note indicated Resident 36 returned to the facility. During an interview, on 7/17/2024 at 10:10 A.M., LPN 6 indicated a transfer and discharge form should be given if a resident was transferred from the facility to another facility. She indicated the transfer and discharge form would have been scanned into the electronic health record. A policy was provided, on 7/17/2024 at 2:34 P.M., by the Assessment Support, titled, "Guidelines for Transfer and Discharge", indicated, " ...According to federal regulations, the facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility. 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility ...." During an interview, on 7/17/2024 at 3:45 P.M., the Executive Director indicated the facility did not issue a transfer and discharge form on 6/19/2024. 3.1-12(a)(6)(A)		will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12, 2024.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II			

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	determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to ensure 1 of 2 residents received a PASRR(Preadmission Screening and Resident Review) assessment in a timely manner. (Resident 40) Finding includes: The record for Resident 40 was reviewed was on 7/11/2024 at 3:40 P.M. Diagnoses included, but were not limited to: dementia, psychotic disorder with hallucinations, mood disturbance and anxiety. A PASARR Level 1 assessment had been completed for Resident 40, on 4/3/2024, with no Level II assessment required. Resident 40 received a new qualifying diagnosis of psychotic disorder and medication change on 4/27/2024. During an interview, on 7/16/2024 at 11:39 A.M., the Social Service director indicated she could not locate an updated PASARR assessment and there should have been one updated for Resident 40 with the new diagnoses/medication. On 7/16/2024 at 4:07 P.M., the Director of Nursing indicated she did not have a policy for PASARR	F 0644	F 644 1. Resident 40 was affected. PASARR Level II has been completed. No Level II assessment is required. 2. All residents with diagnoses of mental disorders have the potential to be affected. All have been reviewed for completion of the level II assessment. Education has been completed with the Social Service Director (SSD) on the level II completion process. All new admissions in the past 30 days have been reviewed to ensure Level II was completed if indicated. 3. As a measure of ongoing compliance, the SSD or Designee will audit 5 new admissions and/or new mental health diagnoses, as available, weekly for one month to ensure, then every other week for two months, and finally monthly for three months. 4. As a quality measure, the ED or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred	08/12/2024

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	assessments.		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide grooming services for 2 of 3 residents reviewed for activities of daily living. (Residents 27 and 29) Findings includes: 1. During an observation for Resident 27, on 7/11/2024 at 11:41 A.M., she had long white whiskers on her chin, upper lip, and cheeks. On 7/12/2024 at 10:40 A.M., during an observation and interview, Resident 27 continued to have the whiskers, and she indicated she had an electric razor her daughter had brought to the facility for management of her whiskers. She indicated she would like them removed. A record review for Resident 27 was completed on 7/15/2024 at 9:31 A.M. Diagnoses included, but were not limited to, dementia, visual hallucinations, and diabetes mellitus type 2.	F 0677	F 677 1. The facility will ensure that residents 27 and 29 receive grooming services for daily living activities. Grooming was provided to residents 27 and 29, with no adverse effects noted. 2. All residents have the potential to be affected. All residents were reviewed for appropriate grooming needs, and grooming was provided. All nursing staff were educated on appropriate grooming/ADL requirements. 3. To measure ongoing compliance, the DHS or Designee will audit 5 residents weekly for one month to ensure proper ADL care has been provided, then every	08/12/2024

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	An Annual Minimum Data Set (MDS) assessment, dated 6/4/2024, indicated Resident 27 required substantial/maximal assistance for grooming, and had moderate cognitive impairment. A current Care Plan indicated Resident 27 had impairment in functional status. The care plan interventions did not address grooming assistance. During an observation, on 7/15/2024 at 9:48 A.M., Resident 27' continued with the whiskers observed previously. On 7/16/2024 at 10:02 A.M., Resident 27's whiskers continued to the upper lip, chin, and cheeks. During an interview on 7/17/2024 at 10:14 A.M., LPN 6 indicated facial hair was to be shaved whenever a resident needed to be shaved, not just on shower days. 2. During an observation, on 7/11/2024 at 10:23 A.M., Resident 29 was observed in his geri chair seated in the common area. He was unshaven with whiskers on his face, chin and had long fingernails. During an observation, on 7/12/2024 at 10:47 A.M., Resident 29 was unshaven with whiskers on his face, chin and had long fingernails. During an observation, on 7/15/2024 at 9:01 A.M., Resident 29 was observed seated at the dining table. He was unshaven, with whiskers on his face, chin and had long fingernails. A record review for Resident 29 was completed		other week for two months, and finally monthly for three months. 4. As a quality measure, the DHS or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	

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	on, 7/16/2024 at 8:53 A.M. Diagnoses included, but were not limited to dementia, chronic kidney disease, weakness, chronic obstruction pulmonary disease, dysphagia and ataxic gait. A Quarterly Minimum Data Set (MDS) assessment, dated 4/26/2024, indicated Resident 29 had severe cognition impairment and was dependent on staff for showering, bathing and requires maximal assist with personal hygiene. A current Care Plan, dated 4/29/2024, indicated Resident 29 had an ADL (activities of daily living) self-care performance deficit and required substantial/max assist with personal hygiene. During an interview on 7/16/2024 at 9:47 A.M., LPN 2 (Licensed Practical Nurse) indicated the resident should have been shaved and his nails should have been trimmed. During an interview on 7/17/2024 at 2:18 P.M., the Regional Support Nurse indicated the facility does not have a policy for ADL care. The staff was to follow their resident procedure guide. 3.1-38(a)(3)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to follow physician orders related to PICC (peripherally inserted	F 0694	F 694 1. The facility will ensure that physician orders related to central	08/12/2024

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	central catheter) line dressing changes for 1 of 1 resident reviewed for antibiotic therapy (Resident 36) Finding includes: During an observation on 7/12/2024 at 9:19 A.M., Resident 36 was observed to have a PICC line inserted to the basilic vein of the right arm. The dressing was dated 7/2/2024, and had paper tape adhered to the upper lateral portion of the dressing, and the dressing was not adhered distal to the lateral portion of the dressing adhered with paper tape. Resident 36 indicated the date, of 7/2/2024, observed on the dressing was the date the dressing had been changed. A record review for Resident 36 was completed on 7/15/2024 at 10:59 A.M. Diagnoses included, but were not limited to, infection of the spinal internal fixation device, osteomyelitis, and MSSA (Methicillin Sensitive Staphylococcus Aureus). An Admission Minimum Data Set (MDS) assessment, dated 6/5/2024, indicated Resident 36 was cognitively intact. A Care Plan, dated 6/3/2024 and revised 7/9/2024, indicated resident 36 required intravenous medication related to bacteremia. The interventions included intravenous site care as ordered. A PICC Insertion Record, dated 7/2/2024 at 1:40 P.M., indicated the PICC line was inserted to the right basilic vein because the left sided midline did not draw blood when frequent blood draws were necessary A Physician's Order, dated 6/5/2024, indicated to		line dressing changes for resident 36 are followed. A central line dressing change was provided to resident 36, and no adverse effects were noted. 2. All residents have the potential to be affected. All residents were reviewed for appropriate central line dressing changes that were needed and provided. All licensed nursing staff were educated on following appropriate physician orders for central line dressing changes. 3. To measure ongoing compliance, the DHS or Designee will audit all central line dressing changes weekly for one month to ensure proper dressing changes are provided, then every other week for two months, then monthly for three months. 4. As a quality measure, the DHS or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024	

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	change the PICC/Midline/CVAD (central venous access device) dressing every 5 days, and as needed. A Physician's Order, dated 6/28/2024, indicated Resident 36 was to receive Cefazolin (antibiotic) 2 grams per 100 milliliters every 8 hours through 7/27/2024. The Medication Administration Record (MAR), dated July 2024, indicated the PICC line dressing was to be changed on 7/5/2024. The nurse did not change the dressing but documented the following: " ...Dressing with new PICC changed 7/3/2024 ...." The MAR indicated a dressing change was completed on 7/10/2024 and a PRN (as needed) dressing change was completed on 7/13/2024. A Nurse's Progress Note, dated 7/13/2024 at 9:58 P.M., indicated a single lumen PICC dressing to the right upper extremity was beginning to come off and was changed using a prepackaged dressing kit. During an interview, on 7/17/2024 at 10:12 A.M., LPN 6 indicated Resident 36's PICC line dressing was to be changed every 5 days. She was not able to find documentation the PICC line dressing was being changed per the Physician's Order. There was also no explanation given as to why the MAR for July 2024 indicated the PICC dressing had been changed on 7/10/2024 when the dressing observed on 7/12/2024 was dated 7/2/2024. A policy was provided on 7/17/2024 at 1:51 P.M. by the Director of Nursing who indicated the policy was the current facility policy. The policy titled, "Catheter Insertion and Care", indicated, "			

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	...Midline catheter dressings will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings ...General Guidelines 1. Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way ...." 3.1-47(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared and served under safe and sanitary conditions related to appropriate cold	F 0812	F 812 1. The facility will follow appropriate storage procedures, food production guidelines, and	08/12/2024

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(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
	food temperatures, disposal of outdated foods, labeling and dating of food items in the refrigerator and freezer, storage of dishware and appliance cleanliness for 1 of 1 kitchens. This had the potential to affect 51of 52 residents who consumed food from the kitchen. Findings include: During an initial observation of the kitchen with Culinary Assistant 5, on 7/11/2024 from 9:40 A.M. through 10:00 A.M., the following was observed: a. Individualized yogurt cups were sitting on the counter beside the refrigerator without being iced. At 10:00 A.M., the yogurt cups were no longer on the counter. Culinary Assistant 5 indicated she had placed them back in the refrigerator. The temperature of the yogurt cups was requested, and the yogurt cup tested was 60.8 Fahrenheit. While Culinary Assistant 5 was checking the temperature of the yogurt cups, she asked, "What's it supposed to temp?" b. The reach in freezer had an opened, undated box of Taquitos (original box) and French fries in a plastic bag with no date or label. c. The reach in refrigerator had chocolate pudding with a use by date of 7/9/2024, green beans with a use by date of 7/10/2024, mashed potatoes with a use by date of 7/10/2024, a small bag of lettuce with a use by date of 7/10/2024, and a large bag of wilted looking lettuce with no label or use by date. d. The kitchen stovetop was observed to have grease and food debris down the side, the reach in refrigerator had food debris down the side and front, the stove/oven had spillage on the side and food debris on the front, and the convection oven		proper storage of clean dishes. No specific resident was affected. 2. All residents have the potential to be affected. All Dining Services Staff were educated on (a.) food stored safely and consistently compliant with temperature regulation (b.) Proper dating and labeling with dates were initiated upon opening items and their expiration dates (c.) Expired food has been discarded according to use-by date (d.) Ensure all equipment and food storage areas are cleaned and free of debris and grease (e.) Ensure all dishes are inverted in a clean, dry area without splash, dust, or contamination. 3. To measure ongoing compliance, the Director of Food Services (DFS) or Designee will audit (a.) food stored safely and consistently compliant with temperature regulations. (b.) Proper dating and labeling with dates when items opened and their expiration dates (c.) Expired food has been discarded according to use-by date (d.) Ensure all equipment and food storage areas are cleaned and free of debris and grease (e.) Ensure all dishes are inverted in a clean, dry area without splash, dust, or contamination. This will occur weekly for one month, every other week for two months, and monthly for three months. 4. As a quality measure, the DFS	

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	155791	A. BUILDING 00 B. WING	07/17/2024

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	had food spillage and grease stains down the front. e. The storage area for dishware was observed to have large salad bowls, side plates, side bowls, and ramekins stored upright and not inverted. 2. During an observation of the kitchen, on 7/12/2024 at 1:31 P.M., the side bowls and ramekins were observed upright and not inverted. 3. During an observation on 7/16/2024 at 10:55 A.M. with the Culinary Director, the same debris and soilage was observed on the reach in refrigerator, stove/oven, and convection oven. During an observation on 7/17/2024 at 10:59 A.M. with the Culinary Director, multiple side dishes and clear bowls, large salad bowls, and a cupcake pan were not stored inverted. The same appliance debris/soilage was observed. During an interview on 7/17/2024 at 11:32 A.M., the Culinary Director indicated dishware should be stored upside down on open shelves, all food opened should be labeled and dated, food should be disposed of by the use by date by the end of the day, and cold foods should be stored on ice or refrigerated when serving. She indicated the appliances had a once-a-week rotation for cleaning. A current policy was provided on 7/17/2024 at 1:30 P.M. by the Director of Nursing. The policy titled, "Storage Procedures", indicated, " ...Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance ...Refrigerated Storage 7. Prepared perishable items as salads, puddings, milk, etc., are stored in a refrigerator and covered,		or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	

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	labeled, and dated until used ...Freezer Storage 3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated ...." A current policy was provided, on 7/17/2024 at 1:30 P.M., by the Director of Nursing. The policy titled, "Food Production Guidelines", indicated, " ...Safe and sanitary handling of food will be employed during food production ...6. Leftovers must be dated, labeled, covered, and immediately refrigerated or frozen for later use, Leftovers must be used within 72 hours ...." A current policy was provided on 7/17/2024 at 1:30 P.M. by the Director of Nursing. The policy titled, "Dish Machine", indicated, " ...Store ware in a clean dry area upside down to avoid direct contact with debris ...." 3.1-21(h)(3)			
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 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:			

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	§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 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.			

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	§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 proper infection control practices were implemented related to lack of handwashing after glove removal during a blood glucose procedure and fanning an area that had been cleansed with alcohol pad during 1 of 3 medication administration observations. (RN 3) Finding includes: During a medication observation, on 7/16/2024 at 8:40 A.M., RN 3 obtained the supplies to perform a blood glucose level and administer insulin to a resident. RN 3 placed the glucometer device and supplies on the resident's bed, washed his hands and applied gloves. RN3 wiped the resident's finger with an alcohol pad and with an opened hand, fanned the area that had been cleansed. After RN 3 obtained the blood sample, he removed his gloves and without washing his hands, administered insulin to the resident. During an interview, on 7/16/2024 at 8:45 A.M., RN 3 indicated he should have washed his hands,	F 0880	F 880 1. The facility will follow appropriate infection control practices during blood glucose procedures and proper handwashing. No specific resident was affected. 2. All residents have the potential to be affected. All residents were reviewed to ensure proper infection control practices were being implemented. All staff were educated on proper handwashing, and all nurses were educated on infection control practices during blood glucose procedures. 3. To measure ongoing compliance, the DHS or Designee will audit all residents who utilize blood glucose procedures and proper handwashing weekly for one month, every other week for two months, and monthly for three months. 4. As a quality measure, the DHS	08/12/2024

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	placed the device on barrier and not fanned the area. On 7/16/2024 at 11:10 A.M., the Director of Nursing provided the policy titled, "Glucometer", dated 9/17/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Appropriate infection control techniques shall be followed during testing procedures...." On 7/16/2024 at 11:01 A.M., the Director of Nursing provided the policy titled, "Guideline for Handwashing/Hygiene", with a review date of 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated..."...3. Health Care Workers (HCW) shall use hand hygiene and times such as:...d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc...." On 7/17/2024 at 1:51 P.M., the Director of Nursing provided the policy titled,"Injectable Medication Administration, and indicated the policy was the one currently used by the facility. The policy indicated..."To administer medication via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner. Equipment Required:...F. Barrier (e.g.,disposable tray or plastic cup), if supplies or medication will be set down in a resident's room...." 3.1-18(b)		or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	F 9999	08/12/2024

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	(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not limited to the following: (1) Resident Rights. (5) Needs of the specialized population served. (6) Care of the cognitively impaired residents. I The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least 12 hours of inservice per calendar year and (6) hours in inservice per calendar year for nonnursing personnel. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 7 of 10 employees had completed required dementia, resident rights and abuse inservices/education. (CNA 7, 11 and 15, QMA 8 (Qualified Medication Aide), Cook 10, LPN 12 and RN 13) Findings include: On 7/17/2024 at 11:30 A.M. employee files were reviewed and the following was noted: 1. CNA 7's start date in the facility was 6/8/2022. There was no documentation of dementia inservice education being completed in 2023-2024 2. CNA 11's start date in the facility was 6/8/2022. There was no documentation of dementia, abuse, or resident rights inservice education being completed in 2023-2024. 3. CNA 15's start date in the facility was 6/26/2018.		1. The facility will ensure that all ongoing in-service education and training for nursing personnel shall include at least 12 hours per calendar year and 6 hours for non-nursing personnel. 2. Cna 7, 11, 15, Qma 8, Lpn 12, and RN 13 have all completed all identified training for 2023-2024. All staff were educated on requirements for assigned annual training based on employee position and in accordance with state and federal regulations. 3. To measure ongoing compliance, the ED or Designee will audit all employee training to ensure current. This will be reviewed weekly for one month, every other week for two months, and monthly for three months. 4. As a quality measure, the ED or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	

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	There was no documentation of dementia, abuse or resident rights inservice education being completed in 2023-2024. 4. QMA 8's start date in the facility was 4/19/2016. There was no documentation of abuse or resident rights inservice education being completed in 2023-2024. 5. Cook 10's start date in the facility was 7/12/2022. There was no documentation of abuse or resident rights inservice education being completed in 2023-2024. 6. LPN 12's start date in the facility was 10/25/2016. There was no documentation of dementia, abuse, or resident rights inservice education being completed in 2023-2024. 7. RN 13's start date in the facility was 5/14/2009. There was no documentation of dementia, abuse, or resdent rights inservice education being completed in 2023-2024. During an interview, on 7/17/2024 at 3:13 P.M., the Administrator indicated the employees had not completed all the required inservice documentation. On 7/17/2024 at 3:20 P.M., Human Resources staff member 16 provided the policy titled, "Mandatory Annual Training's ", dated 2/8/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...[name of facility] requires all employees to complete assigned training's on an annual basis. Training's are determined and assigned based on the employee's position within the organization and in accordance with State and Federal agency requirements...2. Training's assignments are			

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	spread out over the course of a calendar year with designated courses to be completed each quarter by current employees...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 16, 17, 2024 Facility number: 012565 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	R0000 The submission of this plan of correction does not indicate an admission by Blair Ridge Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided and the living environment provided to the residents of Blair Ridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economical and efficient manner. The facility hereby maintains it substantially complies with the participation requirements for skilled health care facilities. To this end, the plan of correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:			

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	(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Baseddd on record review and interview, the facility failed to provide services to ensure a resident who received anticoagulant and antibiotic therapy concurrently was effectively monitored for adverse consequences for 1 of 2 residents reviewed for discharge. (Resident 8) This deficient practice resulted in Resident 8 experiencing internal bleeding that required emergent treatment with fresh frozen plasma and vitamin K at a hospital. Finding includes: A record review for Resident 8 was completed on 7/16/2024 at 2:23 P.M. Diagnoses included, but were not limited to, diabetes mellitus type 2, atrial fibrillation, and hypothyroidism. Current Physician's Orders for Resident 8 included instructions indicating a recheck of the PT/INR may be warranted within 7-14 days of a medication change, to monitor for signs and symptoms of bleeding, and notify the Physician of change in condition and many drugs interact with Coumadin (Warfarin) to affect clotting time: most antibiotics, antifungals, anticonvulsants, anti-ulcer drugs, SSRI antidepressants, various other drugs. Use caution when starting, changing, or discontinuing any medications on residents taking Coumadin. The orders were signed by nursing staff daily on the March and April 2024 Medication Administration Record (MAR). The Medication Administration Record (MAR) for	R 0036	R 036 1. The facility will consult the resident's physician and legal representative when it notices a significant decline in condition or a need for altered treatment due to adverse consequences of concurrently receiving antibiotic and anticoagulant treatment for resident 8. The resident has been discharged from the facility. 2. All assisted living residents have the potential to be affected. All assisted living residents receiving concurrent antibiotic and anticoagulant treatment were reviewed, with no adverse effects noted. All licensed nursing staff were educated on the importance of monitoring and consulting with physicians when residents receive concurrent antibiotic and anticoagulant therapy. 3. To measure ongoing compliance, the DHS or Designee will audit all residents in assisted living receiving concurrent antibiotic and anticoagulant treatment weekly for one month, every other week for two months, and then monthly for three months. 4. As a quality measure, the DHS or Designee will review any	08/12/2024

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	February, March and April 2024 indicated Resident 8 received the following medications: -Warfarin (an anticoagulant) tablet 2 milligram daily on Sunday, Tuesday, Wednesday, Thursday, and Saturday during period of 1/18/202024-3/25/2024 -Warfarin tablet 1 milligram daily on Monday and Friday during the period of 2/16/2024-3/25/2024 -Ceftriaxone (an antibiotic) 1 gram injection once on 3/19/2024 -Levofloxacin (an antibiotic) tablet 750 milligrams once a day from 3/20-2024 - 3/26/2024 -Warfarin tablet 1 milligram daily on Friday 3/26/24-4/15/2024 -Warfarin tablet 2 milligram daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Saturday during the period of 3/26/2024-4/15/2024 -Cefuroxine (an antibiotic) tablet 500 mg twice a day 3/30/2024 - 4/8/2024 Review of Nursing Progress Notes for 3/26/2024 (Day 7 after the antibiotic therapy commenced) - 4/8/2024 and the March and April MAR documentation indicated although nursing staff were signing the orders to acknowledge the potential interaction between the antibiotic and anticoagulant therapies, there was no documentation the physician was notified of the potential adverse drug interaction and the need to increase the monitoring of the resident's PT/INR laboratory levels. The resident's Warfarin therapy was increased slightly on 3/26/2024, despite the potential interaction between the medications and the order to recheck the resident's PT/INR day 7 -14 after starting other medicatioins, including antibiotics. The current Physician's orders indicated to monitor the resident's PT/INR blood levels monthly. The most recent PT/INR lab test, prior		findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	

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	to the resident's discharge to an acute care facility, was performed on 3/21/2024. The results included a PT level of 22.0 seconds (normal parameters), and an INR of 1.8 (acceptable therapeutic range). A Nurse's Progress Note, on 4/9/2024 at 7:00 A.M., indicated a Certified Nursing Assistant responded to a pendant call and observed Resident 8 on the floor beside his recliner. Resident 8 refused to be rolled over or move his extremities due to pain. The resident was informed an ambulance would need to be called for further evaluation. On 4/9/2024 at 10:51 A.M., a Nursing Progress Note indicated Resident 8 was admitted to the hospital with an acute Lumbar 1 fracture and an INR greater than 9 According to the International Normalized Ratio (INR) Stat Pearls - NCBI (National Centers for Biotechnology Information) bookshelf: "For patients who are on anticoagulant therapy, the therapeutic INR ranges between 2.0 to 3.0 (seconds it takes for blood clotting.) INR levels above 4.9 are considered critical values and increase the risk of bleeding." A Hospital History and Physical, dated 4/9/2024 at 3:08 P.M., indicated Resident 8 had computerized tomography (CT scan) abdomen/pelvis to rule out any internal bleeding due to a supratherapeutic (blood level that greatly exceeds the normal therapeutic range) PT level of greater than 100 (normal 9.8-13.2 seconds) and INR level of greater than 9.4 seconds (normal 0.89-1.18). The results indicated the resident experienced an intramuscular hematoma (a collection of blood) and retroperitoneal (membrane that lines the			

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(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
	abdominal cavity) bleed. The supratherapeutic INR was reversed with 2 units of fresh frozen plasma and vitamin K. A current policy was provided on 7/17/2024 at 1:54 P.M. by the Regional Director of Clinical Services. The policy titled, "Anti-Coagulant Assessment Guidelines", indicated, " ...To provide guidelines for monitoring residents on anticoagulant therapy ...1. Each resident receiving Anticoagulant drug therapy will be monitored for side effects. 2. Residents receiving Coumadin will have labs ordered by physician to monitor and adjust dosing. 3. For residents receiving Coumadin, the most recent Coumadin lab will be reviewed prior to administering Coumadin. The nurse will ensure that an order is in place for the next Coumadin lab. 4. Residents on Anticoagulants will be care planned to monitor for side effects of anticoagulant therapy ...." There was no specific facility policy provided regarding specific instructions for administering antibiotics and anticoagulants concurrently.			
R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. Based on observation, record review, and interview the facility failed to provided oxygen signage for 1 of 2 residents reviewed for oxygen therapy. (Resident 5). Finding includes: A record review for Resident 5 was completed on	R 0153	R 153 1. The facility will follow safety precautions when oxygen is administered or stored to resident 5. Oxygen signage was placed, and no adverse effects were noted. 2. All assisted living residents	08/12/2024

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	155791	A. BUILDING 00 B. WING	07/17/2024

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	7/17/2024 at 9:43 A.M. Diagnoses included, but were not limited to, obstructive sleep apnea, congestive heart failure, and chronic obstructive pulmonary disease. Current Physician Orders, included the following: "... oxygen at 3-4 liters per nasal cannula continuously, and titrate as needed", and "Bi-Pap (bilevel positive airway pressure) with oxygen at 3 liters to wear during the night and as needed during the day...." During an observation on 7/17/2024 at 10:34 A.M., signage for oxygen use was not displayed outside the Resident's room. During an interview, on 7/17/2024 11:08 A.M., the Director of Assisted Living indicated Resident 5 used oxygen, and should have an oxygen sign outside his room. A current policy was provided on 7/17/2024 at 1:56 P.M., by the Regional Director of Clinical Services. The policy was titled, "Liquid Oxygen Storage and Transfer". The policy did not address the use of oxygen in use signs outside of the room.		have the potential to be affected. All residents receiving oxygen therapy were reviewed, and oxygen signage was placed. No adverse effects were noted. All staff members were educated in proper oxygen administration and storage. 3. To measure ongoing compliance, the DHS or Designee will audit all residents in assisted living receiving oxygen therapy for correct signage placed weekly for one month, every other week for two months, and then monthly for three months. 4. As a quality measure, the DHS or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual			

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	resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to have the resident or resident representative sign the service plan for 4 of 8 residents reviewed for service plans. (Residents 4, 5, 8, and 9) Findings include: 1. A record for Resident 4 was completed on 7/16/2024 at 1:47 P.M. Diagnoses included, but were not limited to, diabetes mellitus type 2, dementia, and anxiety disorder. Service Plans were completed on 1/1/2024 and 7/1/2024. There were no resident or resident representative signatures on the service plan	R 0217	R217 1. The facility will have residents or resident representatives sign service plans for residents 4, 5, 8, and 9. The resident or resident representative signs all service plans with no adverse effects noted. 2. All assisted living residents have the potential to be affected. All service plans are reviewed and signed by the resident or resident representative. The director of Assisted Living is educated on service plans being signed. 3. To measure ongoing	08/12/2024

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	review. During an interview, on 7/17/2024 at 11:04 A.M., the Director of Assisted Living indicated the service plans for 1/1/2024 and 7/1/2024 had not been signed by the resident or resident representative. 2. A record review for Resident 5 was completed on 7/17/2024 at 9:43 A.M. Diagnoses included, but were not limited to, obstructive sleep apnea, congestive heart failure, and chronic obstructive pulmonary disease. A Service Plan was completed on 3/18/2024. There were no resident or resident representative signatures on the service plan review. During an interview, on 7/17/2024 at 11:05 A.M., the Director of Assisted Living indicated the service plan for 3/18/2024 had not been signed by the resident or resident representative. 3. A record review for Resident 8 was completed on 7/16/2024 at 2:23 P.M. Diagnoses included, but were not limited to, diabetes mellitus type 2, atrial fibrillation, and hypothyroidism. Service Plans were completed on 10/13/2023 and 4/13/2024. There were no resident or resident representative signatures on the service plan review. During an interview on 11/17/2024 at 11:07 A.M., the Director of Assisted Living indicated the service plans for 10/13/2023 and 4/13/2024 had not been signed by the resident or resident representative. 4. A record review for Resident 9 was completed		compliance, the DHS, or Designee, will audit two service plans weekly for one month, every other week for two months, and then monthly for three months. 4. As a quality measure, the DHS or Designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 12th, 2024.	

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	on 7/16/2024 at 3:49 P.M. Diagnoses included, but were not limited to, hypertension, depressive disorder, and obstructive sleep apnea. Service Plans were completed on 10/11/2023 and 4/10/2024. There were no resident or resident representative signatures on the service plan review. During an interview on 11/17/2024 at 11:07 A.M., the Director of Assisted Living indicated the service plans for 10/11/2023 and 4/10/2024 had not been signed by the resident or resident representative. A current policy was provided, on 7/17/2024 at 1:56 P.M. by the Regional Director of Clinical Services. The policy titled, "AL [Assisted Living] Evaluation and Service Plan Guidelines", indicated, " ...to provide documentation of nursing and ancillary care needs to develop a service plan, to determine acuity level based on the amount of assistance provide with both activities of daily living (ADL) and nursing care ...2. A service plan shall be identified and implemented in response to the resident's evaluation and on collaboration with the resident and/or responsible party. The Assisted Living Director or designee will discuss the services he/she requires ...."			