PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			02/22/2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					IVERWALK WAY N		
FIVESIA	AR RESIDENCES C	OF NOBLESVILLE		NOBLE	SVILLE, IN 46062		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
R 0000							
Bldg. 00							
Blag. 00	This visit was for the Investigation of Complaints		D O	$\begin{bmatrix} R \ 0000 \end{bmatrix}$ The submission of this F			ı
	IN00428364 and IN	-	I K U	)00	Correction does not constitute		
	11100420304 and 111	00723003.				n) /	
	Complaint INIONA29	264 No deficiencies related to		admission by this provider of		пу	
	-	364 - No deficiencies related to			conclusion set forth in the		
	the allegations are c	ned.			statement of deficiencies or ar	ıy	
	Complaint INIO0422	883 - State deficiencies related			violation of regulations.		
	-	e cited at R0117 and R0240.			This	4 -	
	to the anegations are	e cited at R011/ and R0240.			This provider respectfully requ		
	Survey dates: February 20 and 22, 2024 be conside lieu of Post				that the 2567 Plan of Correction		
			be considered for desk review	ın			
					lieu of Post Survey Review.		
	Facility number: 00	9441/					
	B 11 11 G	00					
	Residential Census:	90					
	FF1						
		ntial Findings are cited in					
	accordance with 410	0 IAC 16.2-5.					
	Quality review com	pleted February 28, 2024.					
D 0447	44044040054	441.3					
R 0117	410 IAC 16.2-5-1.4	• •					
	Personnel - Deficie	-					
Bldg. 00	• •	ufficient in number,					
	•	training in accordance with					
		ws and rules to meet the					
	twenty-four (24) ho	our scheduled and					
	unscheduled need	ls of the residents and					
	services provided.	The number, qualifications,					
	and training of stat	ff shall depend on skills					
	required to provide	e for the specific needs of					
	the residents. A m	inimum of one (1) awake					
	staff person, with	current CPR and first aid					
	certificates, shall b	oe on site at all times. If					
	fifty (50) or more re	esidents of the facility					
		esidential nursing services					
	or administration of medication, or both, at						
		ng staff person shall be on					
	. ,	-					

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

(X6) DATE

TITLE

Janice A. Pegues Executive Director 03/11/2024

Any defiency statement 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		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				ETED	
			B. WI	B. WING			02/22/2024	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R		7235 R	IVERWALK WAY N			
FIVE STA	AR RESIDENCES	OF NOBLESVILLE		NOBLE	SVILLE, IN 46062			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Residential facilities with						
		d (100) residents regularly						
		tial nursing services or						
		medication, or both, shall						
		(1) additional nursing staff and on duty at all times for						
	l -							
	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.							
		v and record review, the facility	R 01	17	1. The nursing staffing scheduled		04/22/2024	
		affing levels in numbers	101	1,	will be reviewed and updated		0 1/22/2021	
	sufficient to meet the needs of residents for 4 of 4 residents reviewed for ADL care. (Residents B, C, F, and E)				(30) thirty days to ensure that			
					sufficient staffing is scheduled			
					routinely. The nursing schedul			
					will be updated as necessary	to		
	Findings include:				reflect staffing level changes to	0		
					ensure staffing accuracy, suffi	cient		
		lity's desired staffing pattern,			to meet the needs of the resid	ents		
		ON on 2/20/24 at 1:55 p.m.,			care levels.			
		wing was the ideal staffing						
		needs of the current facility			2. The nursing staffing schedu			
	population:				will be reviewed and updated	-		
	D (6.00	2.00			and as changes occur to ensu	re		
	Days (6:00 a.m. to care staff)	2:00 p.m.) - four CNAs (direct			that the staffing levels are	the		
	· ·	n. to 10:00 p.m.) - four CNAs			sufficient to meet the needs of residents care levels.	ше		
	• • •	. to 6:00 a.m.) - two CNAs			residents care levels.			
	Tvigitis (10.00 p.m.	. to 0.00 d.m.) - two CIVIS			3. The Director of Resident Ca	ar <sub>e</sub>		
	Review of staffing	schedules for February 11 to			(DRC) and/or designee, in the			
	_	a ten day period) indicated the			absence of the DRC, will be			
		rn was not obtained during the			responsible for overseeing and	d		
	following days and				monitoring the nursing departr			
					schedule, ensuring that the			
	On Saturday, 2/17/	24, day shift - three CNAs			staffing levels are sufficient to			
	assigned; evening shift- 1.5 CNAs assigned.				meet the care needs of the			
	On Sunday, 2/28/24, day shift- two CNAs				residents. The DRC and/or			
	assigned; evening	shift- 1.5 CNAs assigned.			designee will ensure that staff	ing		
	_	2, day shift- three CNAs			changes are documented in th	ne		
assigned.				scheduling system to reflect				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	UILDING	onstruction 00	(X3) DATE COMPL <b>02/22</b> /	ETED	
	PROVIDER OR SUPPLIEF			7235 R	ADDRESS, CITY, STATE, ZIP COD IVERWALK WAY N SVILLE, IN 46062		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	Confidential interviews were conducted during the survey.				accuracy, scheduling staffing replacements as necessary do staff call off/absences.	ue to	
	Staff interviews indregarding the ability showers:  a. The suggested staper unit. It required needs met. When the member assigned to always completed, to the next day, but there were already. When there was on were often not done one direct care staff.  b. During waking howers are deed help with all showers. When the showers did not alw the nurse was handlunits. Activity staff breakfast time. Mo possible on these day the shower, no emp monitor and assist a required over site did not alw the description.	affing was two direct care staff of two staff to get all ADL care there was only one staff of a unit, showers were not staff tried to move the shower it didn't always work because showers assigned to that day. By one staff on duty, showers es. Shifts frequently had only sper unit.  Sours, two staff were always entia unit. All residents and the was only one staff on duty, ways get done. In the morning, ling medications on multiple of did not come in until after raning showers were just not all the other residents who of to dementia. One direct care and an average of two times a			4. Nursing department scheduling be reviewed daily to ensure that sufficient scheduling is in place to meet the care needs the community residents.	e	
	the ADL requireme resided on the demo care staff was assig done. Although ma	staff member, could not meet all nts of the residents who entia unit. When one direct ned, showers were often not any nurses were helpful, they are unit to the next and were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/22/2024	
	ROVIDER OR SUPPLIEI			7235 RI\	DDRESS, CITY, STATE, ZIP COD VERWALK WAY N SVILLE, IN 46062		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	happened frequentl						
	d. It required two of to each unit to ensure When only one staff showers were not a move them to the new possible.						
	e. It was not always possible to meet all the ADL needs if only one direct care staff was assigned to a unit. On the dementia care unit, it was almost impossible to meet all the ADL needs for the residents. Showers were often missed when only one direct care staff was assigned to the dementia unit. Staff prioritized toileting because it was the resident's number one need. One direct care staff member per unit often happened two times a week.						
	A current CNA assignment sheet, provided by the DON on 2/22/24 at 11:08 a.m., indicated the following information about the residents on the dementia unit:						
		vere 15 residents on the one of the residents at the					
	Eleven of the 15 refrom staff to toilet	sidents required assistance every two hours.					
	Twelve of the 15 residents required assistance for all ADLs.						
	One of the 15 resid assistance every ho	ents required toileting ur.					
	One of the 15 resid assist with ADLs.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/22/2024	
	ROVIDER OR SUPPLIER		7235 R	ADDRESS, CITY, STATE, ZIP COD IVERWALK WAY N SVILLE, IN 46062	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Two of the 15 resident staff when walking.	ents needed assistance from			
		dents required a wheelchair e for purposeful mobility.			
	for the Assisted Liv	assignment sheet information ing Unit indicated 34 of 75 ssistance with showering.			
	DON indicated the was two direct care facility was unable per unit per shift du difficulties. The scl accurately reflect th not always documer relatively new to the Director and himsel records, but had not address identified co	on 2/22/24 at 2:40 p.m., the ideal staffing for waking hours staff per unit. Sometimes the to provide two direct care staff et to call offs and staffing nedules reviewed may not et coverage obtained. He did not the corrections. He was et facility. The Dementia Unit f did review the ADL flow eyet developed a system to oncerns, educate staff about and/or develop a plan to			
	reviewed on 2/20/24 diagnoses included chronic pain. The r secured dementia un	sed clinical record was 4 at 11:39 a.m. Discharge dementia, depression, and esident had resided on the nit. Resident B was with an anticipated return to			
	plan need which income bathing assistance.	nost current, 12/10/23, service licated the resident needed Approaches to this problem endent on staff for my entire			

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/22/2024
	PROVIDER OR SUPPLIER  AR RESIDENCES OF NOBLESVILLE	7235 RI	ADDRESS, CITY, STATE, ZIP COD IVERWALK WAY N SVILLE, IN 46062	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Review of the resident's ADL flow sheets indicated, in January 2024, the resident received one shower for the month and eight partial baths. In February 2024, through 2/14/24, the resident had received one shower and four partial baths in the 14 day period.			
	2. Resident C's closed clinical record was reviewed on 2/20/24 at 11:58 a.m. Discharge diagnoses included dementia and hypertension. The resident had resided on the secured dementia unit. The resident was discharged from the facility on 2/15/24, with an anticipated return to the facility.			
	The resident had a most current 12/13/23 service plan need which indicated the resident required assistance with bathing. Approaches to this problem included, "I need physical assist with bathing but I can participate in part of the bathing activity."			
	Review of the resident's ADL flow sheets indicated in January 2024, the resident received 13 stand-by assistance showers. In February 2024, the resident had not bathed or showered.			
	3. Resident F's clinical record was reviewed on 2/20/24 at 2:46 p.m. Current diagnoses included dementia and depression. The resident had resided on the secured dementia unit.			
	The resident had a most current, 12/14/23, service plan need which indicated needing assistance for bathing. Approaches to this problem included, "I am dependent on staff for my entire bathing activity."			
	Review of the resident's ADL flow sheets indicated in January 2024, the resident received			

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI <b>02/22</b>	LETED		
PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062					
SUMMARY (EACH DEFICIENT REGULATORY OF four showers and so month. In February resident received two baths.  4. Resident E's climate 2/20/24 at 2:35 p.m. dementia and hyper resided on the security of the resident had a replan need which included, bathing but I can paractivity."  Review of the resident indicated in January received seven part showers. In February resident received the baths or showers.  A current, 5/12/23, Service Plan", which	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Even partial baths for the 7 2024, through 2/20/24, the 8 wo showers and four partial 8 ical record was reviewed on 8 ical record was reviewed on 9 ical record was reviewed on 1 ical record was reviewed on 1 ical record was reviewed on 1 ical record was reviewed on 2 ical record was reviewed on 3 ical record was reviewed on 4 ical record was reviewed on 5 ical record was reviewed on 6 ical record was reviewed on 7 ical record was reviewed on 7 ical record was reviewed on 8 ical record was reviewed on 9 ical record was reviewed on the record was record was reviewed on the record was recor	7235 R	IVERWALK WAY N	D BE	(X5) COMPLETION DATE		
"This policy prov documenting, via ir services required ar residents F. The continent of following: 1. Areas if resident 2. What services sl 3. When/how ofter provided"							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 02/22/202			2024	
FIVE STA	ROVIDER OR SUPPLIER	DF NOBLESVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062				
(X4) ID		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	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
R 0240	,	,					
R 0240 Bldg. 00	activities of daily libased upon individed assed on interview failed to ensure residuance for 4 of 4 "Activities of Daily (Residents B, C, E at Findings include:  1. Resident B's clost reviewed on 2/20/24 diagnoses included chronic pain. The resecured dementia undischarged 2/17/24, the facility.  The resident had a replan need which included "I am deputathing assistance, included "I am deputathing activity."  Review of the reside indicated, in January one shower for the resident had received one shower for the resident C's clost reviewed on 2/20/24 diagnoses included The resident had resunit. The resident was assistance and the resident had resunit. The resident resident was assistance and the resident had resunit. The resident resident was assistance and resident had resunit. The resident resident was assistance and resident had resunit. The resident resident resident had resunit. The resident resi	Deficiency and assistance with ving, shall be provided dual needs and preferences. and record review, the facility dents received needed shower residents reviewed for Living" (ADL) assistance and F).  sed clinical record was 4 at 11:39 a.m. Discharge dementia, depression, and esident had resided on the nit. Resident B was with an anticipated return to  most current, 12/10/23, service licated the resident needed Approaches to this problem endent on staff for my entire  ent's ADL flow sheets y 2024, the resident received month and eight partial baths. hrough 2/14/24, the resident ower and four partial baths in  sed clinical record was 4 at 11:58 a.m. Discharge dementia and hypertension. sided on the secured dementia was discharged from the	R 02	240	1. Resident Activities of Daily Living (ADL)/showers will be monitored daily for (30) thirty to ensure that sufficient staffing scheduled routinely to allow for adequate resident ADL's/show. The nursing schedule will be updated as necessary to reflect staffing level changes to ensure staffing accuracy, sufficient to provide resident ADL's/shower.  2. The nursing staffing schedul will be reviewed and updated of and as changes occur to ensure that the staffing levels are sufficient to provide resident ADL's/showers. Resident ADL's/showers will be monitored for completion.  3. The Director of Resident Car (DRC) and/or designee, in the absence of the DRC, will be responsible for overseeing and monitoring the nursing department schedule, ensuring that the staffing levels are sufficient to meet the ADL/shower care need the residents. The DRC and designee will ensure that staffich changes are documented in the scheduling system to reflect accuracy, scheduling staffing	g is r yers.  ct re s. le daily re ed ment eds l/or ng e	04/22/2024
unit. The resident was discharged from the facility on 2/15/24, with an anticipated return to					accuracy, scheduling staffing replacements as necessary du	ie to	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/22/2024			
	PROVIDER OR SUPPLIER  AR RESIDENCES OF NOBLESVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
TAG	the facility.  The resident had a most current 12/13/23 service plan need which indicated the resident required assistance with bathing. Approaches to this problem included, "I need physical assist with bathing but I can participate in part of the bathing activity."  Review of the resident's ADL flow sheets indicated in January 2024, the resident received 13 stand-by assistance showers. In February 2024, the resident had not bathed or showered.  3. Resident F's clinical record was reviewed on 2/20/24 at 2:46 p.m. Current diagnoses included dementia and depression. The resident had resided on the secured dementia unit.  The resident had a most current, 12/14/23, service plan need which indicated needing assistance for bathing. Approaches to this problem included, "I am dependent on staff for my entire bathing activity."  Review of the resident's ADL flow sheets indicated in January 2024, the resident received four showers and seven partial baths for the month. In February 2024, through 2/20/24, the resident received two showers and four partial baths.  4. Resident E's clinical record was reviewed on 2/20/24 at 2:35 p.m. Current diagnoses included dementia and hypertension. The resident had resided on the secured dementia unit. T  The resident had a most current 12/17/23 service plan need which indicated the resident needed	TAG	staff call off/absences, to ensu that the nursing department is able to meet the resident ADL/shower needs.  4. Nursing department scheduland resident shower documer will be reviewed daily to ensure that sufficient scheduling is in place to meet the ADL/showe care needs of the community residents.	ules ots			
	assistance with bathing. Approaches to this						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/22/2024	
	PROVIDER OR SUPPLIER		7235 R	ADDRESS, CITY, STATE, ZIP COD RIVERWALK WAY N ESVILLE, IN 46062	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
		I need physical assist with rticipate in part of the bathing			
	indicated in January received seven part showers. In Februar	ent's ADL flow sheets 2024, the resident had ial baths and no full baths or 2024, through 2/21/24) the ree partial baths and no full			
	Confidential intervi	ews were conducted during			
	Staff interviews indicated the following concerns regarding the ability to complete resident showers:				
	per unit. It required needs met. When the member assigned to always completed, to the next day, but there were already so When there was only	affing was two direct care staff I two staff to get all ADL care here was only one staff o a unit, showers were not Staff tried to move the shower it didn't always work because showers assigned to that day. by one staff on duty, showers c. Shifts frequently had only of per unit.			
	needed on the demended help with all showers. When the showers did not alw the nurse was handlunits. Activity staff breakfast time. Mo possible on these dathe shower, no emp	ours, two staff were always entia unit. All residents I ADLs such as toileting and re was only one staff on duty, ways get done. In the morning, ing medications on multiple f did not come in until after rning showers were just not ays. If one person went into loyee would be available to all the other residents who			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 00  B. WING			COMPLETED 02/22/2024	
	PROVIDER OR SUPPLIER			7235 RI	.ddress, city, state, zip cod VERWALK WAY N SVILLE, IN 46062		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION DATE
	1 -	o to dementia. One direct care ned an average of two times a					
	the ADL requireme resided on the deme care staff was assig done. Although ma were going from on	taff member, could not meet all nts of the residents who entia unit. When one direct ned, showers were often not ny nurses were helpful, they e unit to the next and were  One direct care staff member y.					
	d. It required two direct care staff to be assigned to each unit to ensure all showers were completed. When only one staff was assigned to a unit, showers were not always done. Staff tried to move them to the next day, but it wasn't always possible.						
	needs if only one di a unit. On the demo impossible to meet residents. Showers one direct care staff unit. Staff prioritize resident's number o	s possible to meet all the ADL rect care staff was assigned to entia care unit, it was almost all the ADL needs for the were often missed when only was assigned to the dementia ed toileting because it was the ne need. One direct care staff ten happened two times a week.					
	DON indicated he we facility. The Demedid review the ADL developed a system concerns, educate stand/or develop a plant.	y on 2/22/24 at 2:40 p.m., the was relatively new to the ntia Unit Director and himself flow records, but had not yet to address identified taff about identified concerns, an to prevent recurrence.					
	A current, 5/12/23, facility policy titled, "Resident Service Plan", which was provided by the DON on						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r /	JILDING	onstruction 00	(X3) DATE COMPL 02/22	LETED	
NAME OF PROVIDER OR SUPPLIER  FIVE STAR RESIDENCES OF NOBLESVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	2/22/24 at 3:03 p.m., indicated the following:  "This policy provides guidelines on documenting, via individualized service plans, the services required and provided to individual residents  F. The continent of service plans includes the following:  1. Areas if resident needs/concerns (ADLs 2. What services shall be provided and by whom. 3. When/how often the service shall be provided"  This finding relates to complaint IN00423883.							

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