STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/22/2024	
NAME OF P	ROVIDER OR SUPPLIEI PLACE	3		460 FO	ADDRESS, CITY, STATE, ZIP COD RKS OF THE WABASH WAY NGTON, IN 46750			
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
Bldg. 00	Survey.  Survey dates: Nove Facility number: 00 Residential Census These State Resideraccordance with 41	: 23 ntial Findings are cited in 0 IAC 16.2-5.	R 00	000				
R 0042 Bldg. 00	Quality review completed December 2, 2024.  410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance  Based on observation and interview, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 23 of 23 residents residing in the facility.  Findings include:  During an observation, on 11/21/24 at 11:12 a.m., a sign on the wall by the facility's front desk indicated State Survey results were located at the facility's front desk located by the main facility entrance. No State Survey results were observed to be at the front desk.  During an observation, on 11/21/24 at 2:55 p.m., no State Survey results or staff personnel were visible at the facility's front desk.  During an observation, on 11/21/24 at 4:30 p.m.,		R 00	042	R 042 410 IAC 16.2-5-1.2(p) Residents' Rights – Noncompliance  1 What corrective action(s) will be accomplished for tho residents found to have been affected by the deficient practice: The State Survey Binder for T place was immediately moved from behind the partition and side prominently displayed at the front desk by the main entrance. The sign will remain on the way exhibiting the State survey bir to ensure that this book will be readily accessible to all reside family members, visitors and side members.	ripton d will ne ce. all nder e ents,	01/15/2025	

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

TITLE (X6) DATE

Melissa Quinn Executive Director 12/17/2024

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 1 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		11/22/	2024
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	£			RKS OF THE WABASH WAY		
TIPTON	PI ACE				NGTON, IN 46750		
111 1011				1			
(X4) ID		STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	1	were not visible at the					
	facility's front desk.				2 How the facility will		
	During an observation, on 11/22/24 at 9:05 a.m., no				identify other residents having	-	
	1	on, on 11/22/24 at 9:05 a.m., no or staff personnel were			the potential to be affected b	-	
	visible at the facility	-			the same deficient practice a		
	visible at the facility	y 5 Holl desk.			what corrective action will be taken:	<i>;</i>	
	During an interview	y, on 11/22/24 at 12:13 p.m., the			This Binder will be prominently	,	
		sistant procured the binder			displayed and will be in an are		
		Survey results from behind a			that can be viewed without an		
	_	edge of the front desk from a			visual hindrances or difficulty v	-	
	_	cument was in front of the			physical accessibility		
	_	I the binder from view. The			F, 5.54. 45555515111.y		
		each from the resident/visitor			3 What measure will be pu	ıt	
		k. The Business Office			into place or what systemic	-	
		the binder had previously			changes the facility will make	9	
		other side of the desk.			to ensure that the deficient		
					practice does not recur:		
	During an observati	on, on 11/22/24 at 1:32 p.m.,			The BOA will be responsible for	or	
	the survey results re	emained behind a document in			checking the location of the bi	nder	
	_	ind the partial wall on the front			each day. The BOA will make		
		vey results were not visible or			sure that the binder and the		
		he resident/visitor side of the			signage remains in place for a		
	_	rsonnel were not manning the			view. All staff, including the B0		
	desk.				will be in-serviced and educate		
					on placement of this book and		
	1	y, on 11/22/24 at 4:40 p.m., the			ensuring its availability at all		
		ated the sign on the wall			times. This training for all staff		
	I	results were at the desk. If			take place Thursday, Decemb	er	
		e State Survey results, they			19, 2024, by the Executive		
		he facility staff. The facility			Director		
	1	y on posting the State Survey			4 11		
	results. The facility	followed the state regulations.			4 How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice		
					will not recure, i.e., what	/ill	
					quality assurance program w	/111	
					be put into place: An audit sheet was created for	r	
					monitoring purposes. The bind	ıcı	

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 2 of 13

PRINTED: 12/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>00</u>	COMPLETED
			B. WING		11/22/2024
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S DEAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	COMPLETION
TAG	REGULATORY OR	OR LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY)	DATE
R 0120	410 IAC 16.2-5-1.	4(e)(1-3)		monitor will be added to the BOA's daily checklist and wireviewed monthly during the quality / safety meeting to end the binder is up to date and accessible to all. The newly initiated audit sheets will be monitored daily for three we weekly for three weeks then monthly for four months. Fin suggestive of compliance wiresult in cessation for monitored to the system of the system	eks, dings II oring emic
	Personnel - Nonco				
Bldg. 00	Based on interview and record review, the facility failed to ensure required dementia training was completed for 2 of 5 employee records reviewed (QMA 4 and CNA 5).  The employee record list, provided by the Administrator on 11/21/24 at 10:20 a.m., indicated QMA 4 was hired on 12/20/16 and CNA 5 was hired on 11/9/23.  1. Review of QMA 4's in-service records, provided		R 0120	R 120 410 IAC 16.2-5-1.4(e) Personnel – Noncompliand  1 What corrective action will be accomplished for the	e n(s) ose
				residents found to have be affected by the deficient practice: b> All employees are require have accurate, complete traper state regulations.	ed to
		or, on 11/22/24 at 10:53 a.m.,		F =	
	-	ad a total of 1.5 hours of		2 How the facility will	
	annual dementia tra			identify other residents have	/ing
		s in-service record, provided by on 11/22/24 at 11:15 a.m.,		the potential to be affected the same deficient practice what corrective action will	by and

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 3 of 13

PRINTED: 12/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/22/2024		
	FPROVIDER OR SUPPLIEI	<b>?</b>	•	STREET ADDRESS, CITY, STATE, ZIP COD 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750			
	SUMMARY (EACH DEFICIEN REGULATORY OF indicated QMA 4 chours of dementia to 2. Review of CNA by the Administrate indicated CNA 5 he dementia training if She completed an a dementia training frafter hire.  During an interview Administrator indicated the in-services completed in-services Completed in-services During an interview Administrator indicated in-services Administrator indicated in-services Completed in-servi	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  completed an additional 0.75  raining on 11/22/24.  5's in-service record, provided  or, on 11/22/24 at 10:53 a.m., ad completed 2.25 hours of in the first six months after hire. additional 1.75 hours of following the first six months  ov, on 11/22/24 at 2:15 p.m., the cated she was unable to retrieve inpleted prior to 1/1/24 from the e provider.  ov, on 11/22/24 at 4:40 p.m., the cated she was still unable to in-services prior to 1/1/24. The e a policy on dementia training.		460 FO	RKS OF THE WABASH WAY NGTON, IN 46750  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  taken: All employees identified as non-compliance with Inservice education will be corrected an compliance by the date of correction.  3 What measure will be pure into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Executive Director will aurall employee files to ensure the dementia specific training is completed per state regulation all current employees. Will conduct a monthly All Star meetings to include 2 hours of dementia specific training in addition to company assigned dementia to be covered through the year.  4 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program when the put into place: All employee files will be audit	e d in  ut  e  dit at at ff f ghout	(X5) COMPLETION DATE
					weekly for 4 months, then more for 4 months and then quarter thereafter for 100% compliance.  5 By what date the system changes will be completed: 1/15/2025	ly ce.	

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 4 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
			B. Wl	NG		11/22/2024		
				_				
NAME OF P	ROVIDER OR SUPPLIER	Ł			ADDRESS, CITY, STATE, ZIP COD			
					ORKS OF THE WABASH WAY			
TIPTON F	PLACE			HUNIII	NGTON, IN 46750			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENC DI AM OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE	
R 0217	410 IAC 16.2-5-2(							
	Evaluation - Defici							
Bldg. 00		,						
Ŭ	Based on record review and interview, the facility		R 02	217	R 217 410 IAC 16.2-5-2(e)(1-5	)	01/15/2025	
		vice plans were reviewed with	110	,	Evaluation- Deficiency		01/10/2020	
		their representative and						
		ignature for 3 of 6 residents						
		e plans. (Residents 5, 6, and 8).			1 What corrective action(s	s)		
					will be accomplished for thos			
	Findings include:				residents found to have beer			
					affected by the deficient			
	1. Resident 5's clini	cal record was reviewed on			practice:			
	11/21/24. Diagnose	s included diabetes mellitus			All Service plans deficient of a	1		
	type 2, hypertension, hypothyroidism, seizure				signature will be made complia			
disorder, muscle weakness and chronic pain.		eakness and chronic pain.			by 1/15/2025			
	His service plan wa	s dated 4/30/24 and lacked						
	signatures by the A	dministrator and the resident						
	or his representative	e.			2 How the facility will			
					identify other residents havir	ng		
	-	y, on 11/22/24 at 2:15 p.m., the			the potential to be affected b	y		
		ated she was unable to find			the same deficient practice a	nd		
		service plans prior to			what corrective action will be	<b>)</b>		
	September 2024.				taken:			
					On 12/09/2024, an audit of			
		cal record was reviewed on			completed service plans for all			
	11/21/24. Diagnose				residents was conducted by th	ıe		
	hypertension (high				Wellness Director identifying			
		th levels of fat or lipids in the			missing signatures. All deficier			
	**	urrent falls and muscle			Service plans will be signed ar	nd		
	weakness.				compliant by 1/15/2025			
		as dated 4/6/24 and signed by						
		n 4/12/24. The service plan						
	was not signed by the	he resident or her			1			
	representative.				3 What measure will be pu	Jt		
	TT ' ' '	1 , 11/0/04			into place or what systemic			
	• •	an was dated 1/8/24 and signed			changes the facility will make	ə		
		or on 1/10/24. The service plan			to ensure that the deficient			
	was not signed by the	ne resident or her			practice does not recur:			
representative.				All resident care plans upon				

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 5 of 13

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		11/22/	/2024
NAMEOU	DDOVIDED OF GURDINE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	ζ.		460 FO	RKS OF THE WABASH WAY		
TIPTON	PLACE			HUNTII	NGTON, IN 46750		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	D	11/22/24 + 2 15 4			completion will be reviewed a	nd	
		v, on 11/22/24 at 2:15 p.m., the cated she found the service			discussed with facility and		
					resident or representative at		
	plans in a filing car	pinet, but they were unsigned.			assigned CP meeting within 7		
	3 Resident Via alim	ical record was reviewed on			days of assessment completion		
		AM. Diagnoses included			A signature will be obtained a time. If Representative decline		
		nutrition, chronic obstructive			meeting, a discussion will occ		
	_	(lung disease that makes it			regarding any changes made		
		d congestive heart failure.			the care plan, notation will be		
	land to oreatine), an				made of who the changes we	re	
	A service plan, date	ed 9/30/24, was signed by the			communicated to, and a copy		
	resident representative on 9/30/24. The physical				the completed service plan wi		
	clinical record lacked biennial assessments and				mailed to obtain signature.		
	corresponding serv						
		e plan, dated 5/12/24, provided					
	·	or on 11/22/24 at 2:15 p.m.,			4 How the corrective		
		ent had a total score of 50			action(s) will be monitored to		
		provided (to demonstrate a			ensure the deficient practice	)	
	level of services red	quired).			will not recure, i.e., what		
	l	1 1 1 1 ( 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			quality assurance program v	vill	
		e plan, dated 6/27/24, provided			be put into place:		
		or, on 11/22/24 at 2:15 p.m.,			A Resident tickler system was	-	
		ent had a total score of 60			into place and a monthly list w		
	points for the service	ces provided.			be created. Weekly audits will	ре	
	The increase in	vices provided from 5/12/24			completed by the Wellness		
		vices provided from 5/12/24			Director to ensure service pla	IIS	
		ring: The resident went from atly to requiring physical			are compliant per policy.		
		wers. The resident had an			The Wellness Director or		
		illnesses. The resident			designee will audit random Se	rvice	
		e in staff member assistance			Plans monthly for 6 months. T		
	with medication ad				monthly list will be reviewed a		
					QI meeting monthly to ensure		
	During an interview	v, on 11/22/24 at 2:15 p.m., the			100% compliance. Findings		
		cated she had been unable to			suggestive of compliance will		
		plans for the resident. She had			result in cessation for monitor	ina	
	_	-			plans at that time	<del>9</del>	
	printed off service plans from the computer to				p.a.io at that mile		

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 6 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG _		11/22/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			RKS OF THE WABASH WAY		
TIPTON I	PLACE				NGTON, IN 46750		
	Littol			1101111	101011, 111 10700	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		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		LETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	D/	ATE
During an interview, on 11/22/24 at 2:38 p.m., the Administrator indicated the service plans were discussed with the resident and resident representative but could not find signed ones.  A facility policy, dated 6/10/24 and titled "Assessment and Service Plan Policies," provided by the Administrator on 11/22/24 at 4:53 p.m., indicated the following:"Whenever an Assessment is updated the Service Plan should also be updated"  410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance				5 By what date the system changes will be completed 1/15/2025	nic		
	interview, the facili were administered a guidelines for 1 of 5 15).  Findings include:  During a medication on 11/22/24 at 11:1 observed:  QMA 4 prepared a pen for Resident 15 dial up the units bef medication into the her error and remover resident's skin. She and injected the mearm. She did not prout the used pen necunits.	on, record review, and ty failed to ensure medications according to professional 5 residents reviewed (Resident administration observation 5 a.m., the following was  Humalog (short acting insulin) to inject 25 units. She did not fore trying to administer the resident's left arm. She realized and the needle from the then dialed up the 25 units dication into the resident's left rime the insulin pen or switch edle before injecting the 25	R 02	296	R 296 410 IAC 16.2-5-6(b) Pharmaceutical Services – Noncompliance  1 What corrective action(s will be accomplished for thos residents found to have beer affected by the deficient practice: /p>  2 How the facility will identify other residents having the potential to be affected by the same deficient practice a what corrective action will be taken: Residents receiving insuling injections via pen have the potential to be affected. The Director of Health & Wellry will initiate education on Medication Errors, proper medical.	s) se n ng yy nd s	5/2025

State Form Event ID: 6C5511 Facility ID: 003376 If continuation sheet Page 7 of 13

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
			B. W			11/22/		
					_		-	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD			
TIDTON	DI 4.05				RKS OF THE WABASH WAY			
TIPTON	PLACE			HUNTII	NGTON, IN 46750			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	QMA 4 states she s	should have primed the			procedures to be followed who	en		
	Humalog pen with 2 units before administering the				administering medication to al	I		
	medication.				facility LPN's and QMA's on			
					12/19/2024 at the monthly all-	staff		
	During an interview	v, on 11/22/24 at 11:30 a.m.,			meeting and signatures will be	)		
	QMA 4 indicated s	he should have changed the			obtained. Any staff who have	not		
	pen needle before a	dministering the medication.			participated in the education w	vill		
					not be allowed to work until it	has		
	Resident 15's medie	cation orders were reviewed on			been completed. This education	on		
	11/22/24 at 11:20 a	.m. She had a current physician			will also be added to the new	hire		
	order for, but not li	mited to, Humalog (short acting			orientation checklist			
	insulin) 25 units su	bcutaneously daily before						
	lunch.							
					3 What measure will be pu	ut		
	During an interview	v, on 11/22/24 at 2:45 p.m., the			into place or what systemic			
	Corporate Nurse in	dicated QMA 4 should have			changes the facility will mak	е		
	primed the pen and	changed out the pen needle			to ensure that the deficient			
	before administerin	g the medication.			practice does not recur:			
					Director of Health & Wellness	will		
	A Cleveland Clinic	document titled "Insulin			ensure that all staff are educa	ted		
	Pens," dated 2/12/2	4, was retrieved on 11/25/24			and aware of proper technique	e and		
	from				procedure by administering			
	https://my.clevelan	dclinic.org/health/treatments/1			Medication administration			
		njections. The guidance			competencies for all licensed			
		les for insulin pens are single-			LPN's and QMA's to be			
		you only use them for one			completed by 1/15/2025 and t	hen		
		hrow them away. Each needle			quarterly thereafter			
		rotective container Prime the						
	_	g means removing air bubbles			4 How the corrective			
		ensures that the needle is open			action(s) will be monitored to	)		
		must prime the pen before each			ensure the deficient practice			
		the insulin pen, turn the			will not recure, i.e., what			
	dosage knob to the	2 units indicator"			quality assurance program v	vill		
					be put into place:			
					Insuli Administration performa			
					will be monitored by the Direct			
					Health & Wellness once week	ly		
					for four weeks, biweekly for 4			
					weeks then monthly for 4 mon			
					to ensure 100% compliance. A	All .		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		11/22/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8		460 FORKS OF THE WABASH WAY			
TIPTON I	PLACE				NGTON, IN 46750		
(X4) ID		STATEMENT OF DEFICIENCIE		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	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					findings of concern will be		
					immediately addressed and discussed at monthly safety		
					committee meetings		
					Committee meetings		
					5 By what date the systen	nic	
					changes will be completed		
					1/15/2025		
R 0328	410 IAC 16.2-5-7.						
Bldg 00	Activities Program	ns - Noncompliance					
Bldg. 00	Based on interview	and record review, the facility	R 0	220	R 328 410 IAC 16.2-5-7(c)(1-3	.	01/15/2025
	failed to employ an		K U	328	Activities Programs -	'	01/13/2023
	ianea to employ an	ricavity Bucción			Noncompliance		
	Findings include:				Transcampinance		
					1 What corrective action(s	s)	
	During an interview	v, on 11/21/24 at 10:55 a.m., the			will be accomplished for tho	-	
	Administrator indic	ated the facility did not			residents found to have been	ı	
	currently have an A	ectivity Director.			affected by the deficient		
					practice:		
	_	v, on 11/22/24 at 2:45 p.m., the			An activity calendar was/is in		
		sistant indicated the Activity			place and activities are carried		
	Director position na	nd been vacant since 3/1/24.			by team members. Activities w		
	During an interview	v, on 11/22/24 at 4:43 p.m., the			continue daily, as well as effor recruit a qualified activity direction.		
	_	rated they did not have anyone			Activity Program Calendars wi		
		ctor position. A regional staff			reviewed, approved, and sign		
	-	facility monthly to discuss any			on by activity director within	54 511	
		wed the activity calendar			company that meets the State		
	uploaded by the fac	ility. The facility did not have			requirement by holding a		
		employment of an Activity			certification through the Nation	nal	
	Director.				Certification Council for Activit		
					Professionals.		
		b description, provided by the					
		1/22/24 at 4:53 p.m., indicated "			2 How the facility will		
		ng, scheduling and conducting			identify other residents having	_	
		de physical, intellectual,			the potential to be affected b	-	
		nd spiritual opportunities for			the same deficient practice a		
	the resident's"				what corrective action will be	Э	

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY LETED 2/2024
NAME OF PI	ROVIDER OR SUPPLIE	R	STREET 460 FC			
TIPTON F	PLACE			NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				taken: An activity calendar was place and activities are by team members. Exe Director will monitor job and continue recruitment a qualified activity direct Executive Director will monthly activity program reviewed, approved, and on by Certified Activity before implementation.  3 What measure will into place or what systic changes the facility with to ensure that the definition practice does not recut Executive Director will repostings and continue refforts for a qualified activity reviewed, approved, and on by Certified Activity reviewed, approved, and on by Certified Activity before implementation.  4 How the corrective action(s) will be monitiensure the deficient program computed by the put into place: Activity program computed by the Executive Director to ecompliance. Executive Director will repostings and applicants until an Activity Director.	carried out cutive postings nt efforts for efforts ensure m is d signed off Director  II be put temic iII make cient ir: monitor job recruitment citivity ector will program is ed signed off Director  re ored to ractice nat gram will  pliance he ensure  monitor job is weekly	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/22/2024	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD DRKS OF THE WABASH WAY		
TIPTON	PLACE		HUNTI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
R 0407 Bldg. 00	410 IAC 16.2-5-12 Infection Control -	2(b)(1-4)	TAU	Executive Director will monitor activity program on a monthly basis to ensure the program here been reviewed, approved, and signed off on by a qualified st member. Monitoring will contion a monthly basis until 6 mo of compliance has been achie or a qualified Activity Director been hired.  5 By what date the system changes will be completed 1/15/2025	r the  nas d aff nue nths eved, has	
Blag. 00	failed to ensure a sy patterns of infection	and record review, the facility versem was in place to analyze a prior to September 2024 for urrently residing in the facility.	R 0407	R 407 410 IAC 16.2-5-12(b)(1 Infection Control - Noncompliance	-4) 01/15/2025	
	provided by the Ad 10:20 a.m., was rev The binder contains corresponding facil 11/2024. The binde prior to 9/2024.  During an interview	tled "Infection Control," ministrator on 11/21/24 at iewed on 11/22/24 at 9:58 a.m. ed surveillance line lists and ity maps from 9/2024 through r contained no documentation  7, on 11/22/24 at 10:39 a.m., the dicated she worked primarily in		1 What corrective action( will be accomplished for the residents found to have bee affected by the deficient practice: The Director of Hea Wellness was reeducated on policies, procedures & state regulations pertaining to Infect control tracking.  2 How the facility will identify other residents havi	se n Ith & stion	
	another facility and infection control su	began completing the rveillance in October to assist ey were attempting to hire a		the potential to be affected to the same deficient practice a what corrective action will b taken:  All residents had the potential	oy and e	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPLE	ETED
			B. WIN	1G		11/22/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			RKS OF THE WABASH WAY		
TIPTON	PLACE				NGTON, IN 46750		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview, on 11/22/24 at 11:15 a.m., the Administrator indicated she was unable to locate				be affected. The Director of H	ealth	
					& Wellness completed an		
		infection control surveillance			observational audit of infection		
		2024. The former DON was and had torn up and threw			control practices with resident		
	_	documents prior to leaving.			transmission based precaution	is	
		cally responsible for the			on 12/09/2024		
	infection control pr				3 What measure will be pu	ս	
	inicction control pr	~ <u></u>			into place or what systemic	u.	
	A facility policy da	ated 2/1/22, titled "Infection			changes the facility will mak		
		able Diseases," provided by			to ensure that the deficient	`	
		on 11/22/24 at 4:40 p.m.,			practice does not recur:		
		ving: "The Community will			The Director of Health & Wellr	ness	
		place to ensure a Resident			will re-educate staff by 1/15/20		
	_	sease is reported immediately			on corporate policy and state		
	appropriate infect	ion control procedures will be			regulations for tracking all		
	implemented as dire	ected by the local health			infections within the building to	o	
	authority"				ensure compliance.		
					An Infection tracking log and		
					community map for color codi	ng	
					has been initiated on all reside	ents	
					that live in the community.		
					4 How the corrective		
					action(s) will be monitored to	o	
					ensure the deficient practice	•	
					will not recure, i.e., what		
					quality assurance program v	vill	
					be put into place:		
					The Wellness Director will rev		
					both infection forms to ensure		
					proper infection control proced	dures	
					are being followed for 100%		
					compliance. These forms will		
					monitored weekly for 4 weeks		
					then biweekly for 4 weeks, the	11	
					monthly thereafter to ensure		
					constant compliance.		
					5 By what date the systen	nic	

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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 <u>00</u>		COMPLETED		
			B. WING		11/22/2024		
NAME OF PROVIDER OR SUPPLIER TIPTON PLACE				STREET ADDRESS, CITY, STATE, ZIP COD 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
					changes will be completed 1/15/2025		

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