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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING 00 B. WING	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STONEBRIDGE HEALTH CAMPUS	3100 SHAWNEE DR S BEDFORD, IN 47421

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 29, 30, December 1, 2, 5, and 6, 2022 Facility number: 003924 Provider number: 155727 AIM number: 200472040 Census Bed Type: SNF/NF: 38 SNF: 13 Residential: 31 Total: 82 Census Payor Type: Medicare: 11 Medicaid: 29 Other: 11 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 8, 2022.	F 0000	The submission of this plan of correction does not indicate an admission by Stonebridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Stonebridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Bales	Clinical Support RN	12/27/2022

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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	following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on			

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	resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on interview and record review, the facility failed to submit a discharge Minimum Data Set (MDS) assessment in a timely manner for 1 of 1 resident reviewed for Resident Assessment. (Resident 41) Findings include: Resident 41's closed clinical record was reviewed on 12/5/22 at 3:30 p.m. The diagnoses included, but were not limited to, unspecified injury of the head and Type II diabetes mellitus. The discharge Minimum Data Set (MDS), dated 7/17/22, for Resident 41 indicated, "Finalized" but had not been submitted to the Centers for Medicare and Medicaid (CMS). The MDS was over 120 days old. During an interview on 12/6/22 at 10:30 a.m., the corporate MDS consultant indicated the discharge MDS, dated 7/17/22, for Resident 41 was inadvertently marked "not for submission". During an interview on 12/6/22 at 11:33 a.m., the MDS Coordinator indicated the facility did not have a policy related to timely submission of the MDS but the facility utilized the Resident Assessment Instrument (RAI) manual.	F 0640	1. MDS (Minimum Data Set) for resident 41 was affected. Resident Discharge Return Not Anticipated MDS dated 7-17-22 was not transmitted into CMS system within 14 days of ARD (Assessment Reference Date) per RAI requirements. MDS was transmitted to CMS and accepted 12-5-22 No adverse effects noted. 2. All discharged residents have the potential to be affected. Full audit of all discharged residents in the last 60 days was completed on 12-21-22. No further deficiencies were found. MDSC (Minimum Data Set Coordinator) provided with education on RAI requirements for MDS transmission (Chapter 5 Submission and Correction of the MDS Assessments- Section 5.1 and 5.2). Education to be completed on 12-21-22. 3. As a measure of ongoing compliance the MDS Consultant or designee will audit 3 discharge residents for timely transmission of Discharge MDS Assessments weekly for 4 weeks, then 2x monthly for 2 months and then monthly for 3 months.	12/28/2022

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			4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately complete an Admission Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for a decline in Activities of Daily Living. (Resident 29) Findings include: Resident 29's clinical record was reviewed on 12/5/22 at 11:27 a.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing) following nontraumatic intracerebral hemorrhage and unspecified protein-calorie malnutrition. The Admission Minimum Data Set (MDS) assessment, dated 9/7/22, indicated Resident 29 required the supervision of one person with eating during the look back period of 9/2/22 through 9/7/22. The physician orders, dated 9/1/22 through 9/6/22, for Resident 29 indicated, "... Enteral feeding:	F 0641	1. Resident 29 was affected. MDS section G0110 H1. Eating was coded incorrected on resident 29's Admission MDS with ARD (Assessment Reference Date) 9/7/22 related to the residents enteral feeding. MDS modified and transmitted with correct coding for G0110 H1 on 12-6-22. No adverse effects noted. 2. Similar residents with enteral feedings have the potential to be affected. All current residents with enteral feedings reviewed for accurate coding of MDS section G0110 H1- Eating support provided. No further deficiencies found. MDSC (Minimum Data Set Coordinator) provided with education on accurate completion of sections G0110 H1 according to the RAI Chapter 3: Section G Functional Status. Education	12/28/2022

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	Formula: Boost Plus or Ensure Plus 1 can [237 milliliters] per G-tube BID [twice a day] 1 bolus feeding [type of feeding where a syringe is used to send formula through the feeding tube] ..." The Medication Administration Record (MAR), dated 9/2/22 through 9/7/22, for Resident 29 indicated the resident received a bolus feeding per G-tube twice a day. During an interview on 12/6/22 at 10:30 a.m., the corporate MDS consultant indicated the Admission MDS assessment for Resident 29 was coded incorrectly. The resident was receiving a bolus feeding and the MDS assessment should have been coded as extensive assistance of one for eating. During an interview on 12/6/22 at 11:33 a.m., they MDS Coordinator indicated the facility did not have a policy on coding MDS's correctly but used the Resident Assessment Instrument (RAI) manual. 3.1-31(d)		completed on 12/21/2022. 3. As a measure of ongoing compliance, the MDS Consultant or designee will conduct an audit of five residents for correct coding of MDS G0110 H1 of the MDS weekly x4 weeks, then twice per month x2 months, then monthly x3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents reviewed for medication administration. This resulted in the resident requiring admission to the hospital intensive care unit. (Resident 45). Finding includes:	F 0760	1. Residents 45 was affected. The resident was immediately assessed and subsequently sent to the hospital. 2. All residents have the potential to be affected by this alleged deficient practice. Nurses and QMA's were educated on medication administration.	12/28/2022

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	During an interview on 11/30/22 at 1:42 p.m., Resident 45 indicated over a month ago, she had received Resident 46's medication. A nurse came into her room with two medication cups which had their names on them. The nurse administered her (Resident 45) Resident 46's medication. Later that evening, the facility "rushed" her to the hospital. On 12/2/22 at 11:19 a.m., Resident 45's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat), hypotension (low blood pressure), diabetes mellitus, accidental poisoning by unspecified drugs. The Admission Minimum Data Set (MDS) assessment, dated 10/18/22, indicated Resident 45 had moderately impaired cognition. The Progress Notes indicated the following: - On 11/4/22 at 7:00 p.m., Resident 45's every one hour vital signs (body temperature, pulse rate, respiration rate, and blood pressure) were initiated. The vitals check were within normal limits. She was answering questions appropriately. - On 11/4/22 at 9:29 p.m., Resident 45 was assisted to bed. Her blood pressure was slightly lower than baseline. She was answering questions appropriately. -On 11/5/22 at 12:21 a.m., Resident 45 was given the incorrect medication at approximately 6:50 p.m. The nurse practitioner indicated to observe resident's vital signs every hour times 24 hours; to send resident to the hospital if mean arterial pressure (MAP, a calculation that doctors use to check whether there's enough blood flow to major		3. As a measure of ongoing compliance, DHS/designee will complete random medication pass audits weekly for 4 weeks, every other week for 2 months, then monthly for 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 m--onths to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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organs) falls below 65; and had a decreased level of consciousness. At 11:00 p.m., her blood pressure was 81/49; her pulse was varying between 80-116 with rapid changes; and she was drowsy. Her MAP had decreased to 60. The nurse called 911, and Resident 45 was transferred to the hospital.

- On 11/5/22 at 12:31 a.m., the emergency room nurse called to verify Resident 45's vital signs while at the facility. The emergency room nurse indicated she was in atrial fibrillation and the Poison Control Center had been contacted.

- On 11/22/22 at 10:27 a.m., the physician indicated Resident 45 was seen for readmission after a hospitalization following a medication error.

The Vitals Report dated 11/1/22 through 11/30/22 indicated the following:

- On 11/1/22 at 8:33 a.m., Resident 45's pulse was 79 and her blood pressure was 107/75.
- On 11/2/22 at 7:50 a.m., Resident 45's pulse was 119 and her blood pressure was 103/68.
- On 11/3/22 at 8:21 a.m., Resident 45's pulse was 114 and her blood pressure was 119/62.
- On 11/3/22 at 7:50 p.m., Resident 45's pulse was 86.
- On 11/4/22 at 7:55 a.m., Resident 45's pulse was 105 and her blood pressure was 115/75.
- On 11/4/22 at 7:15 p.m., Resident 45's pulse was 128 and her blood pressure was 132/70.
- On 11/4/22 at 7:37 p.m., Resident 45's pulse was 116 and her blood pressure was 89/51.
- On 11/4/22 at 7:50 p.m., Resident 45's pulse was 128 and her blood pressure was 132/70.
- On 11/4/22 at 7:51 p.m., Resident 45's pulse was 116 and her blood pressure was 89/51.
- On 11/4/22 at 8:54 p.m., Resident 45's pulse was

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77 and her blood pressure was 85/54.
- On 11/4/22 at 10:02 p.m., Resident 45's pulse was 84 and her blood pressure was 81/56.
- On 11/4/22 at 11:24 p.m., Resident 45's pulse was 96 and her blood pressure was 81/49.

Resident 45's Inpatient Discharge Instructions, dated 11/5/22, indicated her reason for visit was for hypotension and new onset atrial fibrillation. She was admitted after accidentally taking extra blood pressure medications which caused her blood pressure to be extremely low requiring intensive care unit (ICU) level of care.

During an interview on 12/5/22 at 11:47 a.m., the Nurse Practitioner (NP) indicated Licensed Practical Nurse (LPN) 1 carried in two cups of medication into Resident 45 and Resident 46's room. Resident 45 was administered Resident 46's medication of cilostazol (medication to treat peripheral vascular disease) 50 milligrams (mg); aripiprazole (antipsychotic medication) 2 mg; buspirone (medication to treat anxiety) 7.5 mg; carvedilol (medication to treat high blood pressure) 6.25 mg; and hydrocodone/acetaminophen (pain medication) 7.5 mg. He started her on a central nervous system assessment (assessment to assess mental status and vital signs) every hour because of the administration of ariprazole, buspirone, and hydrocodone/acetaminophen could decrease her vital signs and level of consciousness. At her midnight central nervous system assessment, her blood pressure had decreased and ordered her to be sent to the emergency room.

During the interview on 12/5/22 at 2:54 p.m., LPN 1 indicated on 11/4/22, Resident 45 liked her medications early and Resident 46 also wanted her medications. She prepped and took Resident 45

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	and Resident 46's medications into the room and placed a medication cup on each of their table. Resident 45 took the medication in the cup which was on her table. Resident 46 looked in the medication cup and asked where her pain pill was. At that time, LPN 1 realized she had give Resident 45 the medications for Resident 46. She indicated she was only to prep and take one resident's medication into the room at a time. On 12/6/22 at 12:05 p.m., the Director of Health Services (DHS) provided the facility's policy, "Medication Administration General Guidelines," with a revised date of 1/2018, and indicated this was the policy currently being used by the facility. A review of the policy indicated..."4) FIVE RIGHTS-Right resident, right drug, right dose, right route and right time, are applied for each medication being administer. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away....Medications are not pre-prepared either in advance of the med pass or for more than one resident at a time. 3.1-48(c)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be 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 place a sign on the door or wall outside a residents room who was on Transmission Based Precautions for 1 of 1 resident reviewed during a random observation. (Resident 11) Findings include: On 11/29/22 at 10:44 a.m., during an initial tour of the facility, a bin with gowns and gloves was observed outside of Resident 11's room and the door was closed. There was no sign on the door or wall to indicate if the resident was on transmission based precautions (TBP). On 12/5/22 at 10:15 a.m., Resident 11's clinical	F 0880	1. Resident 11 was affected. There was no sign on the door or wall outside the resident's room who was on transmission based precautions (TBP). 2. All residents on TBP have the potential to be affected by this alleged deficient practice. A complete audit of all residents requiring isolated in Transmission Based Precautions was conducted to ensure signs were in place. All staff were educated on TBP and associated signage. 3. As a measure of ongoing compliance, the DHS or designee will complete random TBP sign	12/28/2022

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	record was reviewed. The diagnoses included, but were not limited to, chronic myeloid leukemia and rheumatoid arthritis. Physician orders, dated 11/9/22 through 11/29/22, for Resident 11 indicated, "... Contact/Droplet Precautions three times a day; 7:00 a.m. through 2:00 p.m., 2:00 p.m. through 10:00 p.m., and 11:00 p.m. through 6:00 a.m. ..." Nursing Progress Notes, dated 11/29/22 at 3:56 p.m., for Resident 11 indicated, "... [doctor name] infection disease was called this shift to ask about isolation precautions r/t [related to] res [resident] dx [diagnosis]. [doctor name] is treating res for mycobacterium chelonae [a rapidly growing mycobacteria that commonly affects the skin] with clarithamyocin [an antibiotic] and no isolation precautions are required. Res taken off contact/droplet precautions. ..." During an interview on 11/29/22 at 10:45 a.m., the Director of Social Services indicated Resident 11 was on TBP for a skin disorder but she was not aware of what type of precautions. During an interview on 12/5/22 at 2:54 p.m., Care Resident Care Associated (CRCA) 1 indicated Resident 11 had been on TBP the prior week but she was not sure what type. She remembered having to wear gowns and gloves. On 12/6/22 at 3:57 p.m., the Interim Executive Director provided the facility policy, "Guidelines for Droplet Precautions" with a revised date of 3/19/20, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Procedures: e. Isolation signs ... 1. Place a sign [preferably yellow] at the doorway instructing visitors to report to the nursing station		audits weekly for 4 weeks, every other week for 2 months, then monthly for 3 months. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from RCA findings for a minimum of 6 weeks and will continue thereafter until compliance is maintained. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	155727	A. BUILDING 00 B. WING	12/06/2022

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	before entering the room ..." 3.1-18(b)(1)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a sit to stand lift was clean for 3 of 6 days during the survey. Findings include: On the following dates, times, and locations, a sit to stand lift was observed with the foot platform containing food crumbs and debris: - On 11/29/22 at 10:00 a.m., in the hallway by Room 304. - On 11/29/22 at 2:20 p.m., in the hallway by Room 109. - On 11/30/22 at 10:55 a.m., in the hallway by the main nurse's station. - On 11/30/22 at 2:00 p.m., in the hallway by Room 109. - On 12/1/22 at 10:10 a.m., in the hallway by Room 107. During an interview on 12/1/22 at 10:19 a.m., the Director of Health Services indicated the foot platform of the sit to stand lift was dirty and in need of cleaning before use. On 12/6/22 at 12:12 p.m., the Director of Health Services provided a list of residents who used the sit to stand lift which indicated two residents used the sit to stand lift for transfers.	F 0921	1. Resident's A & B were affected. The foot platform of the sit to stand lift contained food crumbs and debris. 2. All residents that use the sit to stand lift have the potential to be affected by this alleged deficient practice. The platform of the sit to stand lift was cleaned and sanitized. Nursing staff was educated on the importance of cleaning and sanitizing equipment. 3. As a measure of ongoing compliance, the DHS or designee will complete random audits of the platform of the sit to stand lift weekly for 4 weeks, every other week for 2 months, then monthly for 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	12/28/2022

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	3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: November 29, 30, December 1, 2, 5 and 6, 2022 Facility number: 003924 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 8, 2022.	R 0000	The submission of this plan of correction does not indicate an admission by Stonebridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Stonebridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies			

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	regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.			
	Based on interview and record review, the facility failed to ensure residents signed their Resident Rights Acknowledgement for 3 of 7 residents reviewed for signed Resident Rights Acknowledgements (Resident 3, Resident 4, Resident 6) Findings include: 1. On 12/6/22 at 10:00 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and depression. The resident was admitted on 9/15/22. The Resident Rights Acknowledgement, dated 9/15/22 at 3:28 p.m., was not signed by the resident or a representative. 2. On 12/6/22 at 10:22 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and dementia. The	R 0026	1. Residents 3, 4 and 6 were affected. Resident Rights Acknowledgements were unsigned. 2. All residential admissions have the potential to be affected. All residential residents were reviewed to ensure signed Resident Rights Acknowledgements are documented. 3. As a measure of ongoing compliance, the DHS or designee will audit new residential admissions for signed resident rights acknowledgements weekly for 4 weeks, as available, then every other week for 2 months, and then monthly for 3 months. 4. The results of the audit observations will be reported, reviewed and trended for	12/28/2022

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	resident was admitted on 11/23/21. The Resident Rights Acknowledgement, dated 11/22/21 at 11:56 a.m., was not signed by the resident or a representative. 3. On 12/6/22 at 10:30 a.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and chronic kidney disease. The resident was admitted on 2/5/22. The Resident Rights Acknowledgement, dated 2/4/22 at 1:41 p.m., was not signed by the resident or a representative. During an interview on 12/6/22 at 3:45 p.m., the Director of Health Services indicated the Resident Rights Acknowledgements were not signed for Resident 3, Resident 4, and Resident 6. On 12/6/22 at 4:05 p.m., the Director of Health Services provided the policy, "Assisted Living Resident Rights Guidelines," reviewed 3/24/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated no instruction for staff to obtain signatures from residents or representatives in regard to the residents receiving a copy of their Resident Rights.		compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing			

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	needs of the resident. Based on interview and record review, the facility failed to ensure staff completed a pre-admission evaluations for residents prior to admission for 4 of 7 residents reviewed for pre-admission evaluations. (Resident 2, Resident 4, Resident 6, Resident 7) Findings include: 1. On 12/6/22 at 9:45 a.m., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and depression. The resident was admitted on 9/15/22. A review of the resident's clinical record indicated no pre-admission evaluation was completed. 2. On 12/6/22 at 10:22 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and dementia. The resident was admitted on 11/23/21. A review of the resident's clinical record indicated no pre-admission evaluation was completed. 3. On 12/6/22 at 10:30 a.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and chronic kidney disease. The resident was admitted on 2/5/22. A review of the resident's clinical record indicated no pre-admission evaluation was completed. 4. On 12/6/22 at 10:45 a.m., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, Diabetes Mellitus type 2 and chronic kidney disease. The resident was admitted on 5/31/22.	R 0214	1. Residents 2, 4, 6 and 7 were affected. Resident's 2, 4, 6 and 7 did not have pre-admission evaluations on file. 2. All residential admissions have the potential to be affected. The admissions team was educated on obtaining these prior to admission. All residential residents were audited to ensure pre-admission documentation is currently in place. 3. As a measure of ongoing compliance, the DHS or designee will audit new residential admissions to ensure pre-admission evaluation is in place weekly, as available, for 4 weeks, then every other week for 2 months, then monthly for 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	12/28/2022

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	A review of the resident's clinical record indicated no pre-admission evaluations was completed. During an interview on 12/9/22 at 12:15 p.m., the clinical nurse consultant indicated the facility did not complete any pre-admission evaluations on Resident 2, Resident 4, Resident 6, nor Resident 7, and the evaluations should have been completed prior to admission. On 12/6/22 at 3:45 p.m., the Director of Health Services provided the policy, "Assisted Living Preadmission Evaluation Guidelines," reviewed 3/24/22, and indicated it was the policy currently being used. A review of the policy indicated, "...1. Residents will receive an evaluation which shall be initiated prior to admission..."			