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	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW LAKE PLACE	2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00406348. Complaint IN00406348 - State deficiencies related to the allegations are cited at R144. Survey dates: August 21, 22 and 23, 2023 Facility number: 010234 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 1, 2023.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jill Smith	Executive Director	09/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was Cardiopulmonary (CPR) and first aid coverage 24 hours a day during the period of August 13, to August 18, 2023. Findings include: The schedule for the time period of August 13 to August 18, 2023, was reviewed on 08/22/23 and 08/23/23. The facility failed to have staff certified in CPR for 8 of 21 shifts and failed to have first aid coverage for 20 of 21 shifts. On August 13, 2023, there was no documentation to show CPR coverage for the third (night) shift and no documentation to show first aid coverage on the first (day), second (evening) or third shifts. On August 14, 2023, there was no documentation to show first aid coverage on the first or second shift. On August 15, 2023, there was no documentation to show CPR coverage for the third shift and no documentation to show first aid coverage for the first, second or third shift. On August 16, 2023, there was no documentation to show CPR coverage for the third shift and no documentation to show first aid coverage for the first, second or third shift. On August 17, 2023, there was no documentation	R 0117	**R 117 410 IAC 16.2-5-1.4(b) Personnel - Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An audit took place on 8/24/2023 of staff charts to identify all staff members who did not hold a current CPR and first aid certification. Those staff members who were identified as not having current were informed and will be scheduled to attend future CPR classes held by the community. DON and ED will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	09/15/2023

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	to show CPR coverage for the third shift and no documentation to show first aid coverage for the first, second or third shift. On August 18, 2023, there was no documentation to show CPR coverage on the second and third shift and no documentation to show first aid coverage for the first, second or third shift. On August 19, 2023, there was no documentation to show CPR coverage on the first and third shift and no documentation to show first aid coverage for the first, second or third shift. During an interview, on August 21, 2023, at 12:56 p.m., the Executive Director indicated if the facility did not have a policy, the facility would follow the state regulations. During an interview, on August 23, 2023, at 11:21 a.m., the Business Office Manager indicated the facility did not have any other CPR or first aid cards; they had provided all their documentation. The facility was unable to provide a policy relating to CPR and first aid coverage by the exit date of August 23, 2023.		All residents had the potential to be affected by this deficient practice. DON and ED will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. CPR and first aid classes will be held at the community for staff to get their certification. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Executive Director (ED) and Director of Nursing (DON) were re-educated on 08/24/2023 on the Indiana State rule to meet the 24-hour scheduled and unscheduled needs of the residents and services. Current staff who are not CPR first aid certified will be scheduled for future classes held by the community. New staff will be screened upon hire to ensure their certifications are up to date. An up-to-date list will be kept with all the staff names who are current with their certifications to ensure 24-hour CPR first aid coverage. DON and/or ED will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. **4. How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure there is 24-hour CPR first aid coverage. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** September 18, 2023	
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			

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	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. (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 ensure 2 of 3 new employees (CNA 2 and CNA 3) had completed their 2-step PPD (a test to screen for tuberculosis) and failed to have an annual PPD test or screening for 1 of 2 existing employees (RN 4) reviewed for tuberculosis (TB). Findings include: The employee records were reviewed on August 22nd and 23rd of 2023. 1. CNA 2 was hired on May 26, 2023. She received	R 0121	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Those staff members who were identified as not having current PPD were informed and will receive the PPD screen or test. **2. How the facility will identify**	09/15/2023

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	a TB skin test on June 05, 2023, and it was read on June 8, 2023. She did not have a second test completed per the documentation provided. 2. CNA 3 was hired on March 03, 2023. She received a TB skin test on June 05, 2023, and it was read on June 8, 2023. She did not have a second test completed per the documentation provided. There was no documentation to show CNA 3 had received any TB skin testing prior to June 5, 2023. 3. RN 4 was hired on September 12, 2022. The facility was not able to provide documentation of a 2 step TB test or an annual assessment/TB test. During an interview, on August 22, 2023, at 2:40 p.m., the Executive Director indicated staff was getting sent out to another provider for their TB testing. The facility started to perform the testing in house, as they got a nurse who was trained to do the testing, but in between the time of sending staff out and getting a nurse to do the testing, the 2 step TB testing was not done. She indicated she was aware new employees needed to have a 2 step TB test. During an interview, on August 23, 20232 at 11:23 a.m., the Assistant Business Office Manager indicated RN 4 informed him her TB was current, but she was not able to find the documentation to show it was current. A facility policy, titled "Tuberculosis Policy & Procedure," dated as revised December 1, 2022, and received from the Assistant Business office Manager on 08/23/2023 at 11:18 a.m., indicated "...The Community will conduct TB testing and screening for all its employees...according to State regulations...employees...must have a symptom		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. An audit took place on 8/24/2023 of staff charts to identify all staff members who did not have a current annual PPD test or screening. Those staff members who were identified as not having current PPD were informed and will receive the PPD screen or test. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The ED, DON/designee will review the Employee TB Records list monthly to make sure that all new and current employees have their up-to-date TB test or screen. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing the Employee TB records list with the	

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	screen and an initial tow-step TB skin test...."		employee file to verify TB records are complete, weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure residents TB records are accurate and complete. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going **5. By what date will the systemic changes be completed?** September 18, 2023	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to maintain a sanitary environment in 1 of 7 rooms reviewed for enviornment. (Room 322) Finding includes: During a telephone interview with a family member of Resident B, on August 21, 2023, at 10:33 am, she indicated when her mother first moved into the facility, she was placed in a model room (305) on the Memory Care Unit. Her mother was to be moved to room 322 and the family had a queen size bed, and other furnishings set up in room 322. She indicated she had requested room 322 to be cleaned for a month and a half and described used tissue and feces on the floor of the bathroom in	R 0144	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident was found to have been affected by this deficient practice. Room 322 was a vacant room and was cleaned and sanitized 8/21/2023 by the housekeeper. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and**	09/15/2023

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	room 322. She indicated this was back in March 2023. The room was not cleaned, and her mother never did move into room 322. Her mother discharged from the facility in April 2023. During an observation of room 322 on August 21, 2023, at 10:52 a.m., there was used tissue and feces found on the floor of the bathroom just outside the shower. The toilet was found to have brown and black colored paper towels in the toilet; there was no water to the toilet. During an interview, on August 21, 2023, at 11:05 a.m., the Director of Nursing indicated she was not aware of the feces and used tissue on the floor of the bathroom, it must have been from the last move out. The room should not have been left with feces on the floor. She indicated they did have housekeeping for five (5) hours every day. The facility was not able to provide a policy by the exit date of August 23, 2023, but did provide a housekeeping cleaning list. A facility document, titled "Apartment Deep Cleaning," dated as last updated July 20, 2022, and received from the Executive Director on August 22, 2023, at 9:25 a.m., indicated "...Clean the bathroom...Sweep the floor...Mop the floor...Clean toilet and surrounding areas...." This State Finding relates to Complaint IN00406348.		**what corrective action will be taken:** A vacant room audit was completed on 8/22/2023 by the housekeeper and maintenance director to ensure no other rooms were affected by this deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Maintenance Director (MD)/designee will assign a weekly room clean list for the housekeeper to complete and turn in weekly to the MD. Rooms vacant and occupied will be cleaned according to policy and procedure. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. The MD/designee will complete audits by checking 3 rooms on the cleaning list weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure cleanliness of rooms. The audit willbe discussed at monthly QI meetings. The QI Committee	

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			will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** September 18, 2023	
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 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 interview and record review, the facility failed to have the heating and air conditioning system inspected yearly. Finding includes: The HVAC (heating, ventilation, and air conditioning) records were requested on August 21, 2023, during the entrance conference with the Executive Director in attendance.	R 0148	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director (MD) will document and keep a record of all heating and cooling	09/15/2023

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	During an interview, on August 21, 2023, at 11:13 a.m., the Maintenance Director indicated he had no records for the HVAC system; no inspection records, no records to show he performed any checks or cleaning on the system, and he was HVAC certified. During an interview, on August 21, 2023, at 11:30 a.m., the Executive Director indicated the facility followed the state regulations. A facility document, titled "HVAC RTU/Air Handlers," undated and received from the Executive Director on August 21, 2023, at 12:56 a.m., indicated the tasks which were to be performed on the HVAC system including, but not limited to, clean and verify proper operation, check the operations of all safeties, inspect and clean condenser coils. The document indicated furnace checks/cleaning was to be performed "...once a year...."		inspections. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. The Maintenance Director (MD) will document and keep a record of all heating and cooling inspections. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The MD will provide the ED with copies of all inspection reports and repair invoices for all heating and cooling items. They will review and maintain these records monthly and ensure that the yearly inspection is complete and documented. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing the	

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			MD inspection reports weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure inspections are complete. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** September 18, 2023	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of			

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	services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure resident services plans had been signed by the resident or responsible party for 3 of 7 residents reviewed for service plans. (Residents 300, 400 and 500) Findings include: 1. The record for Resident 300 was reviewed on August 21, 2023, at 2:16 p.m. Diagnoses included, but were not limited to, dementia, hypertension, and insomnia. The document, titled "Assessment and Negotiated Service Plan Summary," dated September 05, 2022, was found unsigned by the family or resident. The document, titled "Assessment and Negotiated Service Plan Summary," dated March 03, 2023, was found unsigned by a facility staff member and the family or resident. The document, titled "Assessment and Negotiated Service Plan Summary," dated June 13, 2023, was found unsigned by the family or resident. 2. The record for Resident 400 was reviewed on August 22, 2023, at 11:37 a.m. Diagnoses included, but were not limited to, chronic bilateral lower extremity venous status ulcers, agitation/anxiety,	R 0217	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 300, 400, and 500 care plans were reviewed and signed by the family and or resident and staff. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Complete chart audit performed on 8/28/2023 to verify that care plans have been signed by all parties. Any care plans found to have missing signatures were flagged for the DON to reach out and have the responsible parties sign the care plan. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** DON and ED will review charts bi-weekly to ensure all care plans	09/15/2023

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	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW LAKE PLACE	2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268

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	and hypertension. The document, titled "Assessment and Negotiated Service Plan Summary," dated July 09, 2023, was found unsigned by the family or resident. 3. The record for Resident 500 was reviewed on August 22, 2023, at 12:30 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hypertension, and gastro-esophageal reflux (GERD). The document, titled "Assessment and Negotiated Service Plan Summary," dated July 09, 2023, was found unsigned by the family or resident. During an interview, on August 23, 2023, at 10:45 a.m., the Director of Nursing indicated the Service Plans were to be signed by the resident or family (if resident was not able to sign) and herself at the time of the Service Plan meeting. If the meeting was held over the phone, she would mail the document and request for it to be signed and returned to the facility. A facility policy, titled "Individualized Service Plan Policy and Procedure," undated and received from the Executive Director on 08/22/2023 at 12:30 p.m.., indicated "...All family and/or Residents need to sign the plan of care agreement...."		have been signed by all responsible parties per policy. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing 3 charts weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure care plans are signed. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** September 18, 2023	