PRINTED: 09/12/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155385 STREET ADDRESS, CITY, STATE, ZIP COD 1555 COMMERCE ST LOGANSPORT, IN 46947 IDENTIFICATION NUMBER 1555 COMMERCE ST LOGANSPORT, IN 46947 IDENTIFICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY IN SUMMARY STATEMENT OF DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION IDENTIFICATION NUMBER 1555 COMMERCE ST LOGANSPORT, IN 46947 IDENTIFICATION NUMBER 1655 COMMERCE ST LOGANSPORT, IN 46947 IDENTIFIED 1655 COMMERCE ST LOGANSPORT STATE, ZIP COD 1555 COMMERCE ST LOGANSP	CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039		
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F 0000 Bldg. 00 This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00440500. F 0000 F 0000 ="" span=""> Submission of this plan of correction does not constitute admission or agreement by the		`			CROSS-REFERENCED TO THE APPROPRIAT	ΓE			
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Licensure Survey. This visit included the Investigation of Complaint IN00440500. Submission of this plan of correction does not constitute admission or agreement by the	g. 00	This visit was for a	Recertification and State	F 0000	="" span="">				
Investigation of Complaint IN00440500. correction does not constitute admission or agreement by the		Licensure Survey.	This visit included the		I				
Complaint IN00440500 - Federal/State deficiencies provider of the truth or facts					admission or agreement by the	Э			
		_			1 5				
related to the allegations are cited at F880. alleged or corrections set forth on		related to the allega	ations are cited at F880.						
the statement of deficiencies. The			. 5 . 6 . 7 . 0 . 10 . 2024						
Survey dates: August 5, 6, 7, 8 and 9, 2024 plan of correction is prepared and		Survey dates: Augu	ust 5, 6, 7, 8 and 9, 2024		1 -				
submitted because of Facility number: 000466 requirements under state and		Facility number: 00	00466						
Facility number: 000466 requirements under state and Provider number: 155385 federal law. Please accept this		I			1				
AIM number: 100289810 plan of correction as our credible					·				
allegation of compliance. Please		111111111111111111111111111111111111111			1 -				
Census Bed Type: find enclosed the plan of		Census Bed Type:			-				
SNF/NF: 6 correction for this survey. Due to					- I	to			
NF: 79 the low scope and severity of the		NF: 79			the low scope and severity of t	he			
Total: 85 survey finding and the sufficient		Total: 85			-				
documentation providing evidence						ence			
Census Payor Type: of compliance with the plan of			e:		1				
Medicaid: 85 correction. The documentation									
Total: 85 serves to confirm the providers allegation of compliance. Thus,		10tai: 85							
These deficiencies reflect State Findings cited in the provider respectfully requests		These deficiencies	reflect State Findings cited in		-				
accordance with 410 IAC 16.2-3.1. the granting of paper compliance					1				
in lieu of a post survey re-visit.									
Quality review was completed on August 15, 2024. Should additional information be		Quality review was	s completed on August 15, 2024.		•				
necessary please contact the					necessary please contact the				
provider directly.					provider directly.				
F 0750	E 0750	400 45()(0)()(1)) (F)						
F 0758									
SS=D Free from Unnec Psychotropic Meds/PRN Bldg. 00 Use			Psychotropic inleds/PRN						
§483.45(e) Psychotropic Drugs.	Diag. 00		notropic Drugs						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in

> TITLE (X6) DATE

Samantha D. Biddle BSN, RN, HFA/Administrator 08/29/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155385	B. WING 08/09/2024				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			OMMERCE ST		
CAMELO	T CARE CENTER				SPORT, IN 46947		
			1	L	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!		DATE
	the following cate	gories:					
	(i) Anti-psychotic;	ht.					
	(ii) Anti-depressar (iii) Anti-anxiety; a						
	(iii) Anti-anxiety, a (iv) Hypnotic	iliu					
	(iv) riypholic						
	Based on a comp	rehensive assessment of a					
	-	ty must ensure that					
		.,					
	§483.45(e)(1) Res	sidents who have not used					
	- ' ' ' '	s are not given these drugs					
		ation is necessary to treat a					
	specific condition	as diagnosed and					
	documented in the	e clinical record;					
	§483.45(e)(2) Res	sidents who use					
	psychotropic drug	s receive gradual dose					
		ehavioral interventions,					
	•	ontraindicated, in an effort					
	to discontinue the	se drugs;					
	- ' ' ' '	sidents do not receive					
		s pursuant to a PRN order					
		ation is necessary to treat					
	-	ific condition that is					
	documented in the	e clinical record; and					
	\$493 45(a)(4) DDI	N orders for psychotropic					
		to 14 days. Except as					
	_	45(e)(5), if the attending					
		cribing practitioner believes					
		ite for the PRN order to be					
		14 days, he or she should					
	-	tionale in the resident's					
		id indicate the duration for					
	the PRN order.	a maiodo dio daladon loi					
	§483.45(e)(5) PRI	N orders for anti-psychotic					
		to 14 days and cannot be					
	_	ne attending physician or					

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Event ID:

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09/12/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/09/2024 155385 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1555 COMMERCE ST CAMELOT CARE CENTER LOGANSPORT, IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility F 0758 F758 The facility will ensure a 08/26/2024 failed to ensure a PRN (as needed) psychotropic PRN (as needed) psychotropic medication was not ordered beyond 14 days or medication was not ordered the attending physician documented their beyond 14 days or the attending rationale in the resident's medical record to physician documented their indicate the duration for the PRN order for 1 of 5 rationale in the resident's medical residents reviewed for unnecessary medications. record to indicate the duration for (Residents 62) the PRN order. 1. Resident 62 prn Ativan order Finding includes: was discontinued. 2. A complete audit was The clinical record for Resident 62 was reviewed conducted to ensure prn on 8/9/24 at 1:44 p.m. The diagnoses included, but psychotropic medication did not were not limited to, acute and chronic respiratory exceed 14 days or if the ordered failure, dependence on a ventilator (machine to exceeded 14 days, the physician move air in and out of your lungs), tracheostomy, documented the rationale. seizure, anxiety disorder, post-traumatic stress 3. The prn medication policy was disorder, and major depressive disorder. reviewed with no changes made. (See attachment A) The staff was A physician's order, dated 2/14/24, indicated to inserviced on the above give one (1) lorazepam (an anxiety medication) 1 procedure. milligram (mg) tablet by gastrostomy tube (a tube 4. The DON or her designee will inserted through the abdomen directly to the review all prn medication stomach). The facility may administer up to 2 administration records daily to tablets in 24 hours as needed (PRN). ensure that prn psychotropic medications do not exceed 14 A care plan, dated 4/2/24, indicated the resident days or the attending physician required the use of an anxiety medication. The documents their rationale in the interventions included, but were not limited to, resident's medical record to administer medication as ordered and observe for indicate the duration. The DON or changes in mood or behavior. her designee will utilize the nursing monitoring tool daily times During an interview, on 8/9/24 at 9:14 a.m., the four weeks, then weekly times four Administrator indicated if the resident had an weeks, then every two weeks order for PRN lorazepam the medication would times two months, then quarterly need to have a stop date after 14 days. thereafter until 100% compliance is obtained and maintained. (See A current policy, titled "PRN Medications," dated attachment B) The audits will be

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Facility ID: 000466

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155385		A. BUILDING B. WING	00 00	COMPLETED 08/09/2024	
	PROVIDER OR SUPPLIER		1555 C	ADDRESS, CITY, STATE, ZIP COD OMMERCE ST NSPORT, IN 46947	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0761 SS=D Bldg. 00	Support Nurse on 8/ "Residents shall no pursuant to a PRN of necessary to treat a contest that is documented it orders for psychotron 14 days. If the attempractitioner believes PRN order to be extishe shall document in medical record and it PRN order. PRN order are limited to 14 day unless the attending practitioner evaluate appropriateness of the shall document in the	and Biologicals and of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include cessory and cautionary and expiration date when e of Drugs and Biologicals ccordance with State and facility must store all drugs cocked compartments cerature controls, and fized personnel to have		reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. =""" b=""> 5. The above corrective meas will be completed on or before August 26, 2025.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155385		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/09/2024	
	PROVIDER OR SUPPLIER	<u>.</u>	1555 C	ADDRESS, CITY, STATE, ZIP COD COMMERCE ST NSPORT, IN 46947	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	separately locked compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the f package drug dist the quantity stored dose can be reading Based on observation review, the facility within eyesight or successible to reside for 3 of 3 residents' observed for medicated and 74) Finding includes: During an observation medication cart: a. One plastic contate Erythromycin Benz for Resident 70. b. A bottle of Lansot treat stomach acid) anticonvulsant medication for Resident 70. There were no staff Resident 22 was obwandering the halls. During an interview indicated the medicated the medicated in the store of the medicated the medicated in the store of the store o	on, interview and record failed to keep medications tored in a location not ants or unauthorized personnel medications randomly ation storage. (Residents 70, 33 storage.)	F 0761	F761 The facility will keep medications within eyesight of stored in a location not access to residents or unauthorized personnel 1. All medications were stored appropriately. 2. All residents have the potential by inserviced of setting medication on top of the medication cart. A complete round of the facility was complete rounded to ensure all medication was stored correctly. No further concerns were noted. See befor corrective measures. 3. The Storing Drug policy are procedures were reviewed with changes made. (See attachmatically the seed of the procedure. 4. The DON or designee will conduct two rounds daily ensually medications are stored perpolicy. The DON or her designing monitor tool daily times four weeks, the every two weeks times two	ed ential ff on not he pleted elow and th no hent on the uring r gnee ring hen

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155385		Ĺ	JILDING	00	COMPL 08/09/	ETED	
	ROVIDER OR SUPPLIER			1555 C	DDRESS, CITY, STATE, ZIP COD OMMERCE ST SPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	from the Clinical Su indicated "drug an a safe, secure and or temperatures and ac nursing and pharma	led "Storing Drugs," received apport Nurse on 8/9/24 2:20p.m., d biologicals will be stored in rederly manner at appropriate cessible only to licensed cy personnel or staff members to administer medications"			months, then quarterly thereaf until 100% compliance is obtai and maintained. (See attachmed) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warrant if compliance is not obtained or maintained, the nurse or QMA will be re-educated one on one to ensure they are knowledgeable about how to properly store medications policy. Additional monitoring will occur if compliance not met by having the administrator complete round twice daily assuring medications is stored per policy. 5. The above corrective meas will be completed on or before August 26, 2024.	ned ent d ded. d er d ds	
F 0880 SS=D Bldg. 00	infection prevention designed to provide comfortable environthe development a communicable discussion (Section 2018). Section 2018 (Section 2018). The facility must exprevention and control of the section 2018 (Section 2018). The facility must exprevention and control of the section 2018 (Section 2018).	on & Control					

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Facility ID: 000466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155385			UILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/09/	ETED	
	PROVIDER OR SUPPLIER	t		1555 CC	DDRESS, CITY, STATE, ZIP COD DMMERCE ST SPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	elements:						
	identifying, reportic controlling infection diseases for all revisitors, and other services under a chased upon the faconducted accord following accepted §483.80(a)(2) Write and procedures for include, but are not (i) A system of suit identify possible of infections before the persons in the faconducted infections before the persons in the faconducted infections to be of infections; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; include pending upon the infection organism involved (B) A requirement the least restrictive under the circums (v) The circumstant prohibit emponomental disease; and	ting to §483.70(e) and d national standards; ten standards, policies, or the program, which must obt limited to: reveillance designed to communicable diseases or they can spread to other cility; whom possible incidents of sease or infections should transmission-based followed to prevent spread w isolation should be used luding but not limited to: duration of the isolation, the infectious agent or d, and that the isolation should be e possible for the resident stances. Inces under which the facility ployees with a sease or infected skin at contact with residents or the contact will transmit the					
	(vi) i ne nand nygi	ene procedures to be	1				

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Event ID:

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Facility ID: 000466

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NAME OF PROVIDER OR SUPPLIER (X9 ID SUMMARY STATEMENT OF DETICIENCIE LEARNING TOTAL COMPLETION (AS SUMMARY STATEMENT OF DETICIENCIE LEARNING TOTAL COMPLETION (AS SUMMARY STATEMENT OF DETICIENCIE LEARNING TOTAL COMPLETION (AS ID) PROVIDER OR SUPPLIER TO GAME PROVIDER OR SUPPLIER TO GAME PROVIDER OR SUMMARY STATEMENT OF DETICIENCIE LEARNING TOTAL COMPLETION (AS ID) TOTA	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER CAMELOT CARE CENTER SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG followed by staff involved in direct resident contact. \$483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. \$483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. \$483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure staff covered their clothing with personal protective equipment while providing catheter care for 1 of 1 resident observed for catheter care and Enhanced Barrier Precautions. (Resident K) Finding includes: During an observation, on 8/9/24 at 10:29 a.m., LEN 2 donned a disposable yellow gown and did not tie the gown at the neck or the waist. The gown fell to LPN 2's slows as she was leaning over the bed to provide catheter care, and her shirt was not covered by the gown. LPN 2 then indicated the gown was bothering her and she removed the gown and put on a new disposable yellow gown. She did not tie the second gown at the neck or the waist. She continued to provide some fell to LPN 2's ellows as she was leaning over the bed to provide catheter care, and her shirt was not covered by the gown. LPN 2 then indicated the gown was bothering her and she removed the gown and put on a new disposable yellow gown. She did not tie the second gown at the neck or the waist. She continued to provide	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
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During an observation, on 8/9/24 at 10:29 a.m., LPN 2 donned a disposable yellow gown and did not tie the gown at the neck or the waist. The gown fell to LPN 2's elbows as she was leaning over the bed to provide catheter care, and her shirt was not covered by the gown. LPN 2 then indicated the gown was bothering her and she removed the gown and put on a new disposable yellow gown. She did not tie the second gown at the neck or the waist. She continued to provide immediately inserviced on how to properly don and doff personal protective equipment. No further concerns were noted. See below for corrective measures. 3. The Enhanced Barrier Precautions policy and procedures was reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure.						-	ntial	1
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the neck or the waist. She continued to provide procedure.								
							ove	
			_			1 *	azill	
catheter care, and the gown fell off her shoulders and down to her elbows. Her shirt was not 4. The DON or his designee will observe three staff members			_			_	WIII	
covered by the gown and the gown was laying on donning and doffing PPE daily to							, to	
the resident's bed instead of covering the shirt of ensure proper use. The DON or								

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IB6R11

Facility ID: 000466

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155385	B. WING 08/09/2024				
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	T CARE CENTER		1		ISPORT, IN 46947		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	LPN 2.				her designee will utilize the		
	Duning on interview	2 on 8/0/24 at 10:26 a m I DN 2			nursing monitoring tool daily ti		
	-	7, on 8/9/24 at 10:36 a.m., LPN 2 d have tied the gown.			four weeks, then weekly times	iour	
	indicated sile should	i have ned the gown.			weeks, then every two weeks times two months, then quarte	rlv	
	The clinical record	for Resident K was reviewed			thereafter until 100% compliar	-	
		i.m. The diagnoses included,			is obtained and maintained. (S		
	but were not limited	_			attachment B) The audits will		
		, gastrostomy status, adult			reviewed during the facility's		
	_	d cystostomy (surgical			quarterly quality assurance		
	opening in the blade	der) with a suprapubic			meetings and the plan of		
	catheter.				correction will be adjusted		
					accordingly if warranted. If		
	_	y, on 8/9/24 at 10:54 a.m., the			compliance is not obtained of		
	_	ndicated the staff should tie the			maintained, the staff membe		
	disposable gowns.				will be re-educated one on or	ne	
	A assument maliary tit	lad "Enhanced Domion			to ensure they are		
		led "Enhanced Barrier 10/2019 and received from the			knowledgeable about how to properly don and doff PPE.		
	· ·	trance, indicated "Enhanced			Additional monitoring will		
		expand the use of PPE beyond			occur if compliance not met	hv	
		exposure to blood and body			having the administrator	,	
		These precautions entail the			observe 3 additional staff		
	_	oves during 'high contact'			members a day don and		
	resident care activit	ies that provide opportunities			doffing PPE.		
		Os [multi drug resistant			5 The above corrective meas	ures	
		hands and clothing to address			will be completed on or before		
		f transmission from residents			August 26, 2024.		
		zation, which can persist for					
long periods of time (e.g., months), and result in							
	the silent spread of	MDKUS.					
	A current Center for	r Disease Control (CDC)					
	_	d and provided by the Clinical					
	* *	/9/24 at 2:17 p.m., indicated					
		ng on personal protective					
		IFully cover torso from neck					
		d of wrists, and warp around					
	the backFasten in	back of neck and waist"					

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ſ ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155385	B. W	NG		08/09/	2024
	ROVIDER OR SUPPLIER			1555 C	ADDRESS, CITY, STATE, ZIP COD OMMERCE ST SPORT, IN 46947		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This citation relates 3.1-18(b)(1) 483.90(e)(1)(ii) Bedrooms Measur Ft/Resident §483.90(e)(1)(ii) M feet per resident in bedrooms, and at single resident roo Based on observatio review, the facility f square feet (sq. ft) p rooms reviewed. (Ref Finding includes: During the initial fact 11:45 a.m., Room 16 Room 16 had 3 beds This was 79.3 squar During the entrance Director provided a Department of Healt	to Complaint IN00440500. The at Least 80 Sq Ileasure at least 80 square in multiple resident ileast 100 square feet in least 100 square feet in	F 09	TAG	F0912 1. It is the policy of Camelot Care Center to provide at least 80 square feet per Resident is multiple Resident Rooms, an at least 100 square feet in a single Resident room. 2. Residents in room 16 were found not to meet this requirement; however a waiv was in effect for the room. 3. A letter was sent to Indian Department of Health (IDOH) 8/22/2024 to request the room waiver continue for these sar rooms (see attachment E). 4. All Residents in Room 16 have privacy; comfort and adequate space to provide nursing care as evidenced by Room 16 are occupied with 3 Residents who can be safely transferred from wheelchair to bed without any problems. A Residents residing in these rooms are unable to ambulate	st nd e er a on n me	
					independently and are dependent upon staff for all transferring to wheelchair/be		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155385	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/09/2024	
	ROVIDER OR SUPPLIER		1555 (ADDRESS, CITY, STATE, ZIP COD COMMERCE ST NSPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
				and transported to their destination. Room 16 is equipped with privacy screen a comfortable bed environment and adequate spaces.	•	

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