STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KEYSTONE WOODS	2335 N MADISON AVE ANDERSON, IN 46011

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00393109. Complaint IN00393109 - Unsubstantiated due to lack of evidence. Survey dates: November 21 and 22, 2022 Facility number: 010409 Residential Census: 49 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 29, 2022.	R 0000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Keystone Woods LLC as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindi Cooper	Executive Director	12/14/2022

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

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure semi-annual assessments were completed for 1 of 2 residents reviewed for closed records. (Resident 55) Findings include: The clinical record for Resident 55 was reviewed on 11/22/22 at 10:15 a.m. The resident had moved out of the facility on 10/31/22. The last resident assessment, provided by the Director of Nursing (DON) on 11/22/22 at 2:44 p.m., was dated 2/28/22. During an interview, on 11/22/22 at 2:00 p.m., the DON indicated the assessment dated 2/28/22 for Resident 55 was the last assessment documented in the clinical record. The semi-annual assessment should have been completed in August, as they are to be completed every 6 months per facility policy. A current facility policy, dated 8/2017, titled "Occupancy Operations Manual," and provided	R 0216	R 216 1. Resident 55 is no longer residing in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Community will use Yardi to ensure semi-annual assessments are completed on time by tracking assessment due dates. In addition, the Community reviewed residents' charts to ensure the semi-annual assessment was updated as required. 4. The Wellness Director or designee will review Yardi weekly to ensure compliance. Yardi will	01/15/2023

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	by the DON on 11/22/22 at 2:31 p.m., indicated the following: "...NURSING ASSESSMENT... 1. Schedule the Initial Nursing Assessment (form HS 009) to be conducted on the Resident at the time of move in ....Follow the state licensing regulation and the State Nurse Act requirements. 2. Complete any additional assessments as determined by the initial and updated move in assessment, as needed...."		be reviewed weekly by Wellness Director or designee to ensure compliance. 5. Systemic changes date: January 15, 2023.	
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 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			

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	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 interview and record review, the facility failed to ensure Service Plans were signed by the resident or their representative for 4 of 7 residents reviewed for Service Plan development. (Residents 2, 7, 9, 31) Findings include: 1. Resident 31's clinical record was reviewed on 11/21/22 at 3:00 p.m. Current diagnoses included, but were not limited to, hypertension, diabetes, and hypothyroidism. The resident's current Service Plan was dated 10/18/22. The service plan was not signed by the resident or the resident's representative. 2. Resident 2's clinical record was reviewed on 11/21/22 at 2:00 p.m. Current diagnoses included, but were not limited to, atrial fibrillation, depression, and hypothyroidism. The resident's current Service Plan was dated 8/16/22. The service plan was not signed by the resident or the resident's representative. 3. Resident 9's clinical record was reviewed on 11/21/22 at 1:30 p.m. Current diagnoses included, but were not limited to, hypertension, and legally blind. The resident's current Service Plan was dated 5/17/22. The service plan was not signed by the resident or the resident's representative During an interview, on 11/22/22 at 10:53 a.m., the Director of Nursing (DON) indicated Residents 31, 2, and 9 did not have current signed Service Plans. 4. Resident 7's clinical record was reviewed on 11/22/22 at 9:37 a.m. Diagnoses included, but	R 0217	R 217 1. Residents 2, 7, 9, and 31's service plans are signed by the resident or their representative. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Wellness Director or designee will conduct monthly audits to ensure that service plans are signed by the resident or their representative. The Community will use Yardi to ensure semi-annual assessments are completed on time by tracking assessment due dates. 4. A monthly audit will be completed by Wellness Director or designee of service plans. Monthly audits well be completed to identify and ensure service plans are signed by residents or POA.	01/15/2023

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	were not limited to, hypertension and arthritis. Review of the resident's service plan, dated 9/16/22, lacked any acknowledgement signatures by the resident or the resident representative. Nurse's notes lacked any documentation of a refusal to sign the service plan. During an interview, on 11/22/22 at 11:13 a.m., the DON indicated Resident 7's service plan lacked any signatures. She should have asked the resident to sign the care plan when she completed the service plan. During an interview, on 11/22/22 at 1:10 p.m., the ED indicated the facility followed the Indiana Department of Health Regulations regarding service plans. A current policy, titled "Occupancy Operations Manual," provided by the DON on 11/22/22 at 2:31 p.m., indicated the following: "...Complete an Initial Service Plan for the Resident....Follow state regulation requirements.... Review with the Community Team Members and the Resident...."			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations;			

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	(B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to complete transfer/discharge documentation for 2 of 2 residents reviewed for closed records. (Residents 55 and 56) Findings include: 1. The clinical record for Resident 55 was reviewed on 11/22/22 at 10:14 a.m. Diagnoses included, but were not limited to, acute bronchiolitis, diabetes mellitus, and history of stroke. The resident moved out of the facility on 10/31/22. The clinical record lacked nursing progress notes following 4/20/22. The record lacked transfer/discharge documentation for the resident's move out date. During an interview, on 11/22/22 at 2:00 p.m., the Director of Nursing (DON) indicated she was unsure where the resident discharged to and the clinical record lacked documentation regarding her discharge. No further nursing progress notes were present in the clinical record after 4/20/22. 2. The clinical record for Resident 56 was reviewed on 11/22/22 at 9:45 a.m. Diagnoses included, but were not limited to, stroke affecting left side, atrial fibrillation, depression and anxiety. A nursing progress note, dated 8/3/22, indicated the resident was transferred to the emergency room on 8/3/22 for left ankle pain and inability to bear weight. During an interview, on 11/22/22 at 2:00 p.m., the DON indicated she was unsure where the resident	R 0354	R 354 1. Residents 55 and 56 are no longer residing in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff were in-serviced on resident transfer/discharged. 4. The Wellness Director or designee will monitor all potential transfer/discharges to ensure proper documentation and proper use of transfer/discharge form.	01/15/2023

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	transferred to following her transfer to the hospital. The clinical record lacked documentation of transfer to another facility, discharge from the facility, or communication with Resident 56's family. During an interview, on 11/22/22 at 2:08 p.m., the Administrator indicated the resident had left the facility to the hospital and did not return. She was unsure where she moved from the hospital, but thought it was a skilled facility. A current facility policy, dated 8/2017, titled "The Move-Out Process," provided by the DON on 11/22/22 at 2:31 p.m., indicated the following: "...Record Transfer 1. When the Resident moves to another location, provide the Resident and/or his/her family/significant other(s) with copies of thee Resident's most current physician orders, medication sheets and service plan and all records required by the state licensing regulation requirements. Record this in the Resident's Service Notes...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to			

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	public health authorities. Based on interview and record review, the facility failed to utilize proper infection prevention and control tracking and reporting for residents and staff with COVID-19. Findings include: Review of the facility Infection Control Log was completed on 11/22/22 at 2:05 p.m., accompanied by the DON. It lacked any documentation or tracking of COVID-19 residents or staff members. The DON indicated she was unable to find the requested Respiratory Surveillance Line Listing for all COVID-19 positive residents and staff. The facility had one COVID -19 positive resident since she began employment in August 2022. During an interview, on 11/22/22 at 2:07 p.m., the Executive Director (ED) indicated the last COVID-19 positive resident was approximately two months ago and she was not familiar with a Respiratory Surveillance Line Listing. She was unsure if the facility had any COVID-19 tracking system for residents and staff. The Corporate Nurse Consultant indicated the facility should have had a COVID-19 binder. During an interview, on 11/22/22 at 2:50 p.m., Licensed Practical Nurse (LPN) 4 indicated all COVID-19 positive results were reported to the DON and the ED. During an interview, on 11/22/22 at 3:11 p.m., the ED indicated the facility did not have a system in place for tracking COVID-19 positive residents or staff members. She was unable to locate any tracking tool for COVID-19. She was not aware of anyone who reported the COVID-19 positive resident to the Indiana Department of Health on	R 0407	1. The Community is utilizing proper infection prevention and control tracking and reporting for residents and staff with COVID-19. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. All in house testing will be tracked and results will be in COVID binder. If any staff or residents are tested in house for COVID, results will be tracked. 4. The Wellness Director or designee will monitor the tracking and reporting of residents and staff with COVID-19 to ensure compliance.	11/22/2022

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	the designated reporting system. At the time of interview, the DON indicated she had not reported the COVID positive resident to the Indiana Department of Health. The ED and the Corporate Nurse Consultant indicated someone should have reported the COVID-19 positive cases to the Indiana Department of Health. During an interview, on 11/22/22 at 3:20 p.m., the ED indicated she was uncertain of the date of the last COVID-19 positive staff member. A current policy, revised on 8/13/22, titled "Novel Coronavirus [2019-nCoV] [COVID-19]," provided by the DON on 11/22/22 at 2:31 p.m., indicated the following: "...Policy: This policy has been incorporated into the Emergency Management planning for this community in addition to the Infection Prevention and Control Plan for this community and will be implemented collaboratively between the Executive Director and the Wellness Director....This community will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of the novel Coronavirus [2019-nCoV]. The community will implement actions according to Center for Disease Control [CDC], State, County and Local Health Departments, State Survey Agency, and World Health Organization recommendations including identification, isolation and informing Health Department of any suspected cases of COVID-19...."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the			

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	resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure clinical records contained current annual health statements for 4 of 7 residents reviewed for annual health statements. (Residents 7, 9, 31 and 39) Findings include: 1. Resident 31's clinical record was reviewed on 11/21/22 at 3:00 p.m. Current diagnoses included, but were not limited to, hypertension, diabetes, and hypothyroidism. The clinical record lacked an annual health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage. 2. Resident 9's clinical record was reviewed on 11/21/22 at 1:30 p.m. Current diagnoses included, but were not limited to, hypertension, and legally blind. The clinical record lacked an annual health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage. During an interview, on 11/22/22 at 10:53 a.m., the Director of Nursing (DON) indicated Residents 31, and 9 did not have annual health statements.3. Resident 49's clinical record was reviewed on 11/21/22 at 3:14 p.m. Diagnoses included, but were not limited to, hyperlipidemia, allergic rhinitis, osteoarthritis, irritable bowel syndrome and macrocytosis. The clinical record lacked a current annual health statement, including history of significant past or present infectious diseases and a statement that the resident shows no	R 0409	R409 1. Resident 39 no longer resides in the Community. Residents 7, 9 and 31's clinical records contain current annual health statements. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Every new resident will have annual health statement upon admission. Annual health statements will be on file for every resident. 4. The Wellness Director or designee will audit charts upon admission and quarterly thereafter to ensure annual health statements are completed on time. 1. Systemic changes date: January 15, 2023	01/15/2023

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	evidence of tuberculosis in an infectious stage. 4. Resident 7's clinical record was reviewed on 11/22/22 at 9:37 a.m. Diagnoses included, but were not limited to, hypertension and arthritis. The clinical record lacked an annual health statement, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage. During an interview, on 11/22/22 at 11:13 a.m., the DON indicated she was unable to find an annual health statement in Resident 7 and Resident 49's clinical records. She was unfamiliar with the annual health statement requirements. During an interview, on 11/22/22 at 1:10 p.m., the ED indicated the facility lacked a policy regarding annual health statements. The facility followed the Indiana Department of Health Regulations regarding annual health statements.			