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	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODRIDGE VILLAGE	17650 GENERATIONS DR SOUTH BEND, IN 46635

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00435348, IN00436750 & IN00438385. Complaint IN00435348 - No deficiencies related to the allegations are cited. Complaint: IN00436750 - State deficiency related to the allegations is cited at R0247. Complaint IN00438385 - No deficiencies related to the allegations are cited. Survey dates: July 16, 17 & 18, 2024 Facility number: 001148 Residential Census: 62 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 8/2/2024.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana Department of Health for 1 of 1 allegations of abuse reviewed. (Residents 6 and 9) Finding includes: During an interview on 7/17/2024 at 11:00 A.M.,	R 0090	The facility will report allegation of abuse to the IDOH per requirements. The incident identified during the State visit was reported while the State was in the building. Follow up has been completed with no new issues noted.	08/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richard Kennedy	Executive Director	08/21/2024

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	Resident 7 indicated he had witnessed an altercation between Resident 9 and Resident 6 on 7/13/2024 around 1:00 P.M. During the altercation, Resident 9 had been drinking and was cursing, and threatening to assault Resident 6. Resident 9's behavior made Resident 7 uncomfortable and Resident 7 worried about his own safety, as well as the safety of other residents. He felt the behavior exhibited by Resident 9 was verbal abuse and intimidation but he did not talk to any of the staff about it. Resident 7 provided a video of the altercation. The video appeared to show the end of the altercation, after staff had already intervened and had assisted both Residents 6 and 9. QMA 2 could be seen taking Resident 6 out of the Activities Room and LPN 3 stayed with Resident 9. "Shut the f--- up" and "f--- you" could be heard on the video, but neither Residents 6 or 9 were facing the recording, and it could not be determined which resident was using foul language or who the foul language was directed at. No threats of physical violence was heard on the video. During an interview on 7/17/2024 at 11:00 P.M., Resident 8 indicated she had witnessed Resident 9 drunk on 7/13/2024 and threatening Resident 6 in the Activities Room around 1:00 P.M. Resident 9 called Resident 6 names and threatened to "beat him up". Resident 8 was scared and considered what she witnessed to be abuse, but she did not report the incident or her concerns to staff. She indicated she did not feel comfortable being in the common areas of the facility because of Resident 9 and on looking was hoping to move out of the facility. During an interview on 7/17/2024 at 12:30 P.M., the Executive Director (ED) indicated he had been made aware of an incident on 7/13/2024 between		The Administrator has been in-serviced on reporting guidelines of reporting to the State Department of Health. 24-hour reports, complaints, grievances and nurses' documentation will be reviewed to ensure that any incident that meets criteria is reported to the state in a timely manner. Audits will continue until problem is considered resolved Problem is considered resolved after three months of no new issues identified.	

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	Residents 6 and 9 in the Activities Room. He believed it was a verbal altercation resolved by staff and he did not receive any reports of threats of violence or name calling between any of the residents. The ED informed about the verbal abuse, but he thought the verbal abuse was directed toward staff and not other residents. He had followed up, on 7/14/2024, by visiting both Resident 6 and 9. Resident 6 did not express any concerns of being abused and did not tell the ED Resident 9 threatened him with physical violence. During an interview on 7/17/2024 at 12:50 P.M., LPN 3 indicated she was alerted to an incident in the Activities Room where Residents 9 and 6 were having an altercation on 7/13/2024. She witnessed Resident 9 slurring his speech and antagonizing other residents. Resident 9 called Resident 6 a "punk" and threatened to "beat him up" Resident 6. Resident 6 asked Resident 9 to leave him alone. Another staff member assisted Resident 6 while she was assisted Resident 9. She called the ED and reported the incident but did not tell him she witnessed threats of physical harm or verbal abuse. She defined verbal abuse as, "Threatening another person with harm, calling someone a name or anything that could be considered derogatory." She indicated did not feel the altercation between Residents 6 and 9 met the criteria of abuse. During an interview on 7/17/2024 at 1:02 P.M., QMA 2 indicated she had witnessed an incident in the Activities Room on 7/13/2024. She believed Resident 9 was drunk and described his behavior as belligerent. She heard Resident 9 tell Resident 6, "You can walk punk, I can't", but denied hearing Resident 9 threaten Resident 6. Resident 6 was upset and had cried, but she felt he was crying out of frustration and not fear. She did not speak to the ED about the event. She defined			

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	verbal abuse as, "Name calling, making threats, or intimidating another resident." She did not consider the incident she witnessed to have been abuse. During an interview on 7/17/2024 at 1:25 P.M., Resident 6 indicated he was involved in an incident that happened on 7/13/2024 in the Activities Room. While sitting in the Activities Room, Resident 9 came in and was drunk. Resident 9 started yelling at Resident 6 and when Resident 6 asked Resident 9 to leave him alone, Resident 9 called him a "punk" and threatened to "beat him up" He was not sure why Resident 9 was upset with him. Resident 6 confirmed he was upset and had cried about the situation due to his frustration of not being able to handle the situation himself. The ED had visited Resident 6 the next day, but he did not express any concerns of abuse to the ED and felt the situation had been handled. He was unsure of whether he told the ED Resident 9 called him a name or threatened him. An attempt to interview Resident 9 was made on 7/17/2024 at 1:40 P.M., but the resident declined to be interviewed. Resident 9's record review was completed on 7/17/2024 at 2:05 P.M. A Nursing Progress Note, dated 7/13/2024 at 1:59 P.M., indicated Resident 9 was cursing at staff and residents. The resident documented to have been crying, starting fights with other residents, and using vulgar words toward other residents. Resident 6's record review was completed on 7/17/2024 at 2:30 P.M. Resident 6's record lacked any documentation to indicate the resident had been in an altercation with another resident or had experienced any emotional distress related to an			

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	altercation. During an interview on 7/18/2024 at 11:38 A.M., the ED indicated he had not reported an incident of abuse through the state reporting system because he was never made aware of any allegations of abuse. He was not aware of the Nurse's Note on 7/13/2024 at 1:59 P.M. When he followed up with Residents 6 and 9 on 7/14/2024, both residents were happy and wanted to move forward from the incident. He was not aware there were witnesses to the incident and had not heard anything about Resident 7 or Resident 8 being scared or having witnessed the abuse. If he had been aware of the name calling or threats to Resident 6, he would have reported the incident. On 7/17/2024 at 2:30 P.M., the ED provided a policy dated, 9/8/2023 at 2:30 P.M., titled, "Abuse, Neglect, Exploitation & Misappropriation of Resident Property", and identified it as the policy currently used by the facility. The policy indicated, " ...Facility staff should immediately report all such allegations to the Administrator/designee and to the Indiana Department of Health in accordance with the procedures in this policy ... A. Abuse. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ... It includes verbal abuse, sexual abuse, physical abuse, and mental abuse ...."			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review the facility failed to attempt to conduct fire drills every six months in conjunction with the local fire department.	R 0092	The facility will conduct fire drills in conjunction with the local fire department unless requests to participate are declined.	09/15/2024

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	Finding includes: Review of the Fire Drill Education/Inservices for the past year (2023/2024) indicated there was no record the facility had attempted to conduct a fire drill in conjunction with the local fire department. During an interview on 7/18/2024 at 11:38 A.M., the Executive Director (ED) indicated the fire department had not been involved in any fire drills in the past year and the facility and they did not have any documentation of communication requesting their involvement. There was no facility policy regarding fire drills.		The local fire department has been contacted to attend a disaster drill scheduled to be conducted before the end of the month. / Facility is awaiting a response to the request. Update: Drill is scheduled for Thursday, / This practice does not affect other elements of the fire drill. 1pm. The Maintenance Department has been in-serviced on requesting participation from the local fire department. Requests for local fire department participation has been added to TELS and is scheduled for twice per year. TELS auditing will be reviewed on a monthly basis to ensure compliance with this regulation.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview,the facility failed to ensure there was at least one awake staff member, certified in CPR (Cardio-pulmonary Recessitation) and First Aide training for 4 of 9 nursing shifts reviewed. This had the potential to affect all 62 residents in the facility. Finding includes: On 7/18/2024 at 1:00 P.M., a review of the nursing staffing schedules, as worked, for both day and	R 0117	Teh facility will ensure that there are qualified personnel in CPR and First Aide on all shifts. Review has indicated that staff were available on all shifts who are certified in CPR. The facility has acquired of the cards since the survey. Teh schedule for the nursing	09/15/2024

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	night shifts, from 7/14/2024 through 7/18/2024 indicated were not covered with personnel certified in CPR and First Aid. Nursing staffing schedules, dated 7/17/2024 night shift and 7/14/2024 night shift and 7/16/2024 both day and night shifts did not have qualified staff working. During an interview on 7/18/2024 at 11:00 A.M.. the ED indicated not all nursing shifts were covered with CPR and First Aide certified staff. On 7/18/2024 at 1:56 P.M., the DON indicated the facility did not have a policy regarding CPR and First Aide staff requirements but followed state regulations.		department has been updated to include who is certified in CPR and First Aide for continued monitoring. The DON, BOM, scheduler and/or designee have been in-serviced in the requirement to have CPR personnel on all shifts. Schedules will be reviewed by the DON or designee will review all schedules when initiated to ensure that the facility is compliant with this regulation. Monthly schedules will be reviewed by the QA Team to ensure continued compliance.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure staff members received annual dementia education/training for 2 of 5 employee files reviewed. (Housekeeper 6 & Dietary Aide 5) Finding includes: On 7/17/2024 at 9:25 A.M., a review of the employee records was completed. The employee records for Housekeeper 6 and Dietary Aide 5 lacked documentation of annual dementia training/education. During an interview, on 7/17/2024 at 9:59 A.M., the DON indicated she had not provided staff members with a annual dementia training/education as required.	R 0120	The facility will ensure that staff members receive annual dementia training per regulations. Employees identified during the survey have been scheduled for dementia training prior to 09/15/2024. Other employees are required to complete their training before 09/15/2024. All training will be completed via Relias. Relias has been established for the use of the staff to complete training per requirements.	09/15/2024

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	On 7/17/2024 at 10:21 A.M., a policy for dementia training was requested but one was not provided prior to the survey exit.		Personnel files will be audited monthly for completion of dementia training. Results of audits will be reviewed monthly by the QA Team to ensure continued compliance. Audits will continue until the problem is considered resolved. The problem will be resolved after three months of no new issues noted.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure second step tuberculin testing was completed for new employees for 3 out of 5 employee records reviewed. (DON (Director of Nursing), CNA 4 and QMA 7) Findings includes: Employee records were reviewed on 7/16/2024 at 10:00 A.M. New employees, hired within 2024, did not have documentation of a completed second step tuberculin kin test having been completed. -DON start date of 4/26/2024 -CNA 4 start date of 4/8/2024 -QMA 7 start date of 5/30/2024 During an interview, on 7/18/2024 at 10:19 A.M., the DON indicated the employees had a first step completed with a local health facility, but they should have had a second step tuberculin skin test performed.. She did not have a policy regarding the facility's Tuberculin prevention	R 0121	The facility will be compliant with TB/employee screening requirements. New Employees will receive first and second TB test upon hire. Records have been reviewed and all staff will have new screenings by the end of the month. Employees will have their files signed off by the Administrator/DON or designee prior to beginning work to ensure compliance with this regulation. A new hire check list has been added to all personnel to ensure that all areas of pre-employment prior to hire.	09/15/2024

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	program and requirements.		Results of audits will be reported to the QA team to ensure continued compliance until this problem is resolved. This problem is considered resolved after 3 months of no new issues noted.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure employee records included general and specific orientation documentation for 3 of 3 employee records reviewed. (DON (Director of Nursing), CNA 4 and QMA 7) Findings include: Employee records were reviewed on 7/16/2024 at 10:00 A.M. The following was missing from the files: -DON, CNA 4, QMA 7 were missing general and specific orientation. -DON start date of 4/26/2024 -CNA 4 start date of 4/8/2024 -QMA 7 start date of 5/30/2024 During an interview on 7/16/2024 at 10:45 A.M., the Business Office Manager indicated she did not have documentation of any general or specific orientation for the employee's files to provide. A policy regarding general and job specific orientation for new employees was requested , on 7/16/2024 at 10:46 A.M., but one was not provided prior to the survey exit date.	R 0123	The facility will ensure employees receive general and specific orientation upon hire. Employees identified during the survey and other employees are scheduled to complete general and specific orientation prior to 09/15/2024. Personnel files will be audited a least monthly to ensure all employees have received general and specific orientation. Audits will be submitted to the QA Team to ensure continued compliance. Monthly audits will continue until the problem is considered resolved. Problem will be considered resolved after three months of audits with no new issues noted.	09/15/2024

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R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on observations and interviews, the facility failed to ensure the building was maintained in a clean and safe manner related to the walls, ceilings, vents and handrails for 2 of 2 floors, including the outside and common areas. This had the potential to affect 62 of 62 residents in the facility. Findings include: 1. During an observation on 7/16/2024 at 9:50 A.M., with the Maintenance Director, the Housekeeping Closet was found unlocked. The door had a "Hazard" sign on it. Another room labeled Equipment was unlocked and the resident laundry room, which was under remodel, was unlocked and had various tools on a table on the second floor. During an observation and interview on 7/16/2024 at 10:42 A.M., the Maintenance Director indicated the Housekeeping Closet, Equipment Room, and Resident Laundry Room should have been locked. 2. During an observation with the Executive Director (ED) and the Housekeeping Supervisor on 7/18/2024 at 10:20 A.M., the following was observed: - A cold air return vent in the dining room was dusty. - There was mold on the ceiling vent and ceiling tiles with water stains in the hallway outside of the Activity Room. - There was unpainted plaster on the walls in the hallways outside of rooms 107, 109, and 115. -The handrails in all hallways, on both the first and second floors had areas where the paint was	R 0148	The facility will maintain the building in a clean and safe manner. The walls, ceilings, vents, handrails, ceiling tiles have all be updated in TELS for weekly follow up. Most of these areas have been completed. The work is on-going. In addition to the areas identified by the State, other areas with the same problems have been identified. The tracking of these items on TELS ensures that each area is addressed. TELS reports will be report to the QA Teams to ensure continued compliance with this regulation. The reports will continue to be reported to the QA Team on a permanent basis to ensure that the facility is maintained in a safe and clean environment. The Director of Maintenance or designee will be responsible for touring the building at least weekly to identify problems that may occur. His tours should ensure that the deficient practice doesn't reoccur. Results of will be reported to the QA Team for	09/15/2024

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	scraped off. -The ceiling vent in the hall between rooms 105 and 107 was rusty and had mold. -Numerous apartment doors, on both the first and second floors, were were scratched and scuffed. -There was a cracked ceiling tile outside of the resident laundry on the 1st floor. -Both elevators had wood paneling that was chipped. -The heating/air conditioning register cover in the small lounge next to room 235 was falling off. -The facility laundry room, on the second floor had stained and missing floor tiles and the walls needed repaired. -A balcony on the front of the building was missing siding and the wood underneath was rotted. During an interview on 7/18/2024 at 11:41 A.M., the ED indicated there was no policy regarding building maintenance and there was no preventative maintenance program.		continued monitoring.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to ensure food and dishes were appropriately stored and protected from contaminants in 1 of 1 kitchens. This had the potential to affect 62 of 62 residents receiving food from the kitchen. Findings include: During an initial kitchen tour,on 7/16/2024 at 9:33 A.M. with the Dietary Manager, the following was observed: a. An ice scoop was on top of the ice machine uncovered.	R 0154	The facility will ensure that foods and dishes are stored and protected from contaminants. All items sited during the survey were corrected during the survey. The kitchen staff has been in serviced on proper storage of food items and dishes. Scoops, dating of foods, and bowls/plates have been addressed during in-services. Proper	09/15/2024

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	b. Bulk storage bins for flour and brown sugar had food scoops inside them on top of the food and a 25 pound box of sugar was not sealed. c. Ham sandwiches, madarin oranges and cut up melon were not labeled and milk was not dated in the refrigerator. d. In the freezer, sausage and pepperoni were opened and not labeled. A veggie burger was not sealed and dated. e. In the dry storage, an opened cake mix and bag of coconut were not sealed and dated. An opened bag of flour was undated. bf. Salad bowls and dessert plates were not stored inverted or covered. During an interview on 7/16/2024 at 9:50 A.M. the Dietary Manager indicated all food should be covered and dated, bulk bin items should be sealed without scoops inside them, dishes should be inverted when stored and the ice scoop should be covered. On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, "Food Storage," and indicated the policy was the one currently used by the facility. The policy indicated "... 6. Scoops are not to be stored in the food containers, but are kept covered in a protected area near the containers. 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. 17. Freezer Temperatures e. Rewrap packages of frozen food which have been opened. This prevents freezer burns and spoilage. g. To freeze leftovers food, package in small airtight units for quick freezing, label and date....." On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, "Sanitation of Ice Machine," undated, and indicated the policy was		techniques have been demonstrated. An audit sheet has been developed for these items to be monitored on a daily basis by the Dietary Manager or designee. The audit sheets will be reported to the QA team to ensure continued compliance. This process will continue until this problem is considered resolved. This problem will be considered resolved after 3 months of no new findings.	

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	the one currently used by the facility. The policy indicated, "1. Place scoop in dish rack and sanitize in dish machine. 2. Allow to air dry. 3. Place in clean plastic container for storage....." On 7/18/2024 at 9:30 A.M., the Dietary Manger indicated the facility did not have a policy regarding dish storage.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on record review and interviews, the facility felled to ensure semiannual evaluations were completed for 5 of 7 residents reviewed. (Resident B, C, 3, 4 and 5) Findings include: 1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension. The Electronic Medical Record (EMR) had no documentation a semi-annual assessment had been completed for Resident C. During an interview, on 7/18/2024 at 10:07 A.M., the DON indicated residents should have a semi-annual evaluation and service plan review. 2. 2. Resident B's record review was completed on 7/16/2024 at 3:05 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked the documentation he had received a semiannual evaluation.	R 0214	All residents will receive semi-annual evaluations per regulatory requirements. All residents have had a review of their records and those who did not have a semiannual assessment or weight has had his/her record updated to include assessments. DON or designee will be in-serviced on completing assessments in a timely manner. Residents will receive semiannual assessments along with service plans which are completed on semiannual basis. Services plans upon completion will be reviewed by the QA Team to ensure semiannual assessments are completed until this problem is considered resolved. This problem will be considered resolved after three months of review by the QA Team	09/15/2024

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			with any additional findings.	
	3. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The record lacked a semi-annual evaluation. The most recent evaluation was completed in June of 2023. There was no evaluations for December of 2023 or June of 2024. 4. A record review for Resident 5 was completed on 7/17/2024 at 3:10 P.M. The resident was admitted to the facility on 4/29/2022 and still resided in the facility. Resident 5's record lacked documentation of a semi-annual evaluation having been completed since admission. 5, A closed record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of a semi-annual evaluation. On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual assessments, semi-annual weights, or admission weights and they follow the State regulations			
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure residents had an evaluation prior to admission for 2 of 7 residents reviewed. (Residents 2 and 3) Finding includes: 1. A record review for Resident 2 was completed on 7/17/2024 at 2:11 P.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from	R 0215	The facility will ensure that all residents receive an evaluation prior to admission. All residents' files have been reviewed for assessment prior to admission. If a file did not have an assessment prior to admissions, that file has been updated with a current assessment.	09/15/2024

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	the facility on 6/19/2024. The record lacked documentation of an evaluation completed prior to 12/8/2023. 2. A record review for Resident 3 was completed on 7/17/2024 at 2:36 P.M. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of an evaluation completed prior to 11/20/2023. During an interview on 7/18/024 at 10:07 A.M., the DON indicated the residents had not had an evaluation completed prior to admission. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding completing pre-admission evaluations but followed state regulations.		Inservice completed on having assessment completed by a nurse prior to admission. All new residents are assessed prior to admissions. Resident files will be audited at least monthly or until problem is considered resolved. The problem will be considered resolved after three months of no new issues noted.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure a self-administration of medication assessment was completed timely for 1 of 7 resident records reviewed, failed to obtain semiannual weights for 2 of 7 resident records reviewed and failed to ensure a weight was obtained upon admission for 1 of 7 residents reviewed. (Residents C, D and 3) Findings include: 1. A record review was completed on 7/16/2024 at 2 P.M., for Resident C. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, and hypertension.	R 0216	The facility will ensure that all residents who are classified as self-administration of medications are assessed quarterly or upon change in condition. DON and/or designee has been in-serviced on completing self-administration assessments. All files have been reviewed and all residents currently have medication assessments if the resident is classified as self-administration of medications. The count is 14 of	09/15/2024

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	The Electronic Medical Record (EMR) for Resident C indicated the last self-medication assessment was completed on 6/29/2023. During an interview on 7/17/2024 at 10:00 A.M., the Director of Nursing (DON) indicated an administration of medication assessment should have been completed quarterly for Resident C.2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Resident D's record lacked the documentation indicating he had been weighed semiannually 3. A record review for Resident 3 was completed on 7/17/2024 at 1:22 P.M. The resident was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. Resident 3's record lacked documentation of an admission weight. On 7/17/2024 at 10:20 A.M., the DON provided a policy titled, "Self-Administration of Medication, "dated 2023, and indicated the policy is the one currently used by the facility. The policy indicated, "A skills assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. The skills assessment is repeated on a quarterly basis or when there is a significant change in condition....." On 7/18/2024 at 1:45 P.M., the DON indicated she did not have a policy for semi-annual weights or admission weights, but the facility followed State regulations.		58. Resident files will be audited at least monthly to ensure that orders and assessments are completed for medication administration. Audits will continue until problem is considered resolved This problem will be considered resolved after three months of no new issues noted. Semi-annual and admissions are to be completed upon admission or a change in condition. The facility is currently obtaining weights from residents on a monthly basis. Files will be reviewed during semi -annual service plans to ensure that each resident has received at least one weight within the prior six-month period. Results of audits will be reported to the QA Team for continued monitoring and compliance.	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview the facility failed to ensure Service Plans were provide, updated and signed by the resident and/or their representative for 7 of 7 residents reviewed. (Residents 4, C, B, D, 2, 3, and 5) Findings include: 1. A record review for Resident 4 completed on 7/16/2024 at 2:00 P.M. and there was no Service Plan for the resident. During an interview, on 7/17/2024 at 9:10 A.M., Resident 4 indicated he did not remember discussing his care or services with staff.2. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. Diagnoses included, but were not limited to: type 2 diabetes, major depressive disorder, and hypertension. Resident C's record indicated a service plan was not completed during the past year.3. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. Resident B was admitted to the facility on 11/26/2021. Resident B's record lacked documentation indicating he had signed a Service Plan. 4. During an interview on 7/16/2024 at 3:09 P.M., Resident D indicated he had not signed a Service Plan and did not know what a Service Plan meant. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022.	R 0217	The facility will ensure that all Service Plans are completed in a timely manner. The DON and designees have updated all Service Plans. The Service Plans are in the process of being signed by the residents and/or representatives. The Nursing Department has been in-serviced on the regulatory requirements to complete services plans on a semi-annual basis. Service Planss will be reviewed on a monthly basis to ensure all are completed. This will be audited by the DON or designee. Results of the audits will be reported to the QA Team on a monthly basis for monitoring continued compliance. QA Team Audit will continue until this problem is considered resolved. It is resolved after 3 months of clean audits.	09/15/2024

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	Resident D's record lacked the documentation indicating he had signed a Service Plan. 5. A closed record review for Resident 2 was completed on 7/17/2024 at 9:27 A.M. Resident 2 was admitted to the facility on 12/8/2023 and discharged from the facility on 6/9/2024. The record lacked documentation of a signed Service Plan. 6. A closed record review for Resident 3 was completed on 7/17/2024 at 1:18 P.M. Resident 3 was admitted on 11/20/2023 and discharged from the facility on 6/10/2024. The record lacked documentation of a signed Service Plan. 7. A record review for Resident 5 was completed on 7/17/2024 at 3:04 P.M. The record indicated Resident 5 was admitted on 4/29/2023. The record lacked the documentation of a signed Service Plan. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy regarding Service Plan requirements, but followed the State regulations.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on record review and interview, the facility failed to notify a Physician about a resident's high blood glucose levels for 1 of 1 resident who was reviewed for insulin use. (Resident B) Finding includes: A record review for Resident B was completed 7/16/2024 at 3:05 P.M. Diagnoses included, but were not limited to, type 2 diabetes mellitus,	R 0247	The facility will notify physicians when there are abnormal readings for blood sugars. The physician was notified about the b/s for resident B. No new orders noted. Nursing staff has been in-serviced on notification with b/s or other vitals are not within normal ranges	09/15/2024

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	schizoaffective disorder, epilepsy and hypertension. A Physicians Order for Resident B, dated, 7/5/2023, indicated the Physician was to be notified if the resident's blood glucose level was 390 milligram (mg) per deciliter (dL) or higher. The Electronic Medical Record (EMR) for Resident B indicated the following blood glucose levels: -7/16/2024 at 7:51 A.M. resident's blood glucose was 390 mg/dL. -7/14/2024 at 4:09 P.M. resident's blood glucose was 427 mg/dL. -7/14/2024 at 7:32 A.M. resident's blood glucose was 403 mg/dL. -7/11/2024 at 11:23 A.M. resident's blood glucose was 420 mg/dL. -7/5/2024 at 11:55 A.M. resident's blood glucose was 393 mg/dL. -6/20/2024 at 3:56 P.M. resident's blood glucose was 426 mg/dL. -6/19/2024 at 12:03 P.M. resident's blood glucose was 400 mg/dL. -6/16/2024 at 11:48 A.M. resident's blood glucose was 425 mg/dL. -6/15/2024 at 9:00 A.M. resident's blood glucose was 420 mg/dL. -6/14/2024 at 11:16 A.M. resident's blood glucose was 422 mg/dL. -6/10/2024 at 3:50 P.M. resident's blood glucose was 427 mg/dL. -6/3/2024 at 11:15 A.M. resident's blood glucose was 410 mg/dL. -6/2/2024 at 7:33 A.M. resident's blood glucose was 427 mg/dL. -5/21/2024 at 4:21 P.M. resident's blood glucose was 401 mg/dL. -5/18/2024 at 12:12 P.M. resident's blood glucose		per physicians. Other areas of notification have been reviewed. Change in conditions will require notification of physician. All notification will be documented in the EMAR to ensure tracking of physician communication. 24-report will be monitored by the DON to ensure continued compliance with notification. Audit of 24-hour reports will be reported to the QA Team for continued monitoring. This will continue until this problem is considered resolved. This problem is considered resolved after 3 month of no new issues.	

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	was 525 mg/dL. -5/16/2024 at 4:00 P.M. resident's blood glucose was 519 mg/dL. -5/14/2024 at 6:18 P.M. resident's blood glucose was 520 mg/dL. Resident B's record lacked the documentation indicating a Physician was notified about high blood glucose levels for any of the dates listed above. During an interview on 7/17/2024 at 3:30 P.M., the Director of Nursing (DON) indicated the staff were to notify the Physician through a text application but she could not locate any documentation the Physician had been notified about Resident B's high blood glucose levels. Staff were also to document in the Electronic Medical Record (EMR) when a Physician has been contacted. The DON indicated the facility did not have a policy regarding following Physician Orders because following Physician Orders was a standard of care and following the standards of care was what the facility did. This citation relates to complaint IN00436750.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review and interview, the facility failed to serve and prepare food under sanitary conditions related to hair nets not being worn and mean no defrosted appropriately. This had the potential to affect 62 out of 62 residents receiving food from the kitchen.	R 0273	The employees of the dietary department will wear hairnets at all times while in the kitchen. The dietary department has been in-serviced on wearing hairnets at all times while in the kitchen. The dietary manager is currently	09/15/2024

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	Findings include: During an initial kitchen observation tour, conducted on 7/16/2024 at 9:33 A.M. with the Dietary Manager, the following was observed: a. In the refrigerator uncooked chicken was thawing above pork and beef. b. Hair nets were not worn by three kitchen staff working and preparing food. During an interview on 7/16/2024 at 9:55 A.M., the Dietary Manager indicated the chicken should not be thawing out above the beef and the pork, and hair nets should be worn by the staff when working in the kitchen. On 7/16/2024 at 1:59 P.M., the Dietary Manager provided a policy titled, " Food Storage," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 17. Freezer Temperatures: c. Holding temperatures for frozen foods is 0 degrees or below 0. Frozen meats must be defrosted in a refrigerator on a tray on a lower shelf....." On 7/17/2024 at 10:10 A.M., the Dietary Manager provided a policy titled, " Personal Hygiene," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... 1. If hair is long and not covered properly with a cap, a hair net must be worn. Hair spray is not an authorized substitute for a hair net....."		auditing compliance of this issue. So far, no new issues noted. Foods will be thawed in the kitchen per regulatory protocol. The dietary department has been in-serviced on the proper handling of foods that are being thawed. "Chicken always goes on the bottom". All audits will be reported to the QA Team for monitoring of continue compliance. The audits will be reported to the QA for 3 months or until this problem is considered resolved. This problem will be considered resolved after 3 months of no new issues noted. Audits will be completed by the Dietary Manager or designee at least weekly. Results of audits will be reported to the QA Team to ensure continued compliance.	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency Based on record review and interview the facility	R 0275	The facility will ensure that all residents have a diet order on file.	09/15/2024

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	failed to ensure residents had a Physician's diet order for 2 of 7 residents reviewed. (Residents 3 & B) Findings include: 1. A record review for Resident 3 was completed on 7/17/2024 at 1:31 P.M. Resident 3's diagnoses included, but were not limited to gastroesophageal reflux disease and hypercholesterolemia. Resident 3 was admitted to the facility on 11/20/2023 and discharged from the facility on 6/10/2024. There was no diet order for Resident 3.. 2. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. Resident D was admitted to the facility on 2/4/2022. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypertension, heart failure and stage 3 chronic kidney disease. Resident D's record lacked the documentation indicating he had a Physician's order for a diet. During an interview on 7/18/2024 at 1:30 P.M., the Director of Nursing indicated residents should have a diet order prescribed from a physician. The facility did not have a policy regarding diet orders but followed State regulations.		The DON and designees have reviewed all residents and have found them to have diet orders per physician orders. Nursing department has been in-serviced on having an order for new and current residents. All have been updated. Audits will be completed by the DON and/or designee on a monthly basis to ensure continued compliance. Results of audits will be reported to the QA Team for review and monitoring. This will continue until this problem is considered resolved which will be 3 months with no new issues noted.	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance Based on observation and interview the facility failed to ensure medications, for residents who self-administer, were stored secured from other residents. Finding includes:	R 0295	All residents who are self-administering medications will have a lockbox for safety and storage of their medications. The DON and/or designee will ensure that every resident who	09/15/2024

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	A record review completed on 7/16/2024 at 2:00 P.M., indicated Resident 4 had an order, dated 5/17/2024, to self-administer his medications. An assessment for self administering medications was completed on 5/14/2024 and indicated the resident was capable of handling his own medications. During an interview, on 7/17/2024 at 9:08 A.M., Resident 4 indicated he handled his own medications and did not have them locked up. He kept them in the top drawer of his dresser. During an observation on 7/17/2024 at 9:08 A.M., Resident 4's medications were kept in the top drawer of his dresser. The resident shared the room with a roommate. During an interview on 7/18/2024 at 9:23 A.M., the DON indicated medications should be secured and she did not know Resident 4 did not have his medications locked up. On 7/18/2024 at 9:37 A.M., the DON provided a current policy, dated 2023, titled, "Self-Administration of Medications." The policy indicated, "...The following condition are met for beside storage to occur: The manner of storage prevents access by other residents...."		has an order for self-administration has a lockbox for the safeguarding of the medications. Residents who are self-administering medications will be monitored and assessed for proper use of lockbox to secure medications when not in use. These assessments will be reported to the QA Team to ensure continued compliance with the use of the lock boxes. This process will continue until this issue is considered resolved. This issue will be resolved after three months of no new issues noted. Residents will be monitored by DON or designee (Nurses/QMA's) to ensure that residents who self-administer medications store them properly. Storage of medications will be audited at least weekly until this problem is considered resolved. Problem will be considered resolved at 3 months of no new issues noted.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on record review and interview, the facility failed to establish an infection control program that included, but was not limited to, a system that enabled the facility to analyze patterns of known	R 0407	The facility will maintain a log for tracking infections throughout the facility.	09/15/2024

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	07/18/2024

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	infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect 62 of 62 residents who reside in the facility. Finding includes: During an interview on 7/17/2024 at 9:54 A.M., the Infection Prevention Nurse was unable to provide an infection control log book showing surveillance of infections throughout the facility. She indicated the facility did have a section in the EMR system, called clinical overview, that identified urinary tract and respiratory infections. However, they did not have a staff member assigned to monitor and carry out an infection control program. On 7/17/2024 at 10:11 A.M., a policy was requested but one was not provided prior to the survey exit.		The log has been initiated by the DON or designee as a tool to monitor infections throughout the facility. The log will include urinary and respiratory infections. The nursing department has been in-services on tracking infections and the logs that will be used for tracking infections. Medications will be crossed referenced with infections to ensure all infections are noted. This will include a 24-hour report review to further compliance. Results of audits will be reported to the QA to ensure continued compliance. This will continue unit this problem is considered resolved. This problem will be considered resolved after 3 months of no new issues noted. Auditing of the Infection Control problem will be conducted by the DON, Regional Nurse or designee. Audits will be conducted at least monthly or until problem is considered resolved. Problem will be considered resolved after three months of no new issues noted.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure annual health statements were	R 0409	All residents will receive an annual health statement per regulations.	09/15/2024

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		A. BUILDING 00 B. WING	07/18/2024

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	obtained for 7 of 7 residents reviewed. (Residents 2, 3, 5, C, 4, B, D) Findings include: 1. A record review for Resident 2 was completed on 7/17/2024 at 9:23 A.M. The resident's record lacked documentation of an annual health statement. 2. A record review for Resident 3 was completed on 7/17/2024 at 1:29 P.M. The resident's record lacked the documentation of an annual health statement. 3. A record review for Resident 5 was completed on 7/17/2024 at 3:16 P.M. The resident's record lacked the documentation of an annual health statement.4. A record review was completed on 7/16/2024 at 2 P.M. for Resident C. The resident's record lacked the documentation of an annual health statement5. A record review for Resident 4 was completed on 7/16/2024 at 2:00 P.M.. The resident's record lacked the documentation of an annual health statement.6. Resident B's record review was completed on 7/16/2024 at 3:30 P.M. The resident's record lacked the documentation of an annual health statement. 7. Resident D's record review was completed on 7/16/2024 at 3:45 P.M. The resident's record lacked the documentation of an annual health statement. During an interview on 7/18/2024 at 10:18 A.M., the Director of Nursing (DON) indicated all residents should have an Annual Health Statement from a physician in their Electronic Medical Record.		All files have been reviewed for annual health statements. Files found not to have an annual health statement are in the process of being updated and should be completed by 09/15/2024. DON /Nursing Department in serviced on maintaining an annual health statement for each resident in the facility. Filles will be reviewed with service plans to ensure continued compliance. Results of audits will be reported to the QA Team to ensure continued compliance. Audits will continue until the problem i considered resolved. The problem will be considered resolved with three months of no new issues noted. Service Plan requirements will be reviewed by the DON or designee. Reviews will occur at least monthly to ensure all service plans are completed per regulatory requirements. Results of reviews will be reported to the QA Team on a monthly basis for continued monitoring and compliance.	

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	During an interview on 7/18/2024 at 1:30 P.M., the DON indicated the facility did not have a policy regarding Annual Health Statements and followed the State regulations.			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview the facility failed to ensure residents had a 1st and 2nd step tuberculosis test (TB) upon admission for 2 of 7 residents reviewed for TB tests. (Resident 3 & 5) Findings include: 1. A record review for Resident 3 was completed on 7/17/2024 at 1:07 P.M. Resident 3 was admitted to the facility on 11/20/2023. The record lacked documentation of a 1st and 2nd TB test upon admission to the facility. 2. A record review for Resident 5 was completed on 7/17/2024 at 3:01 P.M. Resident 5 was admitted to the facility on 4/29/2023. The record lacked documentation of a 1st and 2nd step TB test upon admission. During an interview on 7/18/024 at 10:07 A.M., the DON indicated the residents did not have their 1st and 2nd step TB tests completed on or prior to admission. During an interview, on 7/18/2024 at 1:45 P.M., the DON indicated the facility did not have a policy but followed the State regulations	R 0410	The facility will be compliant with TB/resident screening requirements. New admissions will receive first and second TB test upon Admission. Inservice will be conducted for the nursing department on 1st & 2nd step TB for residents and staff. Records have been reviewing and all residents will have new screenings by the end of the month. All residents will have 1st steps completed, pending for 2nd steps per protocol. Admissions packets will be reviewed/audited to ensure process is completed. This will be audited by the DON and/or designee. Results of audits will be reported to the QA team to ensure continued compliance. The audit process will continue until there have been 3 months with no new issues noted	09/15/2024