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	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT WINDERMERE	9745 OLYMPIA DR FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00300188. Complaint IN00300188-Substantiated. No deficiencies related to the allegations are cited. Survey Dates: July 18 and 19, 2019. Facility Number: 002999 Residential: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 29, 2019	R 0000	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Hearth at Windermere as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are			

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

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	attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on Record review and interview the facility failed to ensure the implementation of a resident's rights for protection of a resident's property from loss and theft by not reporting nor investigating a report for stolen pain medication by a resident for 1 of 5 resident's reviewed for resident's rights. (Resident 58). Findings include: Resident 58's admission assessment completed on 6/28/19 indicated Resident 58 was alert and oriented to person, place and time. Resident 58 was able to self-administering her own medications. An interview conducted on 7/19/19 at 10:20 a.m., with Resident 58 indicated, that the night after admission on , an unknown staff member entered her room in the middle of the night. When Resident 58 woke to find the staff member at bedside, she asked the staff member why she was in her room to which the staff member replied, "you had your call light on". The resident indicated that her call light pendant was on her bedside table and did not remember turning her call light on at that time. Resident 58 indicated she remembered hearing the staff member going through her medicine cabinet, in her washroom, then leaving her room. Resident 58 indicated she arose after the staff member left and went to her medicine cabinet to find that her new bottle of pain medication was missing. Resident 58 indicated she went to nursing staff after the incident and reported that someone took her pain medication	R 0091	1. Resident 58 missing medication was reported, and the resident was reimbursed the cost of the medication. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Staff will be in-serviced on the protection of the resident's property from loss and theft, proper reporting and investigation. In addition, grievance forms will be available at the reception desk for residents and families to complete or for use by the staff that receive any oral report of misappropriation. Staff will be in-serviced on the appropriate procedure when a grievance is reported. 4. The Executive Director or designee will review all grievance forms as they are received for the next 7 months. The Quality Assurance Committee will monitor all reports of theft and incident reports monthly for the next 7 months. 5. Correction: September 9, 2019	09/06/2019

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	and asked "shouldn't the police be called?". Resident 58 reported that no one on night shift called the police. Resident 58 indicated the following morning, two members of administration (the then Business Office Manager and the then Marketing Manager) came to her room inquiring about the proposed theft of medication. Resident 58 stated the two former members of administration indicated they would "look into it" but that she never heard back from them. Resident 58 stated, "a couple days later" the unit manager (UM) of the dementia unit (MC UM) interviewed her concerning her allegation of theft and was told, "we will get back with you". Resident 58 indicated no further information was communicated to her about the investigation of theft. An interview with MC UM was conducted on 7/19/19 at 1:30 p.m.. MC UM indicated she was made aware of proposed medication theft 'a couple days after the incident' when getting report in the morning. MC UM indicated, she heard other nurses talking about an incident where Resident 58's pain medication was taken by a Certified Nursing Assistant (CNA) a couple nights previous and that the CNA indicated she was not going to return to her job. MC UM indicated, she felt as though "no one was taking it (the theft) seriously and went to talk to the resident. MC UM indicated after talking with Resident 58, she called the Executive Director (ED). MC UM indicated the ED was already aware of the allegation made by Resident 58 and asked MC UM to write a statement regarding what Resident 58 had alleged and what MC UM had heard regarding said allegation. MC UM stated, " I wrote a statement about Resident 58's medication going missing" that day. MC UM indicated she gave the written statement to the ED (employed at that time) because the facility did not have a Director of Nursing at that time. MC UM indicated Resident 58 had two bottles of Norco, one was almost empty			

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	and a new bottle. MC UM indicated she heard that the CNA, who allegedly took the medication, transferred a 'few' tablets from the new bottle of Norco to the almost empty bottle of Norco, then took the new bottle of pills and left the facility. An interview with the Director of Nursing (DON) on 7/19/19 at 11:30 a.m., indicated no reportable incidents for Resident 58 have been made since admission. DON indicates that Resident 58 self-administers her medications and there is no record of the medications that Resident 58 takes on a daily basis. Also, the DON indicated there aren ' t any nursing notes related to a possible theft of medications.			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.			

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	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review the facility failed to assure 2nd step tuberculin tests were completed for 3 of 5 employee records reviewed. (Housekeeper 1, Certified Nursing Assistant 2 and Certified Nursing Assistant 3) Findings include: 1. The employee record for HSKP (Housekeeper) 1 was reviewed on 7/19/19 at 12:30 p.m. The date of employment for HSKP 1 was 5/6/2019. The employee record did not contain information that a 2nd step tuberculin test had been administered. During an interview on 7/19/2019 at 1:15 p.m., the BOM (Business Office Manager) indicated there was no record of a 2nd step tuberculin test being administered and that HSKP 1 should have had a 2nd step tuberculin test. 2. The employee record for CNA (Certified Nursing Assistant) 2 was reviewed on 7/19/19 at 12:30 p.m. The date of employment for CNA 2 was 5/14/2019. The employee record did not contain information that a 2nd step tuberculin test had been	R 0121	1.Housekeeper 1, CNA 2 and CNA 3 were administered the first step PPD and will be given the second step PPD within the guideline. 2.The Community reviewed each employees record to determine which employees, if any, could be affected by the alleged deficient practice. 3.The Director of Nursing or designee audited all staff records to identify staff that are not in compliance. Any staff identified as out of compliance will receive the first step PPD and will be given the second step PPD within the guidelines. Each department head will be in-serviced on ensuring new hires TB test are completed prior to contact with residents. 4.The Executive Director or designee will review all new hire packets to ensure compliance. 5.Correction: September 9, 2019	09/09/2019

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	administered. During an interview on 7/19/2019 at 1:15 p.m., the BOM (Business Office Manager) indicated there was no record of a 2nd step tuberculin test being administered and that CNA 2 should have had a 2nd step tuberculin test. 3. The employee record for CNA 3 was reviewed on 7/19/19 at 12:30 p.m. The date of employment for CNA 3 was 6/6/2019. The employee record did not contain information that a 2nd step tuberculin test had been administered. During an interview on 7/19/2019 at 1:15 p.m., the BOM (Business Office Manager) indicated there was no record of a 2nd step tuberculin test being administered and that CNA 3 should have had a 2nd step tuberculin test. On 7/19/2019 at 1:18 p.m., the BOM provided the Mantoux Testing Policy which indicated Employee Partners must undergo TB testing within 14 days of hire (or as indicated by state regulations). The initial test should follow CDC (Center for Disease Control) guidelines regarding one or two-step process (unless state regulations specify differently).			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including			

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	appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure triple blade razors were kept secured on the memory care unit with the potential to affect 1 of 1 resident randomly observed on the unit during the environmental tour. (Resident 51) Findings include: An environmental tour of the facility was conducted with the Maintenance Director on 7/19/19 at 11:15 a.m. During the tour, Resident 39's restroom, located on the memory care unit of the facility, was observed. Resident 39's apartment door was already open upon entrance. He was lying in bed, and his restroom door was open as well. An 8 pack of triple blade razors was on the vanity of his restroom sink. Upon leaving Resident 39's room, Resident 51 was observed wandering, by herself, up and down the same hallway where Resident 39's room was located. Resident 51's 7/8/19 Nursing Summary indicated she was confused, unaware, and ambulated alone. It indicated she was not alert and oriented. An interview was conducted with the DON (Director of Nursing) during the environmental tour on 7/19/19 at 11:15 a.m., after Resident 39's restroom observation. She indicated unsecured	R 0148	1.The triple blade razor was removed from Resident 51 room. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.Staff will be in-serviced on items that must be kept locked and secured. The Director of Nursing or designee will monitor three resident rooms each week for 8 weeks then monthly for 7 months. 4.The Executive Director or designee will randomly audit resident's rooms for the next 7 months to ensure compliance. 5.Correction: September 6, 2019	09/06/2019

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	chemicals should not be stored on the memory care unit, but was unsure about razors. An interview was conducted with ED 2 on 7/19/19 at 12:17 p.m. She indicated each resident on the memory care unit should have personal items in a bin at the nurse's station or in a locked area for items they shouldn't have, like scissors or things they could ingest that would hurt them.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure completion of an evaluation of a resident's admission weight for 1 of 5 residents whose admission record was reviewed. (Resident 45) Findings include: A record review conducted on 7/18/19 at 1:28 p.m., indicated Resident 45's admission weight had not been recorded upon admission. An interview, conducted on 7/18/19 at 1:34 p.m., with Licensed Practical Nurse (LPN) 5 indicated, on admission, the resident's weight should have been recorded on the medical record but, upon review of	R 0216	1.Resident 45 weight was recorded and documented in the clinical file. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.All nurses will be in-serviced on admission assessments and proper documentation for an assessment. 4.The Director of Nursing or designee will audit all new admission files within 48 hours after admission for the next 7 months.	09/06/2019

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	Resident 45's admission paperwork and assessment, the admission weight had not been recorded at the time of admission.		5.Correction: September 6, 2019	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review the facility failed to maintain complete medical records for 1 of 5 records reviewed. (Resident 21) Findings include: The clinical record for Resident 21 was reviewed on 7/18/2019 at 2:10 p.m. The diagnosis for Resident 21 included, but were not limited to Dementia. She was admitted to the memory care unit of the facility on 11/7/18. The clinical record did not contain a service plan for Resident 21. During an interview on 7/19/2019 at 1:45 p.m., the Director of Nursing indicated that she was unable to find a service plan for Resident 21. She believed it was completed, however was unable to locate it.	R 0349	1.Resident 21's service plan was completed. Conference call will be set up with out of state responsible party and documented. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.The Director of Nursing or designee will audit all resident charts to ensure all service plans are in residents files. In addition, unit managers will be in-serviced on service plans. 4.The Executive Director, Director of Nursing, Quality Assurance Committee, or designee will conduct regular audits of residents files to ensure compliance. 5.Correction: September 6, 2019	09/06/2019
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution.			

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	(3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a resident's transfer form included the name of the receiving institution, date of last TB (tuberculosis) test, and date of last chest x-ray for 1 of 2 closed records reviewed. (Resident 81) Findings include: The closed clinical record for Resident 81 was reviewed on 7/19/19 at 9:30 a.m. The diagnoses for Resident 81 included, but were not limited to, dementia. A list of residents who were transferred or discharged from the facility in the last 90 days was provided by the DON (Director of Nursing) on 7/18/19 at 11:05 a.m. The list indicated Resident 81 was discharged to another facility. Resident 81's 5/11/19 Resident Transfer Form did not include the name of the facility to which Resident 81 was transferring, the date of her last TB test, or the date of her last chest x-ray. The form included fields for this information, but they were not completed. An interview was conducted with the DON on 7/19/19 at 1:05 p.m. She reviewed Resident 81's 5/11/19 transfer form and indicated the name of the	R 0354	1.Resident 81 is no longer in the Community. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.All nursing staff will be in-serviced on proper completion of transfer forms, including the name of the receiving institution, date of last TB and date of last chest x--ray. 4.The Executive Director, Director of Nursing or designee will review all transfer records for 7 months to ensure compliance with all required information, including the name of the receiving institution, date of last TB test and date of last chest x-ray. 5.Correction: September 6, 2019	09/06/2019

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	receiving institution, date of last TB, and date of last chest x-ray were not included on her transfer form. An interview was conducted with ED (Executive Director) 2 on 7/19/19 at 3:00 p.m. She indicated the facility should have completed the transfer form.			
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure a resident's clinical record included physician notification of death and disposition of the body and personal possessions for 1 of 2 closed records reviewed. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed on 7/19/19 at 10:00 a.m. The diagnoses for Resident 80 included, but were not limited to, chronic kidney disease. A list of residents who were transferred or discharged from the facility in the last 90 days was provided by the DON (Director of Nursing) on 7/18/19 at 11:05 a.m. The list indicated Resident 80 died in the facility on 4/25/19. The clinical record, including the 4/25/19 nurse's notes, did not include physician notification of death and disposition of the body and personal possessions.	R 0357	1.Resident 80 expired. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.All nursing staff will be in-serviced on documenting in the resident's clinical record notification to the physician of the death and disposition of the body and personal possessions. 4.The Executive Director, Director of Nursing or designee will review all transfer record for 7 months to ensure that notification to the physician of the death and disposition of the body and personal possessions are documented in the clinical file. 5.Correction: September 6, 2019	09/06/2019

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	An interview was conducted with the DON (Director of Nursing) on 7/19/19 at 10:39 a.m. She indicated the facility did not have any documentation regarding the disposition of Resident 80's belongings. She indicated she just spoke with Resident 80's hospice provider who would be faxing over documentation regarding the disposition of body and physician notification of death, but the documentation was not currently in the facility. An interview was conducted with ED (Executive Director) 2 on 7/19/19 at 3:00 p.m. She indicated the facility should have included physician notification of death and disposition of the body and personal possessions in Resident 80's clinical record.			
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 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.	R 0410	1.Resident 45 was administered	09/06/2019

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	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT WINDERMERE	9745 OLYMPIA DR FISHERS, IN 46038

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	Based on record review and interview, the facility failed to ensure tuberculin skin tests were administered prior to or at the time of admission for 1 of 5 records reviewed. (Resident 45) Finding includes: The closed record for Resident 45 was reviewed on 7/18/19 at 11:42 a.m.. The resident was admitted to the facility on 6/20/19. There were no tuberculin (TB) skin tests available for review related to the admission. Interview with the Licensed Practical Nurse (LPN) 5 on 7/18/19 at 1:31 p.m., indicated a TB (tuberculosis) test should have been completed and recorded in the medical record prior to admission.		the first step PPD and will be given the second step PPD within the guideline. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.The Director of Nursing or designee audited all resident's records to identify residents that are not in compliance. Any resident identified as out of compliance will receive the first step PPD and will be given the second step PPD within the guideline. In addition, the Director of Nursing or designee will monitor three residents charts each week for 8 weeks then monthly for 7 months. 4.The Executive Director or designee will randomly monitor three resident charts for the next 7 months to ensure compliance. 5.Correction: September 6, 2019	