STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155746	A. BUILDING 00 B. WING	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 28, 29, 30, 31, and June 3, 2024. Facility number: 000539 Provider number: 155746 AIM number: 100267280 Census Bed Type: SNF/NF: 36 SNF: 1 Residential: 20 Total: 57 Census Payor Type: Medicare: 4 Medicaid: 16 Other: 17 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/6/24.	F 0000	Parkview Haven respectfully requests a desk review for compliance based on low scope and severity.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of	F 0554	**TAG # – F554 Resident Self Admin Meds-Clinically Approp** **1 What corrective action(s)**	06/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Max Jones	Administrator	07/01/2024

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	medications and had a physician's order to self-administer medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 139 and 9) Findings include: 1. On 5/28/24 at 11:17 a.m., Resident 139 was observed seated in her recliner in her room. The nebulizer machine on her bedside table was on and she had the mask in place over her mouth and nose. The resident indicated her nebulizer treatment was in progress. There were no staff present in the room or near the room. The resident's record was reviewed on 5/30/24 at 2:35 p.m. Diagnoses included, but were not limited to, hypertension, chronic kidney disease, and atrial fibrillation. The Admission Minimum Data Set (MDS) assessment, dated 5/17/24, indicated the resident was cognitively intact. A Physician's Order, dated 5/16/24, indicated ipratropium-albuterol solution 0.5 mg (milligrams) -3 mg/3 ml (milliliters) two times a day. There was a lack of any physician's order for self-administration of the medication or any self administration of medication assessment. During an interview on 5/31/24 at 10:31 a.m. with the Director of Nursing (DON), he indicated there were no orders for self-administration of the nebulizer treatment and no self-administration assessment had been completed. A facility policy, titled, "Oral Inhalation Administration", received from the DON as		**will be accomplished for those residents found to have been affected by the deficient practice;** a Regarding resident #139, Nurses were educated they are to remain with resident for the duration of a nebulizer treatment. b Regarding resident #9, medication was immediately removed from room and sent home with POA. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education provided regarding F-Tag #554 – Resident Self Admin Meds-Clinically Appropriate **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Director of Nursing/Assistant Director of Nursing/Designee will observe a nebulizer treatment 1x/week for 3 months, 1x per month x 3 months, quarterly	

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	current, indicated "...Nebulizer Administration...13. Remain with resident for the treatment unless the resident has been assessed and authorized to self-administer..." 2. During a random observation on 5/28/24 at 4:14 p.m., a bottle of sore throat spray (phenol anesthetic) was sitting on top of the dresser. During an interview at the time, Resident 9 indicated she received the medication from her most recent hospital stay and kept it in her room in case she needed to use it. On 5/29/24 at 11:06 a.m., the sore throat spray was noted on top of the dresser. Resident 9's record was reviewed on 5/29/24 at 4:04 p.m. Diagnoses included, but were not limited to, fracture of the left tibia and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 4/8/24, indicated the resident was cognitively intact for daily decision making. There were no orders for a throat spray or self-administration of the medication. There was also no self-administration of medication assessment completed. During an interview on 5/31/24 at 9:56 a.m., the Director of Nursing indicated he had no further information to provide. A policy for medication self administration was requested, but none were provided prior to exit. 3.1-11(a)		thereafter x 3 quarters, PRN as needed to ensure compliance. b Residents will be informed they may not self-administer medication unless the self-administration of medication assessment is completed and a physician order is on file to be able to self-administer medication. Residents will be informed upon admission and at the monthly Resident Council meeting monthly x 3 months, quarterly thereafter x 3 quarters, PRN as needed to ensure compliance. c Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure an area of discoloration was assessed and monitored for 1 of 2 residents reviewed for skin conditions (non-pressure related). (Resident 1) Finding includes: On 5/28/24 at 11:26 a.m., Resident 1 was sitting in the recliner in her room. She had a discoloration noted to the outer portion of her right calf. At the time, Resident 1 indicated her lower leg sometimes bothered her, so she would put some cream on the affected area. On 5/30/24 at 11:37 a.m., Resident 1 was sitting in the recliner in her room. The outer portion of her right calf was discolored. The resident indicated she had put some cream on it, but it was still hurting. Resident 1's record was reviewed on 5/29/24 at 12:13 p.m. Diagnoses included, but were not limited to, venous insufficiency and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/24, indicated the resident was moderately impaired for daily decision making.	F 0684	**TAG # – F684 Quality of Care** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Resident 4 educated to alert nursing staff if she has an injury while on leave of absence from facility. Staff in-serviced on skin assessments, documentation and reporting. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Leave of Absence Return to Facility questionnaire to be completed upon return to facility	06/21/2024

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	A Physician's Order, dated 2/15/24, indicated a weekly skin assessment was to be performed. The May 2024 Medication Administration Record (MAR) indicated the weekly skin assessment was completed on 5/3, 5/6, 5/10, 5/13, 5/17, 5/20, 5/24, 5/27, and 5/31/24. There was no documentation related to the discoloration on the outer right calf. During an interview on 5/31/24 at 3:02 p.m., the Director of Nursing indicated there was no recent documentation related to a discoloration on the right calf. A policy for skin monitoring was requested but none were provided prior to exit. 3.1-37(a)		when out with family/friends by nurse/designee. **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Upon return from a resident being on leave of absence with family/friends, staff will complete the Leave of Absence Return to Facility questionnaire to ensure resident returned without incident. If an incident occurred, Director of Nursing/designee will complete an incident investigation. Incident reports are reviewed 5x per week/PRN by Director of Nursing/designee. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure orders for a pressure ulcer dressing were specific and dressings were in place per physician's orders for 1 of 1 residents reviewed for pressure ulcers. (Resident 1) Finding includes: On 5/28/24 at 11:36 a.m., Resident 1 was observed in her room. She had a nude colored dressing on her right buttocks. There was no date on the dressing. The resident, at that time, indicated she had a wound on her buttocks that caused her some pain. She thought the staff were putting cream on the area. During an observation of the wound on 5/31/24 at 1:29 p.m., the Director of Nursing (DON) wiped calmoseptine from Resident 1's buttocks. There was no dressing noted to either side of the buttocks. There were two discolored areas on the middle cleft on both cheeks. There were no open areas noted at the time. Resident 1's record was reviewed on 5/29/24 at 12:13 p.m. Diagnoses included, but were not limited to, chronic kidney disease, venous insufficiency, and peripheral vascular disease. The Quarterly Minimum Data Set (MDS)	F 0686	**TAG # – F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Treatment orders were immediately corrected. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education provided regarding F-Tag #686 Treatment/Svcs to Prevent/Heal Pressure Ulcer **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality**	06/21/2024

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	assessment, dated 5/18/24, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 5/11/24, indicated the resident had a pressure ulcer to the left and right gluteal cleft. Interventions included, but were not limited to, assess and record the condition of the skin surrounding the pressure ulcer, assess the pressure ulcer, and keep the area clean and dry. A Physician's Order, dated 5/11/24, indicated to change dressing to the left buttock every two days or if soiled as needed. The May 2024 Medication Administration Record (MAR) indicated the left buttock dressing was completed on 5/11/24, 5/21/24, 5/25/24, and 5/27/24. On 5/13/24, 5/15/24, 5/17/24, 5/19/24, 5/23/24, and 5/31/24 the wound was left open to air. On 5/29/24 the resident refused the treatment. A Physician's Order, dated 2/15/24, indicated a weekly skin assessment was to be completed. The May 2024 MAR indicated the weekly skin assessment was completed on 5/3, 5/6, 5/10, 5/13, 5/17, 5/20, 5/24, 5/27, and 5/31/24. A Nurses' Note, dated 5/11/24 at 8:32 p.m., indicated the resident requested the nurse to assess an area of discomfort on the buttock. There were two small areas near the middle cleft on both cheeks. The area to the right cheek measured 2 cm (centimeters) by 3 cm. The skin surrounding was reddened and there was a slightly raised area with a small opening. The left side wound measured 1 cm by 2 cm. It was slightly raised with a small opening in the skin. There were no signs of infection or drainage noted. Barrier		**assurance program will be put into place;** a Wound nurse/designee to review would treatment orders 2x/week for 4 weeks, 1x/quarter for 3 quarters, PRN as needed to ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	

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	cream and a dressing was applied to the left cheek. A Wound Management Detail Report, dated 5/16/24 at 10:42 a.m., indicated the resident had a stage 2 pressure area to the right buttock measuring 1.5 cm by 2 cm. The wound bed was red with granulation tissue. The treatment was calmoseptine on the wound area. There were no further wound assessments or measurements for either of the pressure areas. During an interview on 6/3/24 at 1:40 p.m., the DON indicated he did not recall the resident having any open areas to the buttocks and a nurse may have added the generic order for the dressing to the area. He was not aware of that order. A policy for wound care and monitoring was requested but none were provided prior to exit. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 1 of 3 residents	F 0689	**TAG # – F689 Free of Accident Hazards/Supervision/Devices** **1 What corrective action(s)**	06/21/2024

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	reviewed for accidents. (Resident 23) Finding includes: On 5/29/24 at 2:56 p.m. and on 5/30/24 at 3:01 p.m., Resident 23 was observed lying in bed with her eyes closed. A wheelchair was next to the resident's bed. The wheelchair had a cushion in the seat area. There was not a Dycem (non slip mat) observed on top or underneath the cushion. Record review for Resident 23 was completed on 5/29/24 at 12:29 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, and history of falling. The Quarterly Minimum Data Set (MDS) assessment, dated 2/23/24, indicated the resident was cognitively impaired. The resident used a wheelchair and required a substantial maximum assistance with transfers. The resident had 3 falls including 1 with an injury since the previous assessment. A Care Plan, dated 12/8/21 and revised 5/28/24, indicated the resident was at risk for falls due to weakness at times, impaired mobility and balance, impaired cognition, incontinence, history of falls, impaired vision, and poor safety awareness. An intervention included to add a Dycem to the wheelchair. The May 2024 Physician's Order Summary indicated an order for a Dycem under the wheelchair cushion to prevent slipping out of the wheelchair. A Progress Note, dated 5/12/24 at 5:56 p.m., indicated the resident slid from her wheelchair to the floor onto her buttocks.		**will be accomplished for those residents found to have been affected by the deficient practice;** ***a*** Dycem was immediately applied to Resident #23 wheelchair. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education provided regarding F-Tag #689 Free of Accident Hazards/Supervision/Devices **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Fall interventions added to the electronic medical record to be physically observed on each shift to ensure compliance.Director of Nursing/Assistant Director of Nursing/designee to run a treatment compliance report 1x/week for 4 weeks, 1x/quarter for 3 quarters, PRN as needed to	

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	During an interview on 5/30/24 at 3:07 p.m., RN 1 indicated the resident was supposed to have a Dycem in her wheelchair. She then went and observed the resident's wheelchair. There was no Dycem on top of the wheelchair cushion. She pulled the cushion up and there was no Dycem underneath the wheelchair cushion. The RN then proceeded to cut a piece of Dycem from a roll to place it into the resident's wheelchair. A policy for fall interventions was requested but none were provided prior to exit. 3.1-45(a)		ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.			

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	(ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post a current daily nurse staffing posting. This had the potential to affect all 37 residents residing in the facility. Finding includes: On 6/3/24 at 10:04 a.m., the Nursing Staffing sheet was posted on the bulletin board near the Nurse's Station. The posting was dated 5/30/24. On 6/3/24 at 11:08 a.m., the Nursing Staffing sheet was posted on the bulletin board near the Nurse's Station. The posting was dated 5/30/24. During an interview on 6/3/24 at 12:08 p.m., the Assistant Director of Nursing (ADON) indicated the Unit Coordinator or Medial Records staff usually updated the staffing posting daily. She was not sure why the posting had not been updated.	F 0732	**TAG # – F732 Posted Nursing Staffing Information** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Daily staffing record was immediately placed. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	06/21/2024

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			Education provided regarding F-Tag #732 Posted Nurse Staffing Information **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Director of Nursing/Assistant Director of Nursing /designee to monitor posted nurse staffing compliance 5x/week for 3 months, 1x/week for 3 months, PRN as needed to ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that			

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	must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			

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	(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure a resident with a chronic wound was placed in enhanced barrier precautions (EBP) for high contact resident care activities for 1 of 1 residents reviewed for EBP (Resident 29) and no education provided to staff as part of the facility's infection control program. This had the potential to affect all 37 residents residing in the facility. Finding includes: On 5/28/24 at 3:09 p.m., Resident 29's room was observed. There were no signs for enhanced barrier precautions on the door or inside of the room. There was no personal protective equipment near the entrance of the room or inside of the resident's room. During an interview on 6/3/24 at 10:18 a.m., LPN 1 indicated she had never had a resident on enhanced barrier precautions. They had at least	F 0880	**TAG # – F880 Infection Prevention & Control** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Staff immediately educated on enhanced barrier precautions and treatment/barrier carts immediately placed in rooms that require it. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident have the potential to be affected by this deficient practice.	06/21/2024

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	one wound in the facility at that time and the resident was not on any type of precautions. Resident 29's record was reviewed on 6/3/24 at 9:00 a.m. Diagnoses included, but were not limited to, adult failure to thrive and cancer to the maxillary sinus. The Admission Minimum Data Set assessment, dated 2/28/24, indicated the resident was moderately impaired for daily decision making. A Wound Assessment, dated 5/29/24 at 4:02 p.m., indicated the resident had a stage 2 pressure ulcer above the left buttock measuring 0.5 centimeters (cm) by 0.5 cm. The wound bed was filled with granulation tissue. The wound had been present since his admission on 2/23/24. There were no physician's orders for enhanced barrier precautions. A policy for EBP was requested but none were provided prior to exit. During an interview on 6/3/24 at 12:07 p.m., the Assistant Director of Nursing indicated that she had not implemented any enhanced barrier precautions in the building as she still needed to read up on what to do for the EBP. She had not provided any education to the facility staff at this time. 3.1-18(b)		**3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education provided regarding F-Tag #880 Infection Prevention & Control **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Director of Nursing/Assistant Director of Nursing/Designee will monitor that enhanced barrier precautions are in place for compliance. Will be monitored weekly x 3 months, quarterly thereafter x 3 quarters, PRN as needed to ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000	Parkview Haven respectfully requests a desk review for	

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	Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 28, 29, 30, 31, and June 3, 2024. Facility number: 000539 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		compliance based on low scope and severity.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility	R 0092	**TAG # – R092 Administration**	06/21/2024

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	failed to invite the fire department to participate in fire drills every six months as required. This had the potential to affect all 20 residents residing in Assisted Living. Finding includes: The annual fire drill documents were reviewed on 5/30/24 at 11:57 a.m. The fire drill records lacked documentation the fire department had been invited to participate in any of the drills. During an interview on 5/30/24 at 12:15 p.m., the Maintenance Director indicated the fire department was not invited every 6 months and he was unaware they were supposed to be invited.		**and Management - Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Staff educated and local fire department were immediately invited to the next scheduled fire drill. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education provided regarding R-Tag #092 **4 How the correct action(s) will be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place;** a Staff entered into TELS (Technology Enabled Life Safety) computer program to invite local fire department to fire drill 2x/year. Staff will provide administrator/designee copy of	

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			email communication with local fire department 2x in the next 12 months. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **5 By what date the systemic changes for each deficient will be completed.** June 21, 2024	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual 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			

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	no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident and the Service Plan was revised and updated for 1 of 7 residents reviewed for Service Plans. (Resident 5) Findings include: Resident 5's record was reviewed on 6/3/24 at 11:22 p.m. Diagnoses included, but were not limited to, hypertension. The resident was admitted to the facility on 1/6/24. A Service Plan, dated 1/8/24, indicated the resident was currently alert and oriented, needed medications administered by a nurse, and needed assistance with bathing. The Service Plan was not signed by the resident and/or the responsible party. A Physician's Order, dated 5/6/24, indicated the resident was to receive physical therapy for 12 sessions over the next four weeks. A Physician's Order, dated 5/8/24, indicated the resident was to receive speech therapy for 12 sessions over the next four weeks. The Service Plan was not updated reflecting the additional physical and speech therapy services. During an interview on 6/3/24 at 12:35 p.m., the Assistant Director of Nursing indicated she was	R 0217	**TAG # – R217 Evaluation - Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a Beginning immediately all new admits will have a service plan meeting within 1 week of admission and every 6 months thereafter or as needed based on change of condition. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All resident have the potential to be affected by this deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education provided regarding R-Tag #217 Evaluation - Deficiency **How the correct action(s) will be monitored to ensure the deficient practice will not**	06/21/2024

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	unable to locate a signed Service Plan and there was no updated Service Plan reflecting the therapy services.		**recur; i.e.; what quality assurance program will be put into place;** a Social services/designee will audit service plans 1x/month for 6 months then 1x/quarter for 2 quarters, PRN as needed to ensure compliance. b Results will be reported to the monthly QAPI meeting for review. After reviewing results, an action plan may be developed, if needed, to ensure compliance. **By what date the systemic changes for each deficient will be completed.** June 21, 2024	