STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155738	A. BUILDING 00 B. WING	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILTON HOME, THE	206 E MARION ST SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and investigation of Complaint IN00416523. This visit included a State Residential Licensure Survey. Complaint IN00416523 - No deficiencies related to the allegations are cited. Survey dates: October 23, 24, 25, 26, 27, and 30, 2023 Facility number: 001141 Provider number: 155738 AIM number: 200905640 Census Bed Type: SNF/NF: 30 Residential: 13 Total: 43 Census Payor Type: Medicare: 1 Medicaid: 23 Other: 6 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3. Quality review completed 11/7/2023.	F 0000		
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally			

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

Frank Bensema | Executive Director | 11/22/2023

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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	accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on observation, record review and interview, the facility failed to provide quarterly statements to 3 of 9 residents with resident trust funds. (Residents 10, 20 and 13) Finding includes: The clinical record for Resident 10 was reviewed on 10/23/2023 at 2:00 P.M. The most recent MDS (Minimum Data Set) assessment for Resident 10, conducted as a quarterly review on 9/20/2023 indicated she was alert and oriented and cognitively intact. The clinical record for Resident 20 was reviewed on 10/7/23 . The most recent MDS assessment for Resident 20, conducted for an admission assessment indicated he scored a 12 out of 15 possible points and was moderately cognitively impaired. The clinical record for Resident 13 was reviewed on 10/26/2023 at 3:00 P.M. The most recent MDS assessment, completed on 8/20/2023 due to a significant change in condition, indicated the resident was alert and oriented and cognitively intact. During a review of the resident trust fund accounting, on 10/26/23 at 1:54 P.M. with the	F 0568	F568 Accounting and Records of Personal Funds 1. For Residents 10 & 13, quarterly statements were provided to the residents. Resident 20 no longer resides in the facility. 2. Residents whose personal funds have been entrusted to the facility and are cognitively intact will be provided with a quarterly statement. Resident representatives will be provided with a quarterly statement, as appropriate for those who are cognitively impaired. 3. Residents who are cognitively intact and whose personal funds have been entrusted to the facility will receive a quarterly statement. Residents who are cognitively impaired and whose funds have been entrusted to the facility will have his/her responsible party provided with a quarterly summary. A new person has taken over the BOM responsibilities. The Corporate Business Office Manager will educate the Business Office Manager on the process for	11/28/2023

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	business office manager BOM, he indicated if the facility was the representative payee for the resident with a resident trust fund, they did not provide the resident with a quarterly statement. On 10/27/2023 at 9:00 A.M., the facility provided quarterly Resident Fund Statements for July through September 2023 for Residents 10, 13 and 20. All of the statements were signed with the same initials. During an interview with the Business Office Manager, on 10/27/2023 at 2:46 P.M. he confirmed the signature was the Administrators' because the facility was the "representative payee" for all three residents. When questioned why the alert and oriented residents, who were their own responsible party, were not given a copy of the quarterly statements, he indicated he was "new" to the position and the Corporate staff member training him informed him they were not given to the residents because the facility was the "representative payee" for all three residents. The current facility policy and procedure, titled, "Transactions Involving Resident Funds," provided by the Director of Nursing on 10/30/2023 at 1:29 P.M., included the following: "...8. Quarterly statements will be provided in writing to the resident, or the resident's representative, within 30 days after the end of the quarter and upon request...." 3.1-6(g)		providing quarterly summaries to residents or responsible parties whose personal funds have been entrusted to the facility. The BOM/designee will audit quarterly documentation that quarterly summaries are provided to residents or families as required for those whose personal funds have been entrusted to the facility. 4. The BOM/designee will present the results of the quarterly audit to the facility's QAPI Committee quarterly for review and/or revision X 1 year or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident			

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	becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of			

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	any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to ensure a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form was provided following the end of Medicare skilled services for 1 of 1 resident who discharged from Medicare services and remained in the facility. (Resident 55) Finding includes: On 10/26/2023 at 1:37 P.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form indicated Resident 55 was not issued an SNF-ABN form. Resident 55's representative was provided a Notice of Medicare Non-Coverage (NOMNC) Form which indicated Resident 55's Medicare coverage would end on 4/23/2023. The form indicated that the representative was notified that their financial liability would begin on 4/24/2023. On 10/26/2023 at 2:16 P.M., the Social Service Director indicated that Resident 55 should have received an SNF-ABN form since she remained in the facility after discharge from Medicare services. On 10/27/2023 at 9:05A.M., the Director of Nursing provided the current policy titled, "Advanced Beneficiary Notices". The policy	F 0582	F582 Medicaid/Medicare Coverage/Liability Notice 1. Resident 55 no longer resides at the facility. 2. No other residents were discharged from Medicare and remained in the facility within the last 6 months. 3. Residents who will be discharged from Medicare and remain in the facility will receive an SNF-ABN form at the appropriate time. A new person has taken over BOM responsibilities. The Corporate BOM will educate the IDT on appropriate issuance of an SNF-ABN form. The BOM/designee will review weekly for residents discharging from Medicare and remaining in the facility to ensure that the SNF-ABN form is appropriately issued. 4. The BOM/designee will present the results of the weekly audit to the facility's QAPI Committee monthly for review and/or revision X 6 months. The Administrator is responsible for overall compliance with this regulation.	11/28/2023

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	indicated, but was not limited to: " ...It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage ...5. The current CMS-approved [Center for Medicare and Medicaid Services] version of forms shall be used at the time of issuance to the beneficiary 9 resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055 ...." 3.1-4(f)(2)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review and interview, the facility failed to ensure food was served at a palatable temperature for 3 of 15 residents reviewed. (Residents 10, 17 and 20) Findings include: During an interview with alert and oriented Resident 10, on 10/23/2023 at 3:10 P.M., she indicated her food was often served cold and did not taste good.	F 0804	F804 Nutritive Value/Appearance, Palatability/Preferred Temp 1. For Resident 10, further interviews were conducted to determine root cause of palatability concerns. These palatability concerns will be addressed. Residents 17 & 20 no longer reside in the facility. 2. Other residents who receive meals have the potential to have	11/28/2023

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	During an interview with Resident 10, on 10/27/2023 at 2:12 P.M., she indicated her lunch food was bland and was barely warm. During an interview with alert and oriented Resident 17, on 10/23/2023 at 2:19 P.M., she indicated the food was not always served hot. She indicated she used to have the staff heat the food up in the microwave but they had removed the microwave from the second floor dining room due to safety concerns. Resident 17 was discharged from the facility on 10/27/2023. During an interview with Resident 20, on 10/24/2023 at 10:24 A.M., he indicated the food was sometimes served cold. During an interview with Resident 20, on 10/27/23 at 2:16 P.M., he indicated his lunch was not very good and was kind of cold. He indicated the macaroni and cheese got hard because it was too cold. During a dining observation, the meal trays were delivered to the second floor of the facility on 10/25/2023 at 1:02 P.M. The trays were transported in an unheated metal cart and the meal plates were covered with a plastic insulated plate cover. There were two meal plates on each tray and there were no insulated plate holders underneath the plates. During an observation of food temperatures of the last tray to be delivered, conducted with the FSS (Food Service Supervisor) on 10/25/2023 at 1:11 P.M., the following food temperatures were obtained: The mashed potatoes were 124 degrees		palatability concerns with meals. Dietary Manager will conduct a resident food committee meeting. Root causes of trends will be addressed. 3. A new Dietary Manager has been hired. The dietary department will be trained by Yona's Regional Consultant on processes R/T food palatability. The Dietary Manager/designee will conduct a food committee meeting bi-weekly X 4 then monthly to determine palatability concerns. He will coordinate implementing plans for correction of noted palatability issues to address those concerns. 4. The Dietary Manager/designee will present the results of the food committee meeting to the facility's QAPI Committee monthly for review and/or revision X 6 months or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	

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	Fahrenheit, the cornbread stuffing was 138 degrees Fahrenheit, the pureed peas were 112 degrees Fahrenheit, and the pureed ham was 110 degrees Fahrenheit. During a dining observation, the meal trays were delivered to the second floor of the facility on 10/27/23 at 12:53 P.M. The meals were delivered in an unheated metal cart and each plate of food was covered with an insulated plastic plate cover and an insulated plastic plate holder was underneath each tray. At 1:02 P.M., the food temperatures of the food tray was assessed with Dietary Aide, Employee 10. The baked fish was 104.5 degrees Fahrenheit, the cauliflower was 100 degrees Fahrenheit and the macaroni and cheese was 116 degrees Fahrenheit. During an interview with dietary aide, Employee 10, regarding the target temperatures for food at the point of service, she indicated she was new to the facility and was not sure how hot the food was supposed to be when served. During an interview with the Registered Dietician, on 10/27/2023 at 1:10 P.M., she indicated the holding temperature should be 140 degrees Fahrenheit or above. She indicated the facility had a plate warmer in the kitchen but did not have hot pallets or an warm/heated delivery cart. She indicated the insulated plate covers and holders should be utilized. During an interview, on 10/27/2023 at 3:30 P.M. with the FSS he indicated the food was at the correct holding temperature in the kitchen before it was served. He indicated he had not conducted any test tray assessments of food temperatures at the point of service. The facility policy, titled, "Safe Food Handling," provided by the Administrator on 10/24/2023 at 11:30 A.M., included the following: "...3. The			

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	Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees Fahrenheit and/or less than 135 degrees Fahrenheit, or per state regulation....10. When hot pureed, ground, or diced food drop into the danger zone (below 135 degrees Fahrenheit) the mechanically altered food must be reheated to 165 degrees Fahrenheit for 15 seconds if holding for hot service...." There was no specific policy provided regarding transporting hot food and target temperatures of hot food to ensure resident palatability. 3.1-21(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store and dispose expired foods for 1 of 1 dietary area observed. This deficient practice had the potential to affect 30 residents of 30 residents who received their meals in the dietary area. Findings include: During an observation on 10/23/2023 at 10:08 A.M., the upright refrigerator had 2 cartons of half and half with an expiration date of 10/9/2023. On 10/23/2023 at 10:15 A.M., the dry storage areas had an opened bag of flour that was not secured with a covering and loose flour was exposed. During an interview on 10/23/2023 at 10:15 A.M., the Dietary District Manager indicated the flour should have been taken to the kitchen and stored in a closed container. On 10/23/2023 at 10:19 A.M., three bags of soft tortilla shells were observed in a cabinet with a best by date of 8/29/2023. During an interview on 10/23/2023 at 10:19 A.M., the Dietary District Manager thought the tortillas may have been stored in the freezer, but was unsure when the tortillas had been pulled from the freezer. On 10/23/2023 at 10:20 A.M., a two-pound three-ounce bag of frosted flakes had a use by date handwritten of 6/21/2023. During an interview on 10/23/2023 at 10:20 A.M., the Dietary District Manager indicated the date on	F 0812	F812 Food Sanitation 1. The items observed to be out of compliance with food storage requirements were discarded. 2. The Surveyor made no other observations of improper food storage. 3. The facility will follow the policy R/T food storage. Yona's Regional Consultant will educate dietary staff on food storage processes. The Dietary Manager/designee will conduct food storage audits 3x/wk with corrections made as needed for compliance. 4. The Dietary Manager/designee will present the results of the audits to the facility's QAPI Committee monthly for review and/or revision X 6 months or until 90% compliance is achieved X 2 weeks. The Administrator is responsible for overall compliance with this regulation.	11/28/2023

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	the frosted flakes package was 10/21/2023. The Dietary District Manager had Cook 3 observe the date written, and Cook 3 indicated the date on the packaging was 6/21/2023. During an observation of the used spices on 10/23/2023 at 10:21 A.M., the following was observed: -16 oz. (ounces) black pepper with no open date or use by date. -thyme 12 oz. dated 9/24/2021 as an open date. -onion powder 2.62 oz. no open date or use by date. -herb seasoning 13 oz. no open date or use by date. -pumpkin pie spice 16 oz. open date of 5/2/2022 with a use by date 8/2/2023. -seasoning salt 5 pound no open date or use by date. -ground sage 1.25 oz. no open date or use by date. -ground mustard opened 8/2/2022, use by date 8/2/2023. -corn starch open box and not sealed. -ground ginger 16 oz. open 8/2/22, and use by 8/3/2023. -ground thyme 12 oz. open 8/3/2022, use by 8/3/2023. -ground nutmeg 16 oz. open 8/3/2023, use by 8/3/2023. -Mrs. Dash seasoning 21 oz. no open date or use by date. -ground cinnamon 2.37 oz. no open or use by date. During an interview on 10/23/2023 at 10:35 A.M., the Dietary District Manager indicated the best practice for spice storage was to discard after 6 months of opening. On 10/23/2023 at 12:01 P.M., an observation of			

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	self-serve cereals was observed in the dining area. Raisin Bran, with a preparation date of 9/282023, and a use by date of 10/20/2023 was observed, with approximately 1 cup left in the canister. Foot Loops in the self-serve container was not dated, and had a half full container. During an interview with CNA 2 on 10/23/2023 at 12:17 P.M., he indicated the cereal is served by the staff in the mornings. On 10/23/2023 at 12:19 P.M., the Dietary District Manger indicated the raisin bran should have been disposed and indicated label on the fruit loops must have fallen off. During an observation on 10/26/2023 at 2:13 P.M., the flour bag in dry storage had a white bag over it, and the bag twisted at the top. The bag did not have any secure closure. A current policy was provided on 10/27/2023 at 10:11 A.M. by the Director of Nursing. The policy was titled, "Quick Resource Tool: Safe Storage of Food". The policy indicated, " ...5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination ...9. All packaged and canned food items will be kept clean, dry, and date marked as appropriate ...." 3.1-21(i)(2)			
R 0000 Bldg. 00	This visit was for a State Licensure Survey. This visit included a Recertification and State Licensure Survey and investigation of Complaint IN00416523.	R 0000		

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	Complaint IN00416523 - No deficiencies related to the allegations are cited. Survey date: October 23, 24, 25, 26, 27, and 30, 2023 Facility number: 001141 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 11/7/2023.			
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			

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	155738	A. BUILDING 00 B. WING	10/30/2023

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	services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, record review and interview, the facility failed to ensure service plans were initiated, reviewed and signed by the resident and/or their representative for 4 of 5 residential residents reviewed. (Residents 5, 6, 7 and 8) Finding includes: 1. Resident 7 was observed ambulating in the facility by himself. During an interview with Resident 7, conducted on 10/30/2023 at 10:00 A.M., he indicated he was independent for dressing, bathing and eating needs but the facility adminsitered his medications to him. He indicated he was admitted to the facility about 4 months ago and he did not recall signing any service plan. The record for Resident 7 was reviewed on 10/27/2023 at 2:45 P.M. Resident 7 was admitted to the facility on 7/13/2023. There were a few care plans observed in the resident's record but there was no service plan. There was no care plan indicating what services regarding activities of daily living the resident was to receive. During an interview with the Director of Nursing, on 10/30/20232 at 1:10 P.M. she confirmed there was no service plan, signed by the resident, completed for Resident 7.2. A record review was completed on 10/27/2023 at 11:00 A.M. Diagnoses included, but were not limited to: diabetes mellitus	R 0217	R217 Evaluation Deficiency 1. For Residents 5, 6, and 8, service plans have been initiated, completed, and signed by the resident. Resident 7 no longer resides at the facility. 2. Other residents requiring service plans have the potential to be affected. Residents will be audited for initiation, completion, and signatures on service plans. Corrections will be made as needed for compliance. 3. The facility will follow the policy R/T service plans. The DON will educate the IDT and nurses on initiation, completion, and signatures on service plans. The SSD/designee will complete an audit weekly for timely completion and signatures on service plans. 4. The SSD/designee will present the results of these audits to the facility's QAPI Committee monthly for review and/or revision x 6 months or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	11/28/2023

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	type 2, chronic obstructive pulmonary disease, and hypertension. A review of Resident 5's service plan was completed. The service plans included refusal of dining assistance, activities, and risk for dehydration. No other service plans were identified. During an interview with the Director of Nursing on 10/30/2023 at 9:45 A.M., she indicated the service plan was incomplete. 3. A record review was completed on 10/27/2023at 11:12 A.M. Diagnoses included, but were not limited to: hypertension, macular degeneration, and cervivocranial syndrome. A review of Resident 6's service plan was completed. The service plans included request for assistance to arrange medical appointments, medication administration, behavior, fall with fracture, pain, and cellulitis. No other service plans were identified. During an interview with the Director of Nursing on 10/30/2023 at 9:49 A.M., she indicated the service plan was incomplete. 4. A record review was completed on 10/27/2023 at 12:16 P.M. Diagnoses included, but were not limited to: generalized anxiety, diabetes mellitus type 2, generalized anxiety, and fibromyalgia. A review of Resident 8's service plan was completed. The service plans included management of medications, assistance of arranging appointments, falls, and advanced directives.			

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	The medical record did not have a signature of Resident 8 review of the service plan. During an interview with the Director of Nursing on 10/20/2023 at 9:56 A.M., she indicated the service plans were incomplete, and a signature could not be found for the service plan. A current policy was provided on 10/30/2023 at 12:43 P.M. by the Director of Nursing. The policy titled, Assisted Living Service Plans", indicated " ...1. A service plan will be completed by the Director of Nursing/Designee within 7 days of moving into the facility and the day of move in ...4. The service plan shall be signed and dated by individuals involved in its development ...."			
R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness			

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	within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual. Based on record review and interviews, the facility failed to ensure there was a mental health screening and history obtained for 1 of 7 residents reviewed. (Residents 7) Finding include: The record for Resident 7 was reviewed on 10/27/2023 at 2:30 P.M. Resident 7 was admitted to the facility on 7/13/2023, with diagnosis, including anxiety disorder, major depressive disorder and post traumatic stress disorder. The resident received funding for their stay through the Medicaid waiver program. There was no documentaiton in the record regarding a mental health screening and mental health history. The resident was being routinely assessed, since his/her admission by a mental health professional. Those notes were in the record. During an interview with the Director of Nursing, on 10/30/2023 at 11:04 A.M. she indicated there was no mental health screening and although their were a few care plans for Resident 7, including a general plan regarding Anxiety, there was no coordination in the development of the care plan with the mental health services provider. During an interview with the Director of Nursing, on 10/30/2023 at 12:34 P.M., she indicated a policy was not available for major mental illness.	R 0378	R378 Mental Health Screening Deficiency 1. Resident 7 no longer resides in the facility. 2. Other Medicaid residents who have been admitted have the potential to be affected. Current Medicaid residents admitted to the facility will be reviewed for the presence of mental health screening. Corrections will be made as needed for compliance. 3. The facility will complete mental health screening as part of the pre-admission process. The DON will educate the IDT on the mental health screening process for Medicaid residents. The SSD/designee will complete a review weekly of residents admitted for completion of the mental health screening process. 4. The SSD/designee will review the results of the audits with the facility's QAPI Committee monthly for review and/or revision X 6 months or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	11/28/2023

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R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to ensure a comprehensive care plan was devleoped within 30 days after admission for a resident with a major mental illness for 1 of 7 residents reviewed. (Resident 7) Finding include: The record for Resident 7 was reviewed on 10/27/2023 at 2:30 P.M. Resident 7 was admitted to the facility on 7/13/2023, with diagnoses including anxiety disorder, major depressive disorder and post traumatic stress disorder. The resident received funding for their stay through the Medicaid waiver program. There was no documentation in the record regarding a mental health screening and mental health history. The resident was being routinely assessed, since his/her admission by a mental health professional. Those notes were in the record. During an interview with the Director of Nursing, on 10/30/2023 at 11:04 A.M. she indicated there was no mental health screening and although there were a few care plans for Resident 7, including a general plan regarding Anxiety, there was no plan to address the resident's depression and post traumatic stress disorder. In addition, there was no coordination in the development of the care plan with the mental health services provider.	R 0382	F382 Mental Health Screening Non-compliance & F383 Mental Health Screening Deficiency 1. Resident 7 no longer resides in the facility. 2. Medicaid residents with major mental health diagnoses have the potential to be affected. Medicaid residents with major mental health diagnoses will have a comprehensive care plan developed for his/her major mental illness in cooperation with mental health service providers. 3. The facility will follow the regulation R/T care planning for Medicaid residents with major mental illness. The DON will educate the IDT on the regulation for major mental health care planning in cooperation with mental health service providers for Medicaid residents. The SSD/designee will audit Medicaid residents newly admitted with major mental illness for appropriate care planning in cooperation with mental health service providers monthly. 4. The SSD/designee will present the results of this audit to the facility's QAPI Committee monthly for review and/or revision X 6 months or until 100% compliance	11/28/2023

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	During an interview with the Director of Nursing, on 10/30/2023 at 12:34 P.M., she indicated a policy was not available for major mental illness.		is achieved. The Administrator is responsible for overall compliance with this regulation.	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements.			
	Based on record review and interviews, the facility failed to ensure a comprehensive careplan was developed in cooperation with mental health service providers for 1 of 7 residents reviewed with major mental illness. (Resident 7) Finding include: The record for Resident 7 was reviewed on 10/27/2023 at 2:30 P.M. Resident 7 was admitted to the facility on 7/13/2023, with diagnosis, including anxiety disorder, major depressive disorder and post traumatic stress disorder. The resident received funding for their stay through the Medicaid waiver program. There was no documentaiton in the record regarding a mental health screening and mental	R 0383	F382 Mental Health Screening Non-compliance & F383 Mental Health Screening Deficiency 1. Resident 7 no longer resides in the facility. 2. Medicaid residents with major mental health diagnoses have the potential to be affected. Medicaid residents with major mental health diagnoses will have a comprehensive care plan developed for his/her major mental illness in cooperation with mental health service providers. 3. The facility will follow the regulation R/T care planning for Medicaid residents with major mental illness. The DON will	11/28/2023

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	health history. The resident was being routinely assessed, since his/her admission by a mental health professional. Those notes were in the record. During an interview with the Director of Nursing, on 10/30/2023 at 11:04 A.M. she indicated there was no mental health screening and although their were a few care plans for Resident 7, including a general plan regarding Anxiety, there was no coordination in the development of the care plan with the mental health services provider. During an interview with the Director of Nursing, on 10/30/2023 at 12:34 P.M., she indicated a policy was not available for major mental illness.		educate the IDT on the regulation for major mental health care planning in cooperation with mental health service providers for Medicaid residents. The SSD/designee will audit Medicaid residents newly admitted with major mental illness for appropriate care planning in cooperation with mental health service providers monthly. 4. The SSD/designee will present the results of this audit to the facility's QAPI Committee monthly for review and/or revision X 6 months or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	
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 resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to provide a health statement from the physician indicating the resident was free of communicable diseases for 1 of 7 residents reviewed for health statements. (Resident 4) Finding includes: A record review was completed on 10/27/2023 at 10:19 A.M. Diagnoses included, but were not limited to: osteomyelitis, diabetes mellitus type 2,	R 0409	R409 Infection Control Non-compliance 1. Resident 4 no longer resides at the facility. 2. Other residents residing in the facility have the potential to be affected. Residents will be audited for the presence of the required health statement. Corrections will be made as needed for compliance.	11/28/2023

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	and depressive disorder. A health statement could not be located in the medical record. During an interview on 10/30/2023 at 9:31 A.M., the Director of Nursing indicated she could not find a health statement in the electronic health record. A current policy was provided on 10/30/2023 at 12:43 P.M. by the Director of Nursing. The policy titled, "Physician Responsibility", indicated, " ...1. A history and physical will be done upon admission and as needed upon substantial change in condition ... a. Physicians may leave orders with the nurses for general care of resident, indicating conditions or symptoms so that nursing personnel will be aware of them ...."		3. Residents will be assessed by a physician and have the required health statement issued on admission and annually. The DON/designee will audit residents monthly for the presence of the required health statement monthly. 4. The DON/designee will present the results of this audit to the facility's QAPI Committee monthly for review and/or revision x 6 months or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction			

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	to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to complete tuberculosis testing and/or assessment for 1 of 7 residents reviewed for tuberculosis screening. (Resident 6) Finding includes: A record review was completed on 10/27/2023at 11:12 A.M. Diagnoses included, but were not limited to: hypertension, macular degeneration, and cervivocranial syndrome. During the record review a two-step Mantoux test and a tuberculosis screening could not be found. During an interview on 10/30/2023 9:49 A.M., the Director of Nursing indicated she could not find Mantoux documentation completed at admission. A policy was provided on 10?30/2023 at 12:43 P.M. by the Director of Nursing. The policy titled, "Resident Screening for Tuberculosis", indicated " ...1. New Resident Screening: a. Prior to or at time of admission, all new residents will receive TB [tuberculosis] testing and/or radiograph in accordance with sate requirements. c. In the absences of preferred testing, the facility shall follow CDC recommendations for targeted testing for TB infection ...."	R 0410	F410 Infection Control Non-compliance 1. Resident 6 has received 2 step TB testing. 2. Other residents residing in the facility have the potential to be affected. The DON/designee will conduct an audit of residents for the presence of TB testing per regulation with corrections made as needed for compliance. 3. The facility will follow the regulation R/T TB testing on admission and annually. The DON will educate nurses on TB testing per regulation. The DON/designee will conduct an audit of residents for TB testing per regulation weekly. 4. The DON/designee will present the results of these audits to the facility's QAPI Committee monthly for review and/or revision X 6 months or until 100% compliance is achieved. The Administrator is responsible for overall compliance with this regulation.	11/28/2023