STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00433696, IN00435416, IN00438185, and IN00440056. Complaint IN00433696 - Federal/State deficiencies related to the allegations are cited at F690. Complaint IN00435416 - No deficiencies related to the allegations are cited. Complaint IN00438185 - No deficiencies related to the allegations are cited. Complaint IN00440056 - Federal/State deficiencies related to the allegations are cited at F690. Survey dates: August 19, 20, 21, 22, and 23, 2024. Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 2 Medicaid: 20 Other: 9 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/27/24.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 10, 2024, to the Complaint Survey completed on August 23, 2024. We respectfully request a desk review for paper compliance. ="" span="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Short	Administrator	09/05/2024

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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F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, record review, and interview, the facility failed to ensure activities were implemented for a cognitively impaired dependent resident for 1 of 1 resident reviewed for activities. (Resident 14) Finding includes: On 8/19/24 at 11:16 a.m., Resident 14 was observed lying in bed with her eyes open and looking up at the ceiling. The room was dark, the television was off, and there was no music playing. On 8/20/24 at 1:07 p.m., Resident 14 was was observed lying in bed with her eyes open and looking up at the ceiling. The room was dark, the television was off, and there was no music playing. On 8/20/24 at 2:25 p.m., Resident 14 was was observed lying in bed with her eyes open and looking up at the ceiling. The room was dark and the television was not on. A bingo activity was being played in the dining area and in some resident rooms. Record review for Resident 14 was completed on 8/20/24 at 1:27 p.m. Diagnoses included, but were not limited to, stroke, aphasia (loss of ability to understand or express speech) and depression. The Annual Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was severely cognitively impaired. The resident had an impairment of both upper and lower extremities for a functional limitation in range of	F 0679	F679 [D] Activities Meet Interest/Needs Each Resident It is the practice of this facility that we ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·Resident 14 had her TV put on and was provided a radio *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents who are on 1:1 activities have been reviewed by the activity director to ensure there is a set curriculum for residents who receive 1:1 activities and the care plan updated as indicated ·Facility audit was conducted on all cognitively impaired dependent residents with no negative outcomes *What measures will be put into*	09/10/2024

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	motion. The resident was dependent on staff for all ADLs (activities of daily living). The Preferences for Routines and Activities, completed by staff, indicated listening to music, keeping up with the news, doing things with groups of people, participating in favorite activities, and participating in religious activities were important to the resident. A Care Plan, revised 4/20/22, indicated the resident would passively observe in group activities when available. The resident was seen for one on one visits with staff three times a week for social and cognitive stimulations. The resident had a customary preference to love a specific singer and a specific actor. The resident would passively observe the roommate's television and music at times. Her roommate would play music and put on movies for them to watch together. When the resident was not participating in group activities, she would enjoy watching television in the common area and or passively observing the happenings around her. Interventions included to assist the resident to and from activities, and to the invite resident to daily activities. A Care Plan, dated 12/19/22, indicated the resident had a personal preference that she preferred 1 on 1 activities. Interventions included to allow the resident 1 on 1 activities, and to provide the opportunity to listen to music she preferred. A Care Plan, dated 6/28/23, indicated the resident was at risk for a decline in activity status due to health condition deficits. An intervention included the staff would invite and encourage the resident to participate in scheduled group activities.		*place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·In-servicing occurred with the activity director on 1:1 activities are being provided for those residents who require them and they are documented properly ·A performance improvement tool has been developed to monitor activities are being implemented and meet the interests/needs of each residents ·IDT reviewed policy for activities *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents to ensure 1:1 activities are being provided and documented. This Quality Assurance Audit Tool will be completed by the Administrator/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 9/10/2024	

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	A Care Plan, revised 4/23/24, indicated the resident chose to remain in room related to her preference. An intervention included to provide activities of interest for resident to do in room. During an interview on 8/21/24 at 8:51 a.m., CNA 1 indicated the resident did not get out of bed to attend activities. The staff would talk with the resident when providing care but had not seen any activities being completed with her in her room. The resident's roommate did not like when they turned on the television or any lights being on in the room. She was unsure if the resident had a radio in her room. During an interview on 8/21/24 at 8:58 a.m., the Activity Director indicated she did not have any set curriculum for residents who received 1 on 1 activities. The residents who received 1 on 1 visits preferred conversations with her. She would do a daily visit with the resident and talk to her. She had not documented any 1 on 1 visits for activities when she completed them. She did not have a computer, so she would document the Activity Assessments on paper and she would provide a copy of the most recent assessment she had completed for the resident. A copy of the most current Activity Assessment completed was not provided by the Activity Director. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review and interview, the facility failed to ensure a resident's wounds were assessed and monitored for 1 of 3	F 0684	F684 [D] Quality of Care It is the practice of this facility to ensure residents receive treatment	09/10/2024

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	residents reviewed for non-pressure skin conditions. (Resident 10) Finding includes: On 8/19/24 at 3:10 p.m. and on 8/20/24 at 2:15 p.m., Resident 10 was observed lying in bed. She had two open areas, approximately 3 centimeters round each, on her right shin. She indicated they had been fluid filled blisters that had opened. The resident's record was reviewed on 8/20/24 at 11:33 a.m. Diagnoses included, but were not limited to, hemiparesis (one sided weakness) and hemiplegia (one sided paralysis) following a cerebral vascular accident, Diabetes Mellitus and heart failure. The Annual Minimum Data Set assessment, dated 6/30/24, indicated the resident was cognitively intact and was dependent on assistance for bed mobility and transfers. A Nursing Note, dated 8/14/24, indicated the resident had been up in a chair for five hours and fluid filled blisters developed to her right leg. The Nurse Practitioner was notified and orders were received to apply skin prep to the blisters. A Physician's Order, dated 8/19/24, indicated to apply Betadine external solution 19% to open blisters twice daily and monitor until resolved. There were no additional progress notes related to assessment or monitoring of the wounds. A Weekly Skin Assessment, dated 8/14/24, indicated the resident's skin was dry and intact. A Weekly Skin Assessment, dated 8/21/24, indicated the skin was dry and there was a treatment in		and care in accordance with professional standards of practice, the comprehensive person-centered care plan and resident choices. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 10 skin impairment of fluid filled blisters is currently healed How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with wounds are subject to be affected by this deficiency An in house audit was conducted of all residents with skin impairments with all have current assessments and monitoring What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A 1:1 in-service was conducted with the wound nurse to assure proper measurements are in place for all skin impairments IDT reviewed policy for skin and wound management system How the corrective actions will be monitored to ensure the deficient practice does not recur. A performance improvement tool	

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	progress to the right lower leg. During an interview on 8/21/24 at 11:20 a.m., the Wound Nurse indicated the Wound Nurse Practitioner had seen the resident that morning to assess the wounds and provided new treatment orders. There had not been an assessment completed before today. The policy, "Skin and Wound Management System", dated September 2022, indicated, "...5. Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. Wound location, characteristics and a physician's order for treatment are documented in the medical record. Wound status will be evaluated and documented in PCC [electronic medical record system] on the Wound Evaluation Flow Sheet form...." 3.1-37(a)		has been initiated that randomly audits five (5) residents to ensure that all skin impairments have been assessed and measured. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 09/10/2024	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review, and interview, the facility failed to follow up on an Occupational Therapy recommendation for a resting hand splint for 1 of 2 residents reviewed for position/mobility. (Resident 8) Finding includes: On 8/19/24 at 10:59 a.m., Resident 8 was observed seated in her wheelchair. Her right hand was contracted (tightening of muscle, tendons and skin that causes joints to shorten and become very stiff)and there was not a splint in place.	F 0688	F688 [D] Increase/Prevent Decrease in ROM/Mobility It is the practice of this facility that we ensure that residents receive necessary care and services in a timely manner related to activities of daily living based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*	09/10/2024

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	The resident's record was reviewed on 8/20/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) and unspecified dementia. The Quarterly Minimum Data Set assessment, dated 6/11/24, indicated the resident had severe cognitive impairment and was dependent for bed mobility and transfers. The resident received Occupational Therapy from 1/30/24 to 3/29/24. An Occupational Therapy Discharge Summary, dated 3/29/24, indicated the resident was to tolerate a resting hand splint for 5 hours a day to ensure joint protection and contracture management. There were no order Physician's Orders for a resting hand splint. During an interview on 8/20/24 at 3:11 p.m., the Director of Rehab indicated she had worked with the resident and she did well with the resting hand splint. She did not know why the splint had not been carried over after discharge from therapy. During an interview on 8/21/24 at 10:00 a.m., the Director of Nursing indicated the resident's mother had been trained on how to use the splint, but she did not want the resident to use it, so the order had never been completed. The record should have some documentation related to the refusal of the splint recommendation. 3.1-42(a)(2)		·Resident 8 and healthcare poa refused splint ·Refusal has been documented ·Physician made aware *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents with contractures have the potential to be affected by the alleged deficiency. ·Audit conducted to assure all therapy recommendations are followed and if not documented appropriately with MD aware *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·IDT reviewed policy and procedure for resident mobility and range of motion ·Functional Maintenance Program form was developed to communicate therapy recommendations to nursing and ensure are followed through is completed ·Nurses and therapy staff in serviced on policy and new form to follow through with recommendations *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly	

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			check (5) patients to assure all therapy recommendations are being followed through with. This Quality Assurance Audit Toll will be completed by the Therapy Director/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 09/10/2024	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on record review and interview, the facility failed to ensure catheter care was completed and urinary output was recorded for 1 of 3 residents reviewed for urinary catheters. (Resident D) Finding includes: The closed record for Resident D was reviewed on 8/22/24 at 10:20 a.m. Diagnoses included, but were not limited to, cerebral infarction, type 2 diabetes mellitus, and malignant neoplasm of the prostate. The resident was admitted to the facility on 3/8/24 and discharged to the hospital on 4/12/24. The Admission Minimum Data Set (MDS) assessment, dated 3/11/24, indicated the resident was cognitively impaired and had an indwelling	F 0690	F690 [D] Bowel/Bladder Incontinence, Catheter, UTI It is the practice of this facility that we ensure that residents receive necessary care and services in a timely manner related to activities of daily living based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·Resident D has discharged from the facility *How other resident having the*	09/10/2024

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	urinary catheter. A Care Plan, updated 3/26/24, indicated the resident had an indwelling urinary catheter. An intervention indicated to monitor and document intake and output. A Physician's Order, dated 3/8/24, indicated 10 cc (cubic centimeters) 18 fr (french, catheter size) Foley catheter with drainage bag to gravity, monitor every shift. The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 3/2024 and 4/2024, lacked any documentation of catheter care or urine output. The Task documentation lacked any documentation of catheter care or urine output. During an interview on 8/23/24 at 10:43 a.m., the Infection Preventionist (IP) indicated the catheter order included monitoring every shift, but she was unable to provide any further documentation that catheter care was completed or urinary output was recorded. A facility policy, titled Urinary Catheter Care, received from the IP as current, indicated, "...Input/Output...2. Maintain an accurate record of the resident's daily output, per facility policy and procedure...Infection Control...2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. a. Do not clean the periurethral area with antiseptics to prevent catheter associated UTIs while the catheter is in place. Routine hygiene [e.g. cleansing of the meatal surface during daily bathing or showering] is appropriate...Documentation. The following		*potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents with catheters have the potential to be affected by the alleged deficiency. ·Audit conducted to ensure all residents with catheters have in their chart a record for urinary output and to ensure completion of catheter care *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·IDT reviewed policy and procedure for catheter care, urinary ·Clinical staff have been in serviced on policy, how to properly record urinary output, and how to provide catheter care ·A performance improvement tool has been developed to monitor that catheter care is being provided and urinary output is recorded *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly check (5) patients to assure all patients with catheters have recording of urinary output and resident is receiving catheter care. This Quality Assurance Audit Toll	

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	information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual[s] giving the catheter care. 3. All assessment data obtained when giving catheter care...." This citation relates to Complaints IN00433696 and IN00440056. 3.1-41(a)(2)		will be completed by the Director of Nursing/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 09/10/2024	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review and interview, the facility failed to care for a PICC line (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) in accordance with professional standards of practice, related to flushing the PICC line for 1 of 1 resident reviewed for intravenous care. (Resident 25) Finding includes: On 8/19/24 at 2:00 p.m., Resident 25 was observed lying in bed in her room. There was a PICC line in place to her right upper arm. She indicated she had surgery last week and was now getting antibiotics through the line. Resident 25's record was reviewed on 8/20/24 at 3:03 p.m. Diagnoses included, but were not limited to, hypertension, abdominal aortic aneurysm, major depressive disorder.	F 0694	F694 [D] Parenteral/IV Fluids It is the practice of this facility that we ensure that residents receive necessary care and services in a timely manner related to activities of daily living based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* The physicians' order for PICC line flush was corrected for resident 25 to flush before and after medication administration *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective*	09/10/2024

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	The Admission Minimum Data Set (MDS) assessment, dated 7/18/24, indicated the resident was cognitively impaired. A Care Plan, updated 8/17/24, indicated the resident was receiving IV (intravenous) antibiotics for a urinary tract infection. A Care Plan, updated 8/19/24, indicated the resident had a PICC line. An intervention indicated to "flush line as needed/per policy." A Physician's Order, dated 8/17/24, indicated meropenem (an antibiotic) 1 g (gram) IV every 8 hours at 12:00 a.m., 8:00 a.m., and 4:00 p.m. A Physician's Order, dated 8/17/24, indicated normal saline flush, 10 ml (milliliters) every shift for IV patency. There were no Physician's Orders to indicate the PICC was to be flushed with saline before and after the administration of the antibiotic medication The Medication Administration Record (MAR), dated 8/2024, indicated the meropenem had been administered as ordered. The normal saline flushes were documented as given once each on the day, evening, and night shifts. There was lack of documentation to indicate the PICC was flushed with saline before and after the administration of the antibiotic medication. During an interview on 8/20/24 at 4:00 p.m., the Director of Nursing (DON) indicated the PICC line should have been flushed before and after the antibiotic administration. She would clarify the orders. A facility policy, titled Medication Infusion, received from the DON as current, indicated, "...7. Intermittent medication administration with no		*action(s) will be taken;* Any resident admitted to or residing in the facility with a PICC line has the potential to be affected by the deficient practice. Facility audit conducted of patients with PICC lines and orders were verified that flushes were being performed before and after antibiotic *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·IDT reviewed policy and procedure for PICC flush protocol ·Nurses have been in serviced on how to properly flush picc line when antibiotics are prescribed ·A performance improvement tool has been developed to monitor that PICC lines are being flushed during antibiotic use according to professional standards *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly check (5) patients to assure all patients with PICC lines have proper orders. This Quality Assurance Audit Toll will be completed by the Director of Nursing/ Designee weekly for three weeks; then monthly for three months, then quarterly x	

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	155733	A. BUILDING 00 B. WING	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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	continuous infusion...c. Flush IV access catheter with preservative-free 0.9% sodium chloride...g. Infuse medication as prescribed and per label instructions...j. Disinfect IV access port with alcohol swab and let air dry, flush with preservative-free 0.9% sodium chloride..." 3.1-47(a)(2)		three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 09/10/2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to incorrect oxygen flow rate for 1 of 2 residents reviewed for respiratory care. (Resident 22) Finding includes: On 8/19/24 at 10:06 a.m., Resident 22 was observed seated in his room. He had a nasal cannula in place that was attached to an oxygen concentrator and the flow rate was set on 2 liters per minute (lpm). On 8/20/24 at 2:25 p.m., the resident was observed seated in his room. His oxygen was on and flowing at 2.5 lpm. The resident's record was reviewed on 8/21/24 at 10:50 a.m. Diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set assessment, dated 6/4/24, indicated the resident was cognitively intact and was on oxygen.	F 0695	F695 [D] Respiratory/Tracheostomy Care and Suctioning It is the practice of this facility that we ensure that residents receive necessary care and services in a timely manner related to activities of daily living based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Resident 22 oxygen was adjusted to ordered liter flow rate and MD made aware *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* Any resident with oxygen has the potential to be affected by the deficient practice. Facility audit conducted of patients with oxygen to ensure	09/10/2024

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	A Physician's Order, dated 7/16/23, indicated the resident was to receive oxygen at 3 lpm continuously. On 8/21/24 at 1:27 p.m., the oxygen concentrator was observed with the Director of Nursing. She indicated it was set on 2.5 lpm. She then adjusted the flow rate from 2.5 lpm to 3 lpm. 3.1-47(a)(6)		they are on ordered flow rate *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·IDT reviewed policy and procedure for oxygen administration ·Clinical staff have been in serviced on checking 02 and assuring they are on proper settings per the physician order ·Oxygen equipment has been labeled to indicate the ordered flow rate ·A performance improvement tool has been developed to monitor that oxygen administration is set at the correct liter flow rate *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly check (5) patients to assure all patients with oxygen are on proper settings per physician orders. This Quality Assurance Audit Toll will be completed by the Director of Nursing/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance	

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			Meeting at least quarterly. *By what date the systemic changes will be made:* 09/10/2024	
F 0912 SS=E Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident Based on observation, record review, and interview, the facility failed to provide a least 80 square feet (SQ FT) per resident in multiple resident rooms and 100 SQ FT in single occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, and 208) Findings include: 1. The floor area of the following single resident room measured: a. Room 111 - 1 resident, 96.2 SQ FT. NF. 2. The floor areas of the following multiple resident rooms measured: a. Room 101 - 1 resident, 150.3 SQ FT, 75.2 SQ FT per bed. NF. b. Room 104 - 0 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF. c. Room 201 - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF. d. Room 202 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. e. Room 204 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. f. Room 206 - 1 resident, 140.0 SQ FT, 70.0 SQ FT per bed. NF. g. Room 208 - 1 resident, 146.9 SQ FT, 73.4 SQ FT per bed. NF. The facility rooms with room variances were	F 0912	F912 [E] Bedrooms Measure Least 80sq FT/Resident It is the practice of this facility to ensure that rooms with a variance have single occupancy. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed by the alleged deficient practice. All rooms have single occupants. Facility records indicate existence of room waiver variance letters from ISDH dating from June 5, 2003, to present ownership. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other residents are affected by this waiver practice. No other resident's safety is affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Residents in waived rooms will continue to occupy as single occupants, not double, therefore	09/10/2024

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	observed on 8/20/24 at 9:45 a.m. The rooms were observed with the following number of beds: Room 101 - 1 bed Room 104 - 1 bed Room 111 - 1 bed Room 201 - 1 bed Room 202 - 1 bed Room 204 - 1 bed Room 206 - 1 bed Room 208 - 1 bed During an interview on 8/19/24 at 8:50 a.m., the Administrator indicated these were the rooms which had the variance waivers and did not have the required square footage. 3.1-19(l)(2)		ensuring their environmental safety. How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) of waivered room to assure they are only being occupied by one person. This Quality Assurance Audit Tool will be completed by the Maintenance Director / Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: 09/10/2024	