PRINTED: 03/22/2022 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		02/24/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					INWORTH CT		
LAKE CIT	ΓY PLACE			WARSA	AW, IN 46580		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
R 0000							
Bldg. 00							
Diag. 00	This visit was for a	State Residential Licensure	l _D o	000	Submission of this response a	nd	ı
		icluded a Recertification and	R 0	000	I -		
	-				Plan of Correction is NOT a le	gai	
	State Licensure Surv	vey.			admission that a deficiency	_	
	C	22 8 24 2022			exists or, that this Statement o		
	Survey dates: Febur	rary 23 & 24, 2022			Deficiencies was correctly cite	-	
	F 11. 1 01	11200			and is also NOT to be construe	∍d	
	Facility number: 01	11389			as an admission against intere	st	
					by the residence, or any		
	Residential Census:	25			employees, agents, or other		
					individuals who drafted or may	be	
		ntial Findings are cited in			discussed in the response or		
	accordance with 410	0 IAC 16.2-5.			Plan of Correction. In addition		
	Quality review com	pleted on 3/3/22.			preparation and submission of		
					this Plan of Correction does N	01	
					constitute an admission or		
					agreement of any kind by the		
					facility of the truth of any facts		
					alleged or the correctness of a	ny	
					conclusions set forth in this		
					allegation by the survey agend	y.	
						•	
R 0092	410 IAC 16.2-5-1.3	3(i)(1-2)					·
	Administration and						
Bldg. 00	Noncompliance	, and the second					
Ü	-	st maintain a written fire					
	· · ·	aredness plan to assure					
		of residents in cases of					
	emergency as follo						
		n facilities shall include the					
	` '	fire alarm signal and					
		rgency fire conditions,					
		ovement of nonambulatory					
	-	_					
		areas or to the exterior of					
	-	required. Drills shall be					
	conducted quarter	iy on each shiit to					
					1		

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

TITLE (X6) DATE

Any defiency statement 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.

State Form Event ID: 50MC11 Facility ID: 011389 If continuation sheet Page 1 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONS		ONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		02/24/2022	
		1	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		HINWORTH CT		
LAKE CI	TY PLACE			AW, IN 46580		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	familiarize all facility personnel with signals					
		ction required under varied				
		st twelve (12) drills shall be				
		When drills are conducted				
		nd 6 a.m., a coded				
	announcement m audible alarms.	ay be used instead of				
		six (6) months, a facility				
		old the fire and disaster drill				
		h the local fire department.				
		ining and drills shall be				
		the names and signatures				
	of the personnel	_				
	Based on interview	and record review, the	R 0092	R 092 Administration and	03/26/2022	
	facility failed to en	sure twelve fire drills were		Management - Noncompliar	ice	
	conducted yearly a	nd at least every six months				
		er drill in conjunction with		1. What corrective action(s)	will	
	-	tment. This has the potential		be accomplished for those		
	to affect 25 Reside	nts residing at the facility.		residents found to have bee	n	
				affected by the deficient		
	Finding includes:			practice:		
	On 2/23/2022 at 10	39 A.M., the Administrator		/p>		
		did not do all the required fire		2 How the facility will ident	ifv	
		and disaster drill with the		other residents having the	"' [,]	
	local fire departme			potential to be affected by the	ne	
	and and are a second			same deficient practice and		
	On 2/23/2022 at 10	0:55 A.M., the Administrator		what corrective action will b	e	
		ot have a fire drill policy but		taken:		
	follow the state gui			An audit of fire drills for the la	est	
				12 months was completed on		
	_	w on 2/23/2022, at 11:19		3/16/2022 by the Executive		
	· ·	ance Director indicated that		Director (ED) to ensuretwelve		
		August. She started doing fire		drills were conducted yearly a		
		nd had one with the local fire		at least every six months hold		
	department in Janu	ary.		and disaster drill in conjunction		
				with the local fire department.		
				Results review with the Regio Director of Facilities Manager		
				(RDFM) and schedule created		
				(ND) W) and soliedule dealed	u 101	

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PRINTED: 03/22/2022 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED	
71.1D 1 D/11V	o. conduction	ELITHON NOMBER.	B. WING	<u>00</u>	- 02/24/2022	
			STREET	ADDRESS, CITY, STATE, ZIP CO	-	_
NAME OF F	PROVIDER OR SUPPLIEF	₹		INWORTH CT		
LAKE CI	TY PLACE		WARS	AW, IN 46580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	RECTION (X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AR DEFICIENCY)	OULD BE COMPLETION PROPRIATE	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	drill completion for the r	DATE	
				of 2022. A fire and disa		
				was completed on 3/16	-	
				the MT in conjunction w	vith the	
				local fire department.		
				3 What measure will b	e put into	
				place or what systemic	c	
				changes the facility wi		
				ensure that the deficie practice does not recu		
				/p>	".	
				4 How the corrective a	` '	
				will be monitored to en		
				deficient practice will i.e., what quality assur		
				program will be put in		
				Effective 3/28/22, the E	D or	
				designee will complete		
				fire drill logs monthly tin		
				are conducted yearly a		
				every six months hold f		
				disaster drill in conjunct	tion with	
				the local fire departmen		
				will be reviewed at mon		
				meeting. The QI Comm determine if continued i		
				are necessary based or		
				consecutive months of		
				compliance. Monitoring	will be	
				on-going.		
				5 By what date the sys	stemic	
				changes will be compl		
				Completion date: 3/26/2	2022	
R 0121	410 IAC 16.2-5-1.	Λ(f)(1_Λ)				
11.0121	Personnel - Nonce					
		1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			UILDING	00	(X3) DATE COMPL 02/24 /	ETED	
NAME OF F	ROVIDER OR SUPPLIER				NDDRESS, CITY, STATE, ZIP CODE		
LAKE CI	TY PLACE				AW, IN 46580		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
Bldg. 00	` '	shall be required for each lility prior to resident					
		en shall include a tuberculin					
		e Mantoux method (5 TU,					
	_	eviously positive reaction					
	•	ed. The result shall be					
	recorded in millime	eters of induration with the					
	date given, date re	ead, and by whom					
	administered. The	facility must assure the					
	following:						
		employment, or within one					
	, ,	employment, and at least					
		r, employees and nonpaid					
	•	ies shall be screened for first tuberculin skin test					
		to the employee starting					
	•	are workers who have not					
		negative tuberculin skin					
		he preceding twelve (12)					
	_	ine tuberculin skin testing					
		two-step method. If the					
	first step is negativ	e, a second test should be					
	performed one (1)	to three (3) weeks after					
		frequency of repeat testing					
		risk of infection with					
	tuberculosis.						
		who have a positive					
		n test shall be required to					
		and other physical and ations in order to complete					
	a diagnosis.	ations in order to complete					
	_	ıll maintain a health record					
		that includes reports of all					
		ed health screenings.					
		vith symptoms or signs of					
		mptoms suggestive of					
	active tuberculosis	s, including, but not limited					
	_	ight sweats, and weight					
		permitted to work until					
	tuberculosis is rule	ed out.	ı				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	JILDING	ONSTRUCTION 00	(X3) DATE : COMPL 02/24 /	ETED	
	ROVIDER OR SUPPLIER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOOK CROSS-REFERENCED TO THE AFTER TAG DEFICIENCY)			TE	(X5) COMPLETION DATE
	facility failed to proscreening for 2 of 5 and health screening	view and interview, the ovide annual tuberculosis employee records reviewed. g for 1 of 5 employee records	R 0	121	R 121 Personnel - Noncompliance 1. What corrective action(s)	will	03/26/2022
	Finding includes:	yee health. (Employee 6 & 7)			be accomplished for those residents found to have been affected by the deficient practice:	1	
	were requested and	0:30 A.M., employee records provided. uments not provided during			/p> /p> 2 How the facility will identi	fy	
	the initial review we review of employee not provide docume receiving an employ Employee 6 began of	ere requested. During the erecords, the facility could entation for Employee 6 yee health screening. employment on 8/12/2019. yee 6 and Employee 7 did not			other residents having the potential to be affected by th same deficient practice and what corrective action will be taken:	е	
	receive annual tuber year of 2021. Employscreening was performed.	rculosis screening for the oyee 6 last tuberculosis ormed on 12/28/2020. perculosis screening was			An audit of employee health screens and annual tuberculor screens was completed 3/11/2 by the Executive Director (ED ensure current employees received a health screen and	2022	
	the Administrator in should have receive screening in 2021.	ov on 2/23/2022 at 3:05 P.M., adicated Employee 6 and 7 and an annual tuberculosis			annual tuberculosis screening Results reviewed by CSM and concerns identified were corrected.	I	
	P.M. The Administrate regulations were followed	sted on 2/23/2022 at 2:17 rator indicated that the State llowed regarding employee osis screenings. A policy was rovided.			3 What measure will be put in place or what systemic changes the facility will make ensure that the deficient practice does not recur:		
					The CSM was reeducated on 3/10/2022 by the Regional Director of Care Services (RD on the need to provide annual tuberculosis screening to		

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 02/24/2022		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
LAKE CIT	TY PLACE			AW, IN 46580			
	SUMMARY ST (EACH DEFICIENCE	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	STREET . 425 CH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) employees and a health scree for new employees prior to resident contact and per state requirements. Licensed nursin staff were reeducated on 3/16/2022 by the CSM on the need to provide annual tuberculosis screening to employees and a health scree for new employees prior to resident contact and per state requirements. 4 How the corrective action(swill be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. Effective 3/28/22, the CSM or designee will complete an audemployee health screens and annual tuberculosis screening for employees and health screening for new	(X5) COMPLETION DATE ening sening sening sethe cur, ee:		
				employees prior to resident contact and per states requirements are completed. audit will occur weekly for 4 weeks, biweekly for 4 weeks, monthly for 4 weeks. Results be reviewed at monthly QI meeting. The QI Committee with determine if continued interviewed are necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	then will vill ews		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MU		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	OO COMPLETED		
			B. W	ING	02/24/2022		
				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER						
LAKE CIT	TY PLACE		425 CHINWORTH CT WARSAW, IN 46580				
					1		
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE ACT		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
					5 By what date the systemic changes will be completed		
					Completion date: 3/26/2022		
					Completion date. 3/20/2022		
R 0243	410 IAC 16.2-5-4(e)(3)					
	Health Services - I	Deficiency					
Bldg. 00	(3) The individual						
	medication shall d	ocument the administration					
		medication and treatment					
	records that indica	te the:					
	(A) time;						
	` '	cation or treatment;					
	(C) dosage (if app	•					
	(D) name or initials administering the	-					
	_	on, interview and record	$ _{R0}$	2.42	R 243 Health Services -	03/26/2022	
		failed to ensure physician's	KU	243	Deficiency	03/20/2022	
	order were followed				Demoisiney		
	observed for medica				1. What corrective action(s)	will	
	(Resident H)				be accomplished for those		
					residents found to have been	n	
	Finding includes:				affected by the deficient		
					practice		
		tration observation began on			/p>		
		A.M. At 11:30 A.M.,			/p>		
		ster Resident H's medications			/p>		
	•	and Diclofenac Sodium cream					
		ee 3 was observed squeezing			2 How the facility will identi	TY	
		nount of the cream into her en applying the cream to			other residents having the		
	-	houlder/upper arm region.			potential to be affected by the same deficient practice and	e	
	Resident II 8 Hgfit Si	nounder/upper arm region.			what corrective action will be	_	
	During an interview	on 2/23/2022 at 11:34 A.M.,			taken:		
	-	ed she should have measured			A medication pass observation	n	
	the amount of gel ac				was completed on 3/15/2022 I		
	_	rovided by the manufacturer.			the CSM on the need to		
		s measurement for 2 grams			ensuregels are labeled with ar	n	
	_	stration. Employee 3 pulled			open date and physician orde		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLETED	
			B. W	ING		02/24/2022	
						<i>52,24,</i>	
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF F	RO TIDER OR BUILDEN	·		425 CH	INWORTH CT		
LAKE CIT	TY PLACE			WARSA	AW, IN 46580		
					,		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the measuring device	ce out of the Diclofenac			are followed, including proper		
	Sodium gel box. It v				measuring of gel medication.	No	
	_	cation. No open date was on			concerns identified.		
	the box of the Diclo	-			concerns identified.		
	the box of the Dicio	orenae Sodium ger.			2 W/b of man and man will be much in	-4-	
	0.000,000	15 D. 16 11 11 11 11			3 What measure will be put in	IIO	
		25 P.M. a clinical record			place or what systemic		
		H was conducted. Diagnosis			changes the facility will make	e to	
		not limited to: hypertension,			ensure that the deficient		
	osteoarthritis, hypot	thyroidism and osteoporosis.			practice does not recur:		
	Resident H admitted	d to the facility on 8/30/21.			The CSM was reeducated by	the	
		r, dated 11/4/2021, indicated			Regional Director of Care		
		1% apply 2 grams topically			Services on 3/10/2022 on the		
		the right shoulder and upper			need to ensuregels are labele	d	
	·	the right shoulder and upper			with an open date and physici		
	arm.					all	
	0 0/00/0000 : 0.0				orders are followed, including		
		32 P.M., the Administrator			proper measuring of gel		
	provided a policy en				medication. Current staff who		
	Administration". Th	ne policy indicated, " The six			pass medications were		
	"right" of medicatio	on and treatments			reeducated by the CSM on		
	administration will	be observed every time a			3/16/2022 on the need to		
	medication is admir	nistered-right resident, right			ensuregels are labeled with ar	า	
		ose, right form and route,			open date and physician orde		
	right time, right doc		are followed, including proper				
	1.5.11 1.1110, 115.111 400		measuring of gel medication.				
					i measuring of ger medication.		
					A Llow the competitive actions	٠,	
					4 How the corrective action(s	•	
					will be monitored to ensure t		
					deficient practice will not rec	ur,	
					i.e., what quality assurance		
					program will be put into plac		
					b> to ensure physician orders	are	
					followed, including proper		
					measuring of gel medications	and	
					gel medications are labeled w		
					an open date. The observation		
					will occur 3 times per week for		
					weeks, 2 times per week for 4		
					weeks, then weekly for 4 weel		
					Results will be reviewed at mo	•	
					QI meeting. The QI Committee	e will	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER		425 CI	ADDRESS, CITY, STATE, ZIP CODE HINWORTH CT AW, IN 46580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				determine if continued intervie are necessary based on 3 consecutive months of compliance. Monitoring will be on-going.		
				5 By what date the systemic changes will be completed Completion date: 3/26/2022		
R 0246	410 IAC 16.2-5-4(, , ,				
Bldg. 00	by a qualified med upon authorization physician. The QM appropriate author administration of a contacts with a nur premises for author PRNs shall be door	ns may be administered ication aide (QMA) only by a licensed nurse or IA must receive				
	facility failed to ens needed medications	iew and interview, the ure authorizations for as administered by a qualified	R 0246	R 246 Health Services - Deficiency	03/26/2022	
	medication aide wer record in 1 of 5 resid medications. (Resid			What corrective action(s) we be accomplished for those residents found to have been affected by the deficient		
	Finding includes:			practice: Resident F was assessed for		
	3:35 P.M., and indicincluded, but not lin hypertension, and proceedings of the Physician of	s reviewed on 2/23/2022 at eated Resident F diagnoses nited to: Parkinson's disease, rosthetic heart valve. an Orders, dated ed she was receiving Tylenol rams) 2 caplets every 6 hours		injury and adverse drug reaction 3/16/2022 by Care Service Manager (CSM). None noted. The QMA was reeducated on 3/15/2022 by the CSM on the need to ensure authorizations as needed medications administered by a qualified	s	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00		COMPLETED	
			B. WI			02/24/2022	
						02/2 1/2022	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					IINWORTH CT		
LAKE CI	TY PLACE			WARSA	AW, IN 46580		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROWIDEDIC DI ANI OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	as needed for pain.				medication aide are documer	nted	
					in the medical record.		
	A Medication Administration Record dated,						
	2/2022, indicated F	Resident F had received the			2 How the facility will ident	ify	
	pain medication on	1 2/14/2022 which was			other residents having the		
	administered by a	QMA (qualified medication			potential to be affected by the	he	
	aide).				same deficient practice and		
					what corrective action will b	e	
	Resident F's Physic	cian Orders, dated 1/5/2022,			taken:		
	indicated she was r	receiving Norco (a narcotic)			/p>		
	10/325 mg (milligr	rams) 1 tablet every 4-6 hours					
	as needed.				3 What measure will be put	into	
					place or what systemic		
	A Medication Adm	ninistration Record dated,			changes the facility will make	re to	
	2/2022, indicated F	Resident F had received the			ensure that the deficient		
	narcotic medication	n on 2/22/2022 which was		practice does not recur:			
	administered by a	QMA.			The CSM was reeducated on		
					3/10/2022 by the Regional		
	During an interview	w, on 2/23/2022 at 4:42 P.M,			Director of Care Services (RD	DCS)	
		rsing indicated that the as			on the need to ensure		
	-	d Norco were administered for			authorizations for as needed		
		e documentation should have			medications administered by	a	
	been on the back of				qualified medication aide are		
		cord, and had not been			documented in the medical		
	authorized by a nur	rse.			record. No additional QMA's		
					currently providing services to	o the	
	-	w, on 2/24/2022 at 9:24 A.M.,			community.		
		rsing indicated that the					
		the as needed medication			4 How the corrective action(
		mented anywhere else. She			will be monitored to ensure		
	-	not have a policy but follow the			deficient practice will not re	cur,	
	Qualified Medicati	on Scope of Practice.			i.e., what quality assurance		
					program will be put into place	ce:	
		25 A.M., the Director of			/p>		
		a scope of practice titled,					
		tion Aide Scope of Practice",			5 By what date the systemic	;	
		ated it was the one currently			changes will be completed		
	-	The scope of practice			Completion date: 3/26/2022		
		Administer previously ordered					
	pro re nata (PRN) i	medication only if					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/24/2022	
	ROVIDER OR SUPPLIER		425 CH	ADDRESS, CITY, STATE, ZIP CODE HINWORTH CT AW, IN 46580	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
R 0273 Bldg. 00	licensed nurse on do is obtained, the QM Document in the resindicating the need symptoms occurred resident record that was contacted, symptoms occurred resident record that was contacted, symptoms occurred resident record that was contacted, symptoms on the cach time the symptom (D) Ensure the resident the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called to great the licensed nurse we end of the nurse's should be called the nurs	and Services - Deficiency ation and serving areas in residents ' units) are ordance with state and id safe food handling ing 410 IAC 7-24. In and interview, the facility intary food service to 12 of ind for food delivery service. In 12:10 P.M. through 12:25 in in incompany the service was observed in in. Employee 8 was observed eyond the rim of the plate	R 0273	R 273 Food and Nutritional Services - Deficiency 1. What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice: Employee 8 was reeducated of 3/14/2022 by the Executive Director (ED) on the need to provide sanitary food service. 2 How the facility will idention other residents having the potential to be affected by the service of the potential to be affected by the service of the potential to be affected by the services.	n on fy

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A. BUILDING 00 COMPLETED B. WING 02/24/2022
STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580
ID PROVIDER'S PLAN OF CORRECTION PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE
same deficient practice and what corrective action will be taken: The ED completed an observational audit of meal service on 3/16/2022 to ensure sanitary food service is provided. Concerns identified were corrected. 3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Current staff were reeducated on 3/16/2022 by the ED to ensure sanitary food service is provided. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ="" p=""> 5 By what date the systemic changes will be completed Completion date: 3/26/2022
L N)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/24/2022			
NAME OF PROVIDER OR SUPPLIER LAKE CITY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	legally authorized (4) The name and resident 's physic (5) The name and family members of contacted in the edeath. (6) Information on (7) A photograph resident). (8) Copy of advar Based on record refacility failed to ensinformation was proportional information File for (Residents B, C, D, Findings include: 1. On 2/23/2022 at review of Resident included, but not linear cardiomyopathy. Resident C was addressed for the cardiomyopathy. Resident C was addressed for the cardiomyopathy. Resident C was addressed for the cardiomyopathy. During an interview the Director of Nurdirective was not in directive should have Emergency Information File indirective should have Emergency Information formation	phone number of the ian of record. Itelephone number of the rother persons to be vent of an emergency or any known allergies. (for identification of the roce directives, if available. View and interview, the sure that all the required ovided in the Emergency of 4 out of 5 records reviewed. F) 2:25 P.M. a clinical record C was conducted. Diagnosis mited to: dyslipidemia and mitted to the facility on w of the Emergency dicated that an advance recluded. V on 2/23/2022 at 2:34 P.M., sing indicated that an advance we been available in the	R 0356	R 356 Clinical Records - Noncompliance 1. What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice: The emergency information of for resident C was updated we an advanced directive on 3/16/2022 by the Care Service Manager (CSM). The emergency information of for resident D was updated we an advance directive and resinformation sheet including, funeral home and hospital preference on 3/16/2022 by the CSM. The emergency information of for resident F was updated we advance directive and reside information sheet including, funeral home preference on 3/16/2022 by the CSM. Resident B no longer resides the community effective 3/10.	ile vith ces ile vith ident he ile ith an nt		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
THIS TERM OF CORRECTION				B. WING		02/24/2022	
							.022
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF TROVIDER OR SOFT EIER				425 CH	IINWORTH CT		
LAKE CI	TY PLACE			WARSA	AW, IN 46580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		AIE	DATE			
	hypertrophy, and do	epression.					
		•					
	Resident D was adr	nitted to the facility on			2 How the facility will ident	ify	
		iew of the Emergency File			other residents having the	·	
		lvance directive, a resident			potential to be affected by the	ne	
		ncluding: funeral home and			same deficient practice and		
		the Emergency Information		what corrective action will be		e	
	File.	z ,			taken:		
	The.				An audit of emergency		
	During an interviev	v on 2/23/2022 at 3:25 P.M.,		information files for current			
	_	rsing indicated that an		residents was completed on			
	advance directive, funeral home and hospital			3/13/2022 by the Administrative		ve	
	should have been available in the Emergency			Coordinator to ensure all required		I	
	Information File.			information is provided in the			
	information i ne.			emergency information file.			
	3. On 2/23/2022 at 3:40 P.M., a clinical record			Results reviewed by the Executive		cutive	
	review of Resident F was conducted. Diagnoses			Director and concerns identified			
	included, but not limited to: Parkinson's disease,				will be corrected by 3/26/2022		
	hypertension and prosthetic heart valve.				3 What measure will be put into		
	71				place or what systemic		
	Resident F was adn	nitted to the facility on			changes the facility will mak	ce to	
	11/3/2021 A review of the Emergency				ensure that the deficient		
	Information File indicated that an advance				practice does not recur:		
	directive, a resident information sheet including:			The CSM was reeducated on			
	funeral home was not in the Emergency			3/10/2022 by the Regional			
	Information File.				Director Clinical Services (RDCS)		
				on the need to ensure an		,	
	During an interview on 2/23/2022 at 4:19 P.M.,			emergency information file for		r	
	the Director of Nursing indicated that an advance			each residents is complete wit		ith	
	directive and the funeral home should have been			the required information.			
	available in the Emergency Information File.4.						
	On 2/23/2022 at 1:39 P.M., a clinical record			4 How the corrective acti		(s)	
	review of Resident B was conducted. Diagnosis			will be monitored to ensure the			
	included, but were not limited to: diabetes			deficient practice will not recur,			
		's disease and osteoarthritis.			i.e., what quality assurance		
					program will be put into place	ce:	
	Resident B was adr	nitted to the facility on			Effective 3/28/22, the CSM or	-	
		w of the Emergency			designee will audit emergenc	I	
		dicated that an advance			files weekly for 4 weeks, biweekly		
	directive, a resident information sheet including:				for 4 weeks, then monthly for	4	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	-	LETED	
			B. WING		. 02/24	/2022
NAME OF P	DOMDED OF CLIPPLIED		STREET	ADDRESS, CITY, STATE, ZIP CO	DE	
NAME OF P	PROVIDER OR SUPPLIER		425 CH	HINWORTH CT		
LAKE CITY PLACE			WARS	AW, IN 46580		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ECTION OULD BE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	the resident's name,	sex, room, phone number,		weeks to ensure require	:d	
		ere not in the Emergency		information is included in		
	Information File. A	Also, not included in the		emergency information f	file.	
	Emergency Informa	ation File were the hospital		Results will be discusse	d in	
	preference, legal rep	presentatives, resident's		monthly QI meeting. The	e QI	
	physician, emergen	cy contacts, and photograph.		Committee will determin	e if	
				continued auditing is ne	cessary	
	_	on 12/23/2022 at 2:40 P.M.,		based on 3 consecutive		
		sing indicated the required		compliance. Monitoring		
	information should			on-going.		
	Emergency Informa	ation File.				
				5 By what date the syst		
		7 P.M., a policy for		changes will be comple		
		ation was requested and one		Completion date: 3/26/2	022	
	-	The administrator indicated				
	the facility followed	I the state regulation.				
R 0410	410 IAC 16.2-5-12	2(e)(f)(g)				
	Infection Control -					
Bldg. 00		uberculin skin test shall be				
Ŭ	. ,	hree (3) months prior to				
		admission and read at				
	forty-eight (48) to	seventy-two (72) hours.				
	The result shall be	e recorded in millimeters of				
	induration with the	e date given, date read, and				
	by whom administ	ered and read.				
	(f) For residents w	ho have not had a				
		tive tuberculin skin test				
		receding twelve (12)				
		ine tuberculin skin testing				
		two-step method. If the				
		ve, a second test should be				
	•	one (1) to three (3) weeks				
		The frequency of repeat				
		d on the risk of infection				
	with tuberculosis.					
	107	ho have a positive reaction				
		kin test shall be required to				
		and other physical and				
	i aporatory examin	ations in order to complete				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WING			02/24/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
LAKE CITY PLACE					IINWORTH CT		
LAKE CI	I Y PLACE			WARSA	AW, IN 46580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	a diagnosis.						
	Based on record review and interview, the		R 04	410	R 410 Infection Control -		03/26/2022
	facility failed to ens	sure resident received timely		Noncompliance		ļ	
	Mantoux Tuberculosis screenings for 2 of 7						
	records reviewed. ((Resident B & G)			1. What corrective action(s)	will	I I
				be accomplished for those			
	Findings include:			residents found to ha		1	
			affec		affected by the deficient		
	1. On 2/23/2022 at	2:45 P.M., a clinical record			practice:		
	review for Resident				Resident B no longer resides		
	"	I, but not limited to:			the community effective 3/10/2	2022	
	dementia, major depression and schizophrenia.						
					Resident G no longer resides		
	Resident G was admitted to the facility on				the community effective 1/31/2	2022	
	9/23/2021. A Tuberculosis Testing and Vaccine						
	Consents and Records form for Resident G						
	indicated she received a Mantoux (skin test for				2 How the facility will identi	fy	
	tuberculosis) 1st step on 9/23/2021 and read on				other residents having the		
	9/26/2021 with negative results. This form				potential to be affected by th	е	
	lacked the documentation to show a 2nd step			same deficient practice and			
	Mantoux had been administered to Resident G.				what corrective action will be	9	
	2/22/22/2				taken:		
	During an interview on 2/23/2022 at 3:15 P.M.,				An audit of resident Mantoux		
		sing indicated that Resident G			Tuberculosis screenings was		
	should have had a second step administered 1 to			completed on 3/16/2022 by			
	3 weeks after the first step.			Executive Director (ED) to e			
	2. On 2/23/2020 at 1:39 P.M. a clinical record			residents receive timely N			
	review of Resident B was conducted. Diagnosis			Tuberculosis screening			
	included, but were not limited to: diabetes			reviewed and concerns i		iea	
	mellitus, Parkinson's disease and osteoarthritis.				were corrected.		
	Dagidant Dayas adı	witted to the facility on			2 What magazine will be put in	nto	
	Resident B was admitted to the facility on				3 What measure will be put in	iilo	
	1/28/2021. An initial tuberculosis screening test				place or what systemic changes the facility will mak	o to	
	was performed on 1/28/2022. The tuberculosis test was read on 1/30/2022 with a negative result			ensure that the deficien		- 10	
		ne was indicated for					
		eading. A second Mantoux		practice does not recur: The CSM was reeducated on			
	was not administere				3/10/2022 by the Regional		
	was not auministere	ou.			Director of Care Services (RD	CS)	
	During an interview	v on 2/23/2022 at 3:05 P.M.,			on the need to ensure residen	•	
	During an interview	v 011 2/23/2022 at 3.03 F.WI.,	- 1		I on the need to ensure residen	w	I

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		02/24/2022	
			_		JEIL IILOLL	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
			425 CH	INWORTH CT		
LAKE CI	TY PLACE		WARS	AW, IN 46580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	the Administrator is	ndicated Resident B should		receive timely Mantoux		
		ond step tuberculosis test.		Tuberculosis screenings.		
				Licensed nursing staff were		
	A policy was reque	sted on 2/23/2022 at 2:17		reeducated 3/16/2022 by the		
		rator indicated that the State		CSM on the need to ensure		
		llowed regarding resident		residents receive timely Manto	oux	
	-	ings. A policy was requested		Tuberculosis screenings.		
	and not provided.	<i>C</i> 1 <i>J</i> 1]		
				4 How the corrective action(s)	
				will be monitored to ensure	•	
				deficient practice will not red		
				i.e., what quality assurance	,	
				program will be put into place	e:	
				Effective 3/28/22, the CSM or		
				designee will audit resident		
				Mantoux Tuberculosis to ensu	ıre	
				residents receive timely Manto	I	
				Tuberculosis screenings. The		
				audit will occur weekly for 4		
				weeks, biweekly for 4 weeks,	then	
				monthly for 4 weeks. Results		
				be reviewed at monthly QI		
				meeting. The QI Committee w	vill l	
				determine if continued intervie		
				are necessary based on 3		
				consecutive months of		
				compliance. Monitoring will be	,	
				on-going. I will do this audit m		
				frequently and trend down like		
				your other audits, this will help		
				identify any residents out of		
				compliance quicker		
				5 By what date the systemic		
				changes will be completed		
				Completion date: 3/26/2022		
				'		
			1			

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