STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF ELKHART	2528 BYPASS ROAD ELKHART, IN 46514

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00399277, IN00395908, IN00393740, IN00392938, IN00387877, IN00375572 and IN00375518. Complaint IN00399277 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00395908 - Substantiated. No deficiency related to the allegations were cited. Complaint IN00393740 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00392938 - Substantiated. State deficiencies related to the allegations are cited at R0036. Complaint IN00387877 - Unsubstantiated due to lack of evidence. Complaint IN00375572 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00375518 - Substantiated. No deficiencies related to the allegations are cited. . Survey dates: January 24, 25, 26 and 27, 2023 Facility number: 014241 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hemmington Mwanza	Executive Director	02/20/2023

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

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	Quality review completed 2/2/23.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to inform the resident's representative of a transfer to the hospital for 1 of 15 residents reviewed for transfer and discharges. (Resident G) Finding includes: A clinical record review for Resident G was completed on 1/25/2023 at 1:27 P.M. Diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, and major depressive disorder. A Nurse's Note, on 9/2/2023 at 10:56 A.M., indicated, " ...Spoke with residents nurse at [hospital name] for update ...." On 9/2/2022 at 1:10 P.M., a Nurse's Note indicated, " ...Spoke with daughter [daughter's name] for medical update ...." A Grievance/Complaint Report was initiated on 9/6/2023 by Resident G's daughter. The grievance indicated the daughter was not notified of Resident G's condition prior to sending the	R 0036	The ED/DON/ADON/Nuses/QMAs will be educated on the need to use the state provided transfer/discharge form accompanied by the bed hold policy for all interfacility transfers or discharges by 2/26/2023 All discharges/transfers will be noted on the resident progress note with notification of transfer given to the Primary Care Physician, family/POA, Case Worker, Executive Director, local Ombudsman (all voluntary discharges) and state Ombudsman (all involuntary discharges) The DON/ADON will maintain a physical binder of all discharge/transfer forms to be uploaded on the Resident's record on Point Click Care (PCC) A Discharge/transfer tracker will be maintained and will be discussed every day as part of the	02/26/2023

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	resident to the hospital. The daughter indicated she was notified by the hospital. The investigation into the grievance indicated that Resident G was sent to the hospital on 9/1/2023, and the nurse notified the daughter on 9/2/2023 of his transfer to the hospital. The clinical record did not have any further documentation related to the transfer to the hospital including family notification. During an interview, on 1/26/2023 at 12:15 P.M., the Director of Nursing indicated if a resident was transferred to the hospital, the nurse was to fill out a transfer form and document in the nurses notes. She indicated the transfer forms should have been completed. On 1/27/2023 at 3:47 P.M., the Director of Nursing provided an undated typed paper titled, "Complete Check List Below", and indicated the facility uses this for transfers. "...Transferring Out To Hospital/ER, LTC Etc.". Complete Transfer Form. Print off Emergency info sheet. Notify Family. Notify PCP. Enter Note in Caremerge. Call Report to Hospital. Fill out Transfer Log/Place Copy of Transfer Form in Transfer Binder...." This State tag relates to Complaint IN00392938.		morning meeting The ED/DON/Designee will audit the Discharge/transfers every month for the next four months and thereafter for compliance Results will be sent to the Continuous Quality Product Management (CQPM) every month for review and recommendations	
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility			

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	must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is			

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	required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with			

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	developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure pertinent transfer and resident clinical information was completed for 1 of 3 residents reviewed for hospitalization. (Residents 5) Finding includes: A closed clinical record review was completed, on 1/25/2023 at 2:15 P.M. Resident 5's diagnoses included, but were not limited to: kidney disease, Parkinson's disease and bipolar. A Health Status Note, dated 4/5/2022 at 10:00 A.M., indicated the resident and best friend called 911 to go to the hospital, because she was not feeling well. Fire Department transported the resident to the hospital. A Health Status Note, dated 4/5/2022 at 9:11 P.M., indicated Resident 5 had returned to the facility. A Service Plan Update Note, dated 9/2/2022 at 10:25 A.M., indicated the resident was hallucinating and was transferred to the hospital for evaluation. A Nurse's Note, dated 9/2/2022 at 4:15 P.M., indicated Resident 5 returned to the facility. A Service Plan Update Note, dated 9/7/2022 at 2:41 P.M., indicated the resident was admitted to the hospital. A Service Plan Update Note, dated 9/25/2022 at 4:15 P.M., indicated Resident 5 returned to the	R 0045	The ED/DON/ADON/Nuses/QMAs will be educated on the need to use the state provided transfer/discharge form accompanied by the bed hold policy for all interfacility transfers or discharges by 2/26/2023 All discharges/transfers will be noted on the resident progress note with notification of transfer given to the Primary Care Physician, family/POA, Case Worker, Executive Director, local Ombudsman (all voluntary discharges) and state Ombudsman (all involuntary discharges) A copy of the discharge/transfer form and the appeals form will be provided to the resident/POA upon discharge/transfer The DON/ADON will maintain a physical binder of all discharge/transfer forms to be uploaded on the Resident's record on Point Click Care (PCC) A Discharge/transfer tracker will be maintained and will be discussed as part of the morning meeting The ED/DON/Designee will audit the Discharge/transfers every month for the next four months and thereafter for compliance Results will be sent to the Continuous Quality Product	02/26/2023

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	facility. A Service Plan Update Note, dated 10/3/2022 at 10:09 A.M., indicated Resident 5 stated she wanted to go to the hospital because she just didn't feel right. 911 called and the resident was transferred to the hospital. The clinical record lacked the documentation to show a Transfer/Discharge form was completed with pertinent resident clinical information for all the transfers to the hospital. During an interview, on 1/26/2023 at 12:15 P.M., the Director of Nursing indicated is a resident was transferred to the hospital, the nurse is fill out a transfer form and document in the nurses notes. She indicated the transfer forms should have been completed. On 1/27/2023 at 3:47 P.M., the Director of Nursing provided an undated typed paper titled, "Complete Check List Below", and indicated the facility uses this for transfers. "...Transferring Out To Hospital/ER, LTC Etc... Complete Transfer Form. Print off Emergency info sheet. Notify Family. Notify PCP. Enter Note in Caremerge. Call Report to Hospital. Fill out Transfer Log/Place Copy of Transfer Form in Transfer Binder...."		Management (CQPM) every month for review and recommendations	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions,			

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	except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were completed timely. Finding includes: A review of the facility fire drills was completed on 1/25/2023 at 9:01 A.M. The fire drills present by the facility for the past year were October 2022, November 2022, and December 2022. During an interview on 1/25/2023, the Executive Director indicated the facility had been denied access to their TELS (life safety software platform for the maintenance department) system due to the corporation not paying the bill owed. The denial began in October 2022, and the facility began documenting fire drills on paper that month. On 1/26/2023 at 9:02 A.M., employee sign-in sheets for the fire drills from January 2022 through September 2022 were requested.	R 0092	Scheduled monthly fire drills for the year that includes each shift for each quarter Fire Drills are captured on the TELs system Payments were made to TELs for access. TELS will be up and running by 2/26/2023 Outstanding fire drill logs (Jan 22 to Sep 22) will be retrieved from TELS by 2/26/2023, printed and placed in the appropriate binder Educated the ED/Maintenance Director on the need to maintain a binder of the monthly fire drill sheets and the participant sign off sheets to be uploaded to TELS every month The ED/designee will audit the fire drill logs and the participant sign off sheets every month for the next four months Results of audits will be sent to	02/26/2023

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	During an interview on 1/26/2023 at 9:45 A.M., the Administrator in Training indicated the TELS system was not accessible. She indicated they did not have any employee sign-in sheets for participation in the fire drills. She indicated the TELS system had the names of those in attendance manually typed into the system. A policy was provided on 1/27/2023 at 3:49 P.M., by the Administrator in Training titled, "Plans for Specific Disasters and Emergencies". The current policy indicated, " ...The Community will comply with the National Fire Protection Association Life Safety Code, 2012 edition, chapters 32 and 33, residential board and care occupancy, slow evacuation capability, or a greater level of fire safety ...Fire drills will be held in accordance with state and local requirements alternating with all work shifts ...Written records of fire drills must be maintained by the MDD [Maintenance Director], with a copy given to the ED [Executive Director]...."		the Continuous Quality Product Management (CQPM) monthly for the next four months for review and recommendations	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on			

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	site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a CPR (Cardiopulmonary Resuscitation) certified and first aid certified was working every shift. Finding includes: A nursing schedule dated 1/22/2023 through 1/28/2023 indicated there were no CPR certified staff on second shift on 1/25/2023. There were no certified staff on 1/23/2023 and 1/28/2023 on third shift. On 1/22/2023 through 1/28/2023, there were no first aide certified staff in the building on third shift. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated a staff member should always be in the building that has CPR and first aid certification. On 1/27/2023 at 1:03 P.M., the Director of Nursing indicated the facility does not have a policy on staff with CPR and first aid certification. She indicated they follow the state regulation.	R 0117	Audited the employee files for CPR and 1st Aid (2/13/2023) Instituted a tracker for CPR and 1st Aid renewal and will be tracked on the CQPM sheet Set up an event on the outlook calendar to remind ED/BMO/DON/ADON and staff about CPR and 1st aid renewal Scheduled training for CPR (2/20/2023) New hires for nursing and administration must possess the BLS Certification prior to completion of hire to ensure compliance. The ED/Designee will audit the employee files for CPR and 1st Aid to ensure that they are up to date, every month for the next four months Results will be sent to the Continuous Quality Product Management (CQPM) for compliance and recommendations	02/20/2023
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the			

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	facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interview, the facility failed to ensure general orientation was available for 10 of 10 employees records reviewed. Finding includes: An employee record review was completed on 1/27/2023 at 8:47 A.M., and indicated QMA	R 0119	Audited and updated all employee files for the general orientation (2/9/2023) A new hire employee tracking sheet has been set up (2/9/2023) to track general orientation A new employee checklist will be used to ensure compliance during	02/26/2023

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	(Qualified Medication Assistant) 7, CAN (Certified Nursing Assistant) 8 & 9, LPN (Licensed Practical Nurse) 10, Receptionist 11, Cook 12, Housekeeper 13, Dining Server 14, Move-In Coordinator 15, and the Activity Director did not have documentation of general orientation completion upon hire. During an interview on 1/26/2023 at 9:50 A.M., the Administrator in Training indicated general orientation was completed every Wednesday. She indicated the staff do not sign any paperwork to recognize the general orientation had been completed. On 1/27/2023 at 1:03 P.M., the Director of Nursing indicated the facility did not have a policy for general orientation.		orientation. The BOM/departmental heads will be educated on the need to complete the general orientation by 2/26/2023 The BOM will ensure the employee file is updated upon completion of the general orientation. The ED/Designee will audit the new employee files every month for the next four month until compliance is achieved. Results will be sent to the Continuous Quality Product Management (CQPM) every month for review and recommendations.	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, interview and record review, the facility failed to ensure dryer vents were free from a build up of lint in 6 of 6 dryers reviewed for fire hazards. (3rd floor & 2nd floor laundry rooms) Findings include: 1. On 1/25/2023 at 10:10 A.M., an observation of the 3rd floor laundry room was completed. The following was observed: The laundry room held 3 washers and 3 dryers. All 3 dryers had removable lint screens on the front of the dryer where the door closes. All 3 lint screen holding areas had a large build up of lint on the bottom of the holding	R 0145	Educated the Environmental Services Director and the housekeeping staff about cleaning the lint traps everyday (fire hazard) A check off chores list will be used by the housekeeping staff when inspecting and cleaning the lint ducts every day. Completed check off chores list will be filed in a binder after everyday assignment ED/designee and the Maintenance director will inspect the lint traps and audit the binder every week for 6 months until compliance is	02/26/2023

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	area. 2. On 1/25/2023 at 10:12 A.M., an observation of the 2nd floor laundry room was completed. The following was observed: The laundry room held 3 washers and 3 dryers. All 3 dryers had removable lint screens on the front of the dryer where the door closes. All 3 lint screen holding areas had a large build up of lint on the bottom of the holding area. During an interview, on 1/26/2023 at 3:24 P.M., the Maintenance Director indicated the dryer lint screen should be cleaned after each use. He was unaware of the build up of lint. On 1/27/20223 at 11:58 A.M., the Administrator in Training provided the policy titled,"Plans for Specific Disasters and Emergencies", dated March 2, 2021, and indicated the policy was the one currently used by the facility. The policy indicated "... Fire Prevention and Response Plan: Who: Users of Clothes Dryers. Responsibilities: Clean lint traps. Document cleaning completed by user on the Lint Trap Log. Min. Freq: After every use...."		achieved Results will be forwarded to the CPQM every month for compliance review and recommendations	
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 needs of the resident. Based on record review and interview, the facility failed to ensure semi annual evaluations were completed for 7 of 15 who were reviewed for	R 0214	1. All resident files were audited for assessments and service plans to ensure they are	02/26/2023

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	service plans. (Residents 3, 4, F, G, 2, B, and C) Findings include: 1. A clinical record review was completed, on 1/25/2023 at 11:46 A.M. Resident 3 was admitted on 4/22/2022. Her diagnoses included, but were not limited to: anxiety, diabetes, Parkinson's disease and hypertension. A Senior Living Standard Level of Care and Service plan, with a score of 8, indicated the type was: Pre-Move In. The form lacked a date when it had been completed. A Senior Living Standard Level of Care and Service Plan, with a score of 2, indicated the type was: 30 Day. The form lacked a date when it had been completed. The clinical record lacked the documentation to show if semiannual evaluations had been completed since admission. 2. A clinical record review was completed on 1/24/2023 at 3:12 P.M. Resident 4's diagnoses included, but were not limited to: diabetes, anxiety and epilepsy. A Level of Service Assessment/Evaluation form had been completed on 11/26/2021. The clinical record lacked the documentation to show if any semi annual evaluations had been completed since 11/2021. 3. A clinical record review was completed on 1/24/2023 at 3:32 P.M. Resident F was admitted on 3/25/2022. Diagnoses included, but were not limited to: dementia, depression, and		up to date 2. (2/16/2023) 3. Comprehensive assessments and service plans for all the residents will be completed (2/26/2023). 4. The DON/ADON will be educated on completing assessments (on admission, change of condition, semi-annually, annually) and Care plans (to be signed by the resident/POA/Representative) by 2/26/2026 5. The DON/ADON and the Administrator will track and audit the assessments and service plans every month for the next 6 months and report to the Quality Assurance every month for completeness and compliance. 6. ED/DON/ADON will audit resident files upon admission and every month for the next 6 months until compliance is achieved 7. Results will be sent to the CPQM every month for compliance and recommendations	

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	hypertension. A Senior Living Standard Level of Care and Service Plan, dated 4/26/2022, indicated the type was: other and was at a level 3. A Senior Living Standard Level of Care and Service Plan undated, indicated the type was a 30 days and was at a level 4. The clinical record lacked the documentation to show if any semi annual evaluations had been completed since 4/26/2022.4. A clinical record review for Resident G was completed on 1/25/2023 at 1:27 P.M. Diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, and major depressive disorder. A Resident Assessment Instrument was completed on 3/20/2020. No further assessments could be located in Resident G's record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated the facility completed quarterly assessments, but the assessments were not being completed. 5. A clinical record review was completed, on 1/26/2023 at 1:44 P.M., and indicated Resident 2 was admitted on 8/11/2020 with diagnoses of : Malignant neoplasm of brain, hypertension, chronic obstructive pulmonary disease, disorder of bone density and structure and hyperglycemia. A record review was completed, on 1/26/2023 at 1:52 P.M., and indicated Resident 2 did not have a semi-annual evaluation completed. 6. A clinical record review was completed on,			

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	1/24/2023 at 10:54 A.M., and indicated Resident C was admitted on 4/8/2022 with diagnoses of: Malignant neoplasm of colon, hypothyroidism, hyperlipidemia, major depressive disorder, insomnia, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease and osteoarthritis. A record review was completed, on 1/24/2023 at 11:03 A.M., and indicated Resident C did not have a semi-annual evaluation completed. 7. A clinical record review was completed, on 1/24/2023 at 2:00 P.M., and indicated Resident B was admitted on 8/10/2020 with diagnosis of: Unspecified dementia, psychotic disturbance, mood disturbance, anxiety, hypothyroidism, major depressive disorder, hypertension and osteoarthritis. A record review was completed, on 1/24/2023 at 2:14 P.M., and indicated Resident B did not have a semi-annual evaluation completed. During an interview, on 1/26/2023 at 3:21 P.M., the Director of Nursing indicated the semiannual evaluations should have been completed per regulations. On 1/27/2023 at 3:49 P.M., The Administrator in Training provided the policy titled, "Resident Pre-Admission Assessment", dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...The potential resident Pre-Move in Assessment is completed, signed, and kept in the resident's electronic record (pre-admission assessment in PointClickCare). The Resident Assessment is updated and completed at the same time as the Service plan (Service Agreement in			

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	PointClickCare) upon admission, 30 days following admission, with any change in condition, every 90 days in accordance with 0217 410 IAC...."			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure admission weights and semi annual weights were completed and failed to ensure a resident who was self medicating had an order to self administer medications for 9 of 15 residents whose weights were reviewed. (Residents 3, 4, 5, F, 2 ,C, B, G and H) Findings include: 1. A clinical record review was completed on 1/25/2023 at 11:46 A.M. Resident 3's diagnoses included, but were not limited to: anxiety, diabetes, Parkinson's disease and hypertension. Resident 3 was admitted to the facility on 4/22/2022. The most current weight was documented on 5/5/2022.	R 0216	Audited resident files for weights (semi-annul and annual) 2/15/2023 Setup a binder for monthly weights (every 7th of the month). Results will be uploaded onto resident file on PCC Resident weights for February were completed and updated (2/7/2023) Educated the DON/ADON/Nurse/QMA on the need to have updated weights every month and part of the assessment (admission, change of condition, semi-annual, annual) ED/designee/DON/ADON will audit the weights binder every month for the next 6 months until	02/26/2023

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	The clinical record lacked documentation to show if previous weights had been obtained prior to or after 5/5/2022. 2. A clinical record review was completed on 1/24/2023 at 3:12 P.M. Resident 4's diagnoses included, but were not limited to: diabetes, anxiety and epilepsy. Resident 4's current weights were documented 3/1/2022, 4/7/2022, and 5/3/2022. The clinical record lacked documentation to show if previous weights had been obtained prior to 3/1/2022 or after 5/3/2022. 3. A closed clinical record review was completed on 1/25/2023 at 2:15 P.M. Resident 5 was admitted on 9/6/2019. Her diagnoses included, but were not limited to: Parkinson's disease, kidney disease, bipolar and chronic obstructive pulmonary disease. Resident 5's current weights were documented on 3/2/2022, 4/7/2022 and 5/7/2022. The clinical record lacked documentation to show if previous weights had been obtained prior to 3/2/2022 or after 5/7/2022. 4. A clinical record review was completed on 1/24/2023 at 3:12 P.M. Resident F's diagnoses included, but were not limited to: diabetes, anxiety and epilepsy. Resident F's weights were documented on 3/28/2022, and 4/7/2022. The clinical record lacked the documentation to show if weights had been obtained since admission on 4/7/2022.		compliance is achieved Results will be sent to the CPQM every month for compliance and recommendations Audited resident files for self-administer medication orders Will assess all the residents self-administering medication for competency by 2/26/2023 Will seek Physician's orders for all the residents self-administering medication by 2/26/2023 Educated the DON/ADON/Nurse to complete and incorporate self-administering of medication assessments on the admission, change of condition, bi-annual and annual assessments ED/DON/ADON will audit the resident files every month for the next 6 months until compliance is achieved Results will be sent to the CPQM every month for compliance and recommendations	

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	During an interview, on 1/27/2023 at 10:28 A.M., the Director of Nursing indicated she could not produce documentation of other weights, and indicated the residents should have been weighed monthly. 5. A clinical record review was completed, on 1/26/2023 at 1:44 P.M., and indicated Resident 2 was admitted on 8/11/2020 with diagnoses including, but not limited to: Malignant neoplasm of brain, hypertension, chronic obstructive pulmonary disease, disorder of bone density and structure and hyperglycemia. A record review was completed, on 1/26/2023 at 1:52 P.M., and indicated Resident 2 did not have a semiannual evaluation completed and a weight was not recorded semiannually. 6. A clinical record review was completed on, 1/24/2023 at 10:54 A.M., and indicated Resident C was admitted on 4/8/2022 with diagnoses including, but not limited to: malignant neoplasm of colon, hypothyroidism, hyperlipidemia, major depressive disorder, insomnia, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease and osteoarthritis. A record review was completed, on 1/24/2023 at 11:03 A.M., and indicated Resident C did not have a semiannual evaluation completed and a weight was not recorded semiannually. 7. A clinical record review was completed, on 1/24/2023 at 2:00 P.M., and indicated Resident B was admitted on 8/10/2020 with diagnosis			

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	including, but not limited to: unspecified dementia, psychotic disturbance, mood disturbance, anxiety, hypothyroidism, major depressive disorder, hypertension and osteoarthritis. A record review was completed, on 1/24/2023 at 2:14 P.M., and indicated Resident B did not have a semiannual evaluation completed and a weight was not recorded semiannually. During an interview, on 1/26/2023 at 3:21 P.M., the Director of Nursing indicated the semi-annual evaluations and weights should have been completed per regulations. 8. A clinical record review for Resident G was completed on 1/25/2023 at 1:27 P.M. Diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, and major depressive disorder. A Resident Weight and Vital Sign Record, initiated on 10/1/2019, indicated an admission			

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	weight was not obtained. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated weights were obtained monthly and upon admission. She indicated it was very unlikely weights would be found. 9. A clinical record review for Resident H was completed on 1/25/2023 at 2:20 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. A Resident Weight and Vital Sign Record, initiated on 5/17/2022, indicated an admission weight was not obtained. A Medication Self-Administration Safety Screen on 5/19/2022, indicated Resident H could self-administer her medications, and that the physician felt that self-administration of medication was appropriate at the time. A physician order was not obtained for Resident H to self-administer her medications. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated weights were obtained monthly and upon admission. She indicated it was very unlikely weights would be found. She indicated a self-medication assessment should be completed at admission and a physician's order obtained for the self-administration. On 1/27/23 at 3:47 P.M., the Director of Nursing indicated there was no policy for weights.			
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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Bldg. 00	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were signed by the resident or their representative for 5 of 15 residents reviewed for service plans. (Resident 3, D, E, H, & 9) Findings include: 1. A clinical record review was completed on 1/25/2023 at 11:46 A.M. Resident 3 was admitted	R 0217	1. All resident files were audited for assessments and service plans up to datedness (2/16/2023) 1. Comprehensive assessments and service plans for all the residents will be completed (2/26/2023). 2. The DON/ADON will be educated on completing	02/26/2023

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	on 4/22/2022. Her diagnoses included, but were not limited to: anxiety, diabetes, Parkinson's disease and hypertension. A Senior Living Standard Level of Care and Service plan, with a score of 8 and indicated the type was: Pre-Move In. The form lacked a date when it had been completed and had no resident or family signatures. A Senior Living Standard Level of Care and Service Plan, with a score of 2 and indicated the type was: 30 Day. The form lacked a date when it had been completed and had no resident or family signatures.2. A clinical record review of Resident D was completed on 1/24/2023 at 10:55 A.M. Diagnoses included, but were not limited to: multiple sclerosis, major depressive disorder, hypothyroidism, and epilepsy. A Quarterly Senior Living Standard Level of Care and Service Plan was completed on 2/18/2022. The service plan did not have Resident D's signature for review. A Resident Service Plan Signature Page was not in Resident D's medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated that the service plan should be signed by the resident or resident representative. 3. A clinical record review of Resident E was completed on 1/24/2023 at 10:33 A.M. Diagnoses included, but were not limited to: hypothyroidism, diabetes mellitus, and hypertension. A Quarterly Senior Living Standard Level of Care and Service Plan was completed on 6/13/2022. The		assessments (Admission, change of condition, semi-annual, annual) and Care plans (to be signed by the resident/POA/Representative) by 2/26/2026 3. The DON/ADON and the Administrator will track and audit the assessments and service plans every week for the next 6 months and report to the Quality Assurance every month for completeness and compliance. 4. ED/DON/ADON will audit resident files upon admission and every month for the next 6 months until compliance is achieved 5. Results will be sent to the CPQM every month for compliance and recommendations	

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	service plan did not have Resident E's signature for review. A Resident Service Plan Signature Page was not in Resident E's medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated that the service plan should be signed by the resident or resident representative. 4. A clinical record review for Resident H was completed on 1/25/2023 at 2:20 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. A 30-day Senior Living Standard Level of Care and Service Plan was completed on 5/17/2022. The service plan did not have Resident H's signature for review. A Resident Service Plan Signature Page was not in Resident H's medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated that the service plan should be signed by the resident or resident representative. 5. A clinical record review of Resident 9 was completed on 1/24/2023 at 3:25 P.M. Diagnoses included, but were not limited to: atrial fibrillation, opioid dependence, and end stage renal disease with dependence on renal dialysis. A 30-day Senior Living Standard Level of Care and Service Plan was completed on7/13/2022. The service plan did not have Resident 9's signature for review.			

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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Resident Service Plan Signature Page was not in Resident 9's medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated that the service plan should be signed by the resident or resident representative. On 1/27/2023 at 3:49 P.M., The Administrator in Training provided the policy titled, "Resident Pre-Admission Assessment", dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...The potential resident Pre-Move in Assessment is completed, signed, and kept in the resident's electronic record (pre-admission assessment in PointClickCare). The Resident Assessment is updated and completed at the same time as the Service plan (Service Agreement in PointClickCare) upon admission, 30 days following admission, with any change in condition, every 90 days in accordance with 0217 410 IAC...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview and record review, the facility failed to ensure food was labeled, dated and stored in a sanitary manner in 1 of 1 kitchens reviewed. Findings include: 1. During a kitchen observation, on 1/24/2023 at	R 0273	A hood cleaning company has been contracted to clean the hood by 2/26/2023 Educated the Culinary Services Manager and kitchen staff on kitchen sanitation and Labelling, dating, proper storage and rotation of food items	02/26/2023

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	9:45 A.M. with the Administer in Training and the Chef, the following was observed: In the walk in freezer there were 5 uncovered dishes of ice cream. An undated plastic bag of frozen doughnuts. An opened and unsealed box of pre made hamburger patties. Pieces of carrots on the floor and under the food racks. In the walk in cooler there was a container of pudding with a used by date of 1/13/2023. An undated container of sliced onions. An opened and unsealed bag of sliced pepperoni. A bag of tortilla shells not sealed and a plastic bag of large carrots unsealed. During an interview, on 1/24/2023 at 10:28 A.M., the AIT indicated the foods should have been covered, sealed and dated and the floors should be swept. 2. During a follow up kitchen observation, on 1/26/2023 at 10:11 A.M., with the chef, the following was observed: The cooking utensil drawer had dried food substances and crumbs. The deep fryer and grill had dark brown sticky grease along the front edge of both appliances. Under the grill were pieces of food and a paper recipe. On the stove/grill hood vent along the bottom edge of the hood were visible lines of dripping grease from the top of the hood. A small salad cooler had an opened and undated bag of shredded cheese. On the bottom of the cooler on the right side was a standing liquid with 2 cardboard egg cartons filled with eggs that were soaked with the liquid. An undated and opened block of cheese. An opened and undated bag of butter with hardened yellow areas. An opened and undated cream cheese.		The Culinary Services Director will implement a cleaning schedule and food audits 2/26/2023 Culinary Service Director will check the cleaning schedules every day and will conduct food audits (for proper storage, labelling, dating, covering and rotation) 2 times per week A separate audit will be done for opened items 2 x per week The Culinary Services Director, the Cook and the Manager on Duty will conduct a Kitchen sanitation inspection and the proper storage (dry, open and frozen foods) 2 times per week ED/Designee together with the Dietary Services Director will audit and review the cleaning schedule and food audits every week for the next 3 months until compliance is achieved Results will be sent to the CPQM for compliance and recommendations	

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	During an interview, on 1/26/2023 at 10:20 A.M., the Chef indicated the grill and stove should be cleaned every night, the vent hood should have been cleaned twice a year. The coolers should be cleaned each week and the food should have dates on them. On 1/27/2023 at 11:58 A.M., the AIT (Administrator in Training) provided the policy titled, "Our Food: Sanitation", with a revised date of March 2, 2021, and indicated the policy was the one currently used by the facility. The policy indicated"...It should also be noted that all holding bins, drawers, racks, etc.,are clean and sanitary at all times... All kitchen and dining room areas shall be cleaned and sanitary at all times. Baseboards, cupboards, walls, counters, ceiling, floors, ledges, vents, hood systems, sprinklers and any general areas shall he kept clean, sanitary and in good condition...." On 1/27/2023 at 11:58 A.M., the AIT provided the policy titled, "Our Food: Food Safety", with a revised date of March 2, 2021, and indicated the policy was the one currently used by the facility. The policy indicated"...Labeling: If an item is not being served, it shall be covered, labeled and dated. All bulk foods not intended for immediate consumption shall be covered with a lid or food film and labeled with item name, date prepared, time prepared and discard date... Storage Standards: ...No product shall be in stock that is outdated. Food items are to be stored in accordance with the standard food storage hierarchy... Proper Storage Rotation: ..Marking the date of receipt on every item will help assure that stock rotation practices are followed... Expiration and Discard Dates: ... Check all merchandise upon receipt for the expiration date to assure freshness. Any items that are expired shall be discarded			

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	and/or returned...." On 1/27/2023 at 3:49 P.M., the AIT provided the policy titled," Appliances", and indicated the policy was the one currently used by the facility. The policy indicated"...All Company kitchen hoods and laundry ducts must be cleaned a minimum of two times per year as specified below. 10 Kitchen Hood Maintenance. A licensed contractor must provide the service to thoroughly clean the kitchen hood...."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to provide transfer and discharge documentation for 3 of 15 residents reviewed for accurate and complete clinical records. (Residents G, H & 5) Findings include: 1. A clinical record review for Resident G was completed on 1/25/2023 at 1:27 P.M. Diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, and major depressive disorder. A Nurse's Note on 9/2/2023 at 10:56 A.M., indicated, " ...Spoke with residents nurse at	R 0349	The ED/DON/ADON/Nuses/QMAs will be educated on the need to use the state provided transfer/discharge form accompanied by the bed hold policy for all interfacility transfers or discharges by 2/26/2023 All discharge/transfers will be noted on the resident progress note with: · A notification of transfer given to the Primary Care Physician, family/POA, Case Worker, Executive Director, local Ombudsman (all voluntary discharges) and state	02/26/2023

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	[hospital name] for update ...." On 9/2/2022 at 1:10 P.M., a Nurse's Note indicated, " ...Spoke with daughter [daughter's name] for medical update ...." On 9/5/2023 at 1:47 P.M., a Nurse's Note indicated, " ...Spoke with the nurse [nurse's name] for update on resident. Resident admitted with altered mental status and pneumonia ...." A Grievance/Complaint Report was initiated on 9/6/2023 by Resident G's daughter. The grievance indicated the daughter was not notified of Resident G's condition prior to sending the resident to the hospital. The daughter indicated she was notified by the hospital. The investigation into the grievance indicated that Resident G was sent to the hospital on 9/1/2023, and the nurse notified the daughter on 9/2/2023 of his transfer to the hospital. On 9/7/2023 at 4:06 P.M., a Nurse's Note indicated, " ...Spoke with daughter on the phone given staff update. Resident hallucinating, lethargic, sleeping a lot, hard to arouse ...." The clinical record did not have any further documentation related to the transfer to the hospital including discharge assessment, nurse's note, or family notification. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated that when a resident transfers to the hospital an assessment should be completed, a transfer/discharge form completed, and the resident's family notified. These actions should be documented in the nurse's notes. She indicated the transfer/discharge form should be a part of the		Ombudsman (all involuntary discharges) · A discharge summary A copy of the discharge/transfer form and the appeals form will be provided to the resident/POA upon discharge/transfer The DON/ADON will maintain a physical binder of all discharge/transfer forms to be uploaded on the Resident's record on Point Click Care (PCC) A Discharge/transfer tracker will be maintained and will be discussed at every day morning meeting The ED/DON/Designee will audit the Discharge/transfers for the completeness of record, every month for the next four months and thereafter for compliance Results will be sent to the Continuous Quality Product Management (CQPM) every month for review and recommendations	

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	medical record. 2. A clinical record review for Resident H was completed on 1/25/2023 at 2:20 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. On 1/25/2023, a list of discharged residents was provided. The list indicated Resident H discharged to home on 10/27/2022. A review of the Nurse's Notes from 9/5/2022 through 10/27/2022, indicated no entries that a discharge occurred. A review of Resident H's assessments indicated a discharge summary was not completed. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated that when a resident discharges from the facility a discharge summary and a transfer/discharge form should be completed. She indicated the transfer/discharge form should be a part of the medical record. 3. A closed clinical record review was completed on 1/25/2023 at 2:15 P.M. Resident 5 was admitted on 9/6/2019. Her diagnoses included, but were not limited to: Parkinson's disease, kidney disease, bipolar and chronic obstructive pulmonary disease. A Health Status Note, dated 4/5/2022 at 10:00 A.M., indicated Resident 5 had called 911 to take her to the hospital. A Health Status Note, dated 4/5/2022 at 9:11 P.M., indicated Resident 5 returned to the facility at 5:20 P.M.			

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	The clinical record lacked a Transfer and Discharge form for the transfer on 4/5/2022. A Service Plan Update Note, dated 9/2/2022 at 10:25 A.M., indicated Resident 5 was hallucinating, confused and weak. Resident 5 was sent to the hospital for evaluation. The clinical record lacked a Transfer and Discharge form for the transfer on 9/2/2022. A Service Plan Update Note, dated 9/7/2022 at 2:41 P.M., indicated Resident 5 was admitted to the hospital. A Service Plan Update Note, dated 9/14/2022 at 9:55 A.M., indicated the resident remained in the hospital. The clinical record lacked a Transfer and Discharge form for the transfer on 9/7/2022. On 1/27/2023 at 3:47 P.M., the Director of Nursing provided an undated typed paper titled,"Complete Check List Below", and indicated the facility uses this for transfers. "Transferring Out To Hospital/ER, LTC Etc.". Complete Transfer Form. Print off Emergency info sheet. Notify Family. Notify PCP. Enter Note in Caremerge. Call Report to Hospital. Fill out Transfer Log/Place Copy of Transfer Form in Transfer Binder...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or			

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	date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review, observation and interview, the facility failed to ensure the emergency binder was complete and accurate with all required resident information for 6 of 12 residents whose emergency information was reviewed. (Residents 3, 4, F, D, E & 9) Findings include: 1. On 1/24/2023, the Director of Nursing provided the Emergency binder for the facility. Resident 3's clinical information sheet lacked a photo, and hospital preference. Resident 4's clinical information sheet lacked a photo, and hospital preference. Resident F's clinical information sheet lacked a photo, and hospital preference. 2. A clinical record review of Resident D was completed on 1/24/2023 at 10:55 A.M. Diagnoses included, but were not limited to: multiple sclerosis, major depressive disorder, hypothyroidism, and epilepsy. A review of the emergency file information for	R 0356	All resident files were audited for a personal photo and hospital of preference 2/16/2023 All resident files will be updated with a resident's photo and a hospital of preference by 2/26/2023 DON/ADON will check for the resident's photo and hospital of preference at move in The ED/DON/ADON were educated on ensuring that the resident file has the resident's photo and the hospital of preference The ED/Designee and the DON/ADON will audit the resident files every month for the next three months until compliance is achieved. Results will be forwarded to the CPQM monthly for quality assurance and recommendations	02/26/2023

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	Resident D indicated a photo and hospital preference was not available for the file. 3. A clinical record review of Resident E was completed on 1/24/2023 at 10:33 A.M. Diagnoses included, but were not limited to: hypothyroidism, diabetes mellitus, and hypertension. A review of the emergency file information for Resident E indicated a photo and hospital preference was not available for the file. 4. A clinical record review of Resident 9 was completed on 1/24/2023 at 3:25 P.M. Diagnoses included, but were not limited to: atrial fibrillation, opioid dependence, and end stage renal disease with dependence on renal dialysis. A review of the emergency file information for Resident 9 indicated a photo and hospital preference was not available for the file. A policy for emergency files was requested. The Director of Nursing indicated the facility followed the state regulation for emergency files.			
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to develop a comprehensive care plan for 5 of 6 residents reviewed for a major mental illness. (Residents 6, 7, 9, B, & C) Findings include: 1. During a record review, on 1/26/2023 at 11:04	R 0382	All resident files for residents with mental illness were audited for mental health diagnosis/screening and comprehensive care plan by 2/16/2023 All residents with mental illness will have a comprehensive care plan 2/26/2023	02/26/2023

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	A.M., no comprehensive mental health care plan was found for Resident 6. The resident was diagnosed with major depressive disorder and anxiety disorder. During an interview with the DON (Director of Nursing), on 1/27/2023 at 1:10 P.M., she indicated that a comprehensive mental health care plan was not developed for Resident 6 but should have been. 2. During a record review, on 1/26/2023 at 1:45 P.M., no comprehensive mental health care plan was found for Resident 7. The resident was diagnosed with major depressive disorder and generalized anxiety disorder. During an interview with the DON, on 1/27/2023 at 1:10 P.M., she indicated that a comprehensive mental health care plan was not developed for Resident 7 but should have been.3. A clinical record review of Resident 9 was completed on 1/24/2023 at 3:25 P.M. Diagnoses included, but were not limited to: atrial fibrillation, opioid dependence, and end stage renal disease with dependence on renal dialysis. Behavioral Health Progress Notes indicated Resident 9 was seen on 9/7/2022, 10/25/2022, 11/22/2022, 12/6/2022, and 1/17/2023. Resident 9 was medicated with clonazepam 1 milligram three times daily, venlafaxine 37.5 milligrams daily for major depressive disorder, and Trazadone 25 milligrams at bedtime, and buprenorephine-naloxone 8-2 milligrams twice daily. The progress note indicated a past psychiatric history of depression, panic disorder, anxiety, history of drug and alcohol abuse, sleep disorder, and dementia.		Setup a move in check list and tracker for auditing All move in for residents with mental illness will be subject to mental health screening, establishing a mental health services and a comprehensive care plan Educated DON/ADON/Sales and Marketing Manager on the need to have a mental health screening pre-admission and a comprehensive care plan within 30 days of admission. Will Educate mental health service providers for the need to coordinate of care in regard to documentation 2/26/2023 The ED/DON/designee will audit all files for residents with mental illness for a pre-admission Mental Health Screening, comprehensive care plans (on admission, bi-annually) and mental health service providers' communication every month for the next 6 months until 100% compliance is achieved. Results will be sent to the Continuous Quality Product Management (CQPM) every month for compliance and recommendations	

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	A mental health care plan could not be found in the medical record.4. A clinical record review was completed, on 1/24/2023 at 2:00 P.M., and indicated Resident B was admitted on 8 /10/2020 with diagnosis of: unspecified dementia, psychotic disturbance, mood disturbance, anxiety, hypothyroidism, major depressive disorder, hypertension and osteoarthritis. A record review was completed, on 1/24/2023 at 2:14 P.M., and indicated Resident B did not have a comprehensive care plan related to a major mental illness completed. 5. A clinical record review was completed on, 1/24/2023 at 10:54 A.M., and indicated Resident C was admitted on 4/8/2022 with diagnoses of: malignant neoplasm of colon, hypothyroidism, hyperlipidemia, major depressive disorder, insomnia, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease and osteoarthritis. A record review was completed, on 1/24/2023 at 11:03 A.M., and indicated Resident C did not have a comprehensive care plan related to a major mental illness completed. During an interview, on 1/26/2023 at 3:21 P.M., the Director of Nursing indicated the comprehensive care plan related to a major mental illness was not completed and should have been. During an interview on 1/27/2023 at 3:30 P.M., the Director of Nursing indicated they followed state regulations and do not have a policy.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be			

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	required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to provide a physician's annual health statement for 11 of 15 residents reviewed for infection control. (Residents D, E, G, H, 9, 3, 4, 5, F, 7, 2, C, & B) Findings include: 1.A clinical record review of Resident D was completed on 1/24/2023 at 10:55 A.M. Diagnoses included, but were not limited to: multiple sclerosis, major depressive disorder, hypothyroidism, and epilepsy. A physician's annual health statement could not be found in the medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated all residents should have a health statement from the physician annually. 2. A clinical record review of Resident E was completed on 1/24/2023 at 10:33 A.M. Diagnoses included, but were not limited to: hypothyroidism, diabetes mellitus, and hypertension. A physician's annual health statement could not be found in the medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated all residents should have a health statement from the physician annually.	R 0409	Audited resident files for annual health statements Requested for physicians orders for annual health statements All annual health statements will be updated by 2/26/2022 Setup a tracker for annual health statements 2/15/2023 The ED/DON/ADON will ensure orders are in place at move in using the move in check list ED/DON/ADON/MSD will be educated on the need to have a valid health statement in place for every resident thereafter annually ED/designee/DON/ADON will audit all charts for the health statement every month for the next six months until compliance is achieved Results will be sent to the CPQM every month for compliance review and recommendations	02/26/2023

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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. A clinical record review for Resident G was completed on 1/25/2023 at 1:27 P.M. Diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, and major depressive disorder. A physician's annual health statement could not be found in the medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated all residents should have a health statement from the physician annually. 4. A clinical record review for Resident H was completed on 1/25/2023 at 2:20 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. A physician's annual health statement could not be found in the medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated all residents should have a health statement from the physician annually. 5. A clinical record review of Resident 9 was completed on 1/24/2023 at 3:25 P.M. Diagnoses included, but were not limited to: atrial fibrillation, opioid dependence, and end stage renal disease with dependence on renal dialysis. A physician's annual health statement could not be found in the medical record. During an interview on 1/26/2023 at 11:16 A.M., the Director of Nursing indicated all residents			

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		A. BUILDING 00 B. WING	01/27/2023

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	should have a health statement from the physician annually.6. A clinical record review was completed, on 1/25/2023 at 11:46 A.M. Resident 3 was admitted on 4/22/2022. Her diagnoses included, but were not limited to: anxiety, diabetes, Parkinson's disease and hypertension. The clinical record lacked an admission health statement of free from Tuberculosis in an infectious state. 7. A clinical record review was completed on 1/24/2023 at 3:12 P.M. Resident 4's diagnoses included, but were not limited to: diabetes, anxiety and epilepsy. Resident 4's clinical record lacked the documentation of an annual health statement of being free from tuberculosis in an infectious state. 8. A closed clinical record review was completed on 1/25/2023 at 2:15 P.M. Resident 5 was admitted on 9/6/2019. Her diagnoses included, but were not limited to: Parkinson's disease, kidney disease, bipolar and chronic obstructive pulmonary disease. Resident 5's clinical record lacked the documentation of an annual health statement of being free from tuberculosis in an infectious state. 9. A clinical record review was completed on 1/24/2023 at 3:32 P.M. Resident F was admitted on 3/25/2022. Diagnoses included, but were not limited to: dementia, depression, and hypertension. Resident F's clinical record lacked an admission health statement of being free from tuberculosis in an infectious state.10. During a record review, on			

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	1/26/2023 at 1:45 P.M., no annual health statement signed by the physician for 2020, 2021, or 2022 were found for Resident 7. During an interview with the DON, on 1/27/2023 at 1:07 P.M., she indicated there were no health statements signed by the physician in the record for Resident 7, but there should have been.11. A clinical record review was completed, on 1/26/2023 at 1:44 P.M., and indicated Resident 2 was admitted on 8/11/2020 with diagnoses of : Malignant neoplasm of brain, hypertension, chronic obstructive pulmonary disease, disorder of bone density and structure and hyperglycemia. The clinical record lacked the documentation to show an admission health statement of free from Tuberculosis in an infectious state and lacked an annual health statement 12. A clinical record review was completed on, 1/24/2023 at 10:54 A.M., and indicated Resident C was admitted on 4/8/2022 with diagnoses of: Malignant neoplasm of colon, hypothyroidism, hyperlipidemia, major depressive disorder, insomnia, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease and osteoarthritis. The clinical record lacked the documentation to show an admission health statement of free from Tuberculosis in an infectious state and lacked an annual health statement 13. A clinical record review was completed, on 1/24/2023 at 2:00 P.M., and indicated Resident B was admitted on 8/10/2020 with diagnosis of: Unspecified dementia, psychotic disturbance, mood disturbance, anxiety, hypothyroidism, major depressive disorder, hypertension and			

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	osteoarthritis. The clinical record lacked the documentation to show an admission health statement of free from Tuberculosis in an infectious state and lacked an annual health statement During an interview, on 1/26/2023 at 3:21 P.M., the Director of Nursing indicated the health assessments were not completed. During an interview on 1/27/2023 at 3:30 P.M., the Director of Nursing indicated there was not a policy for health assessment to be completed.			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility	R 0410	Resident files audited for current	02/26/2023

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	failed to ensure residents receive a Mantoux screening for Tuberculosis upon admission and annually for 9 of 15 residents reviewed. (Residents 7, 3, 4, 5, F, G, 2, C, and B) Findings include: 1. During a record review, on 1/26/2023 at 1:45 P.M., an annual TB test for 2020, 2021, or 2022, could not be found for Resident 7. During an interview with the DON (Director of Nursing), on 1/27/2023 at 1:07 P.M., she indicated TB testing was not done and should have been.2. A clinical record review was completed, on 1/25/2023 at 11:46 A.M. Resident 3 was admitted on 4/22/2022. Her diagnoses included, but were not limited to: anxiety, diabetes, Parkinson's disease and hypertension. The clinical record lacked the documentation to show the resident had received an admission 1st and 2nd step Mantoux Tuberculosis test. 3. A clinical record review was completed on 1/24/2023 at 3:12 P.M. Resident 4's diagnoses included, but were not limited to: diabetes, anxiety and epilepsy. The clinical record lacked the documentation to show that the resident had received an annual Mantoux test since 1/26/2020. 4. A closed clinical record review was completed on 1/25/2023 at 2:15 P.M. Resident 5 was admitted on 9/6/2019. Her diagnoses included, but were not limited to: Parkinson's disease, kidney disease, bipolar and chronic obstructive pulmonary disease.		TB testing (1st step, 2nd step, Annual, Questionnaire of symptoms) A TB testing Clinic has been set up for 2/23/2023 Implemented a TB testing tracker (1st step, 2nd step, Annual, Questionnaire of symptoms) All new admissions will be approved by the ED when the TB testing requirement is met ED/DON/ADON will audit resident files for up to datedness every month for the next 6 months until compliance is achieved Results will be sent to the CPQM every month for compliance and recommendation	

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	The clinical record lacked the documentation to show that the resident had received an annual Mantoux test in 2021 and 2022. 5. A clinical record review was completed on 1/24/2023 at 3:32 P.M. Resident F was admitted on 3/25/2022. Diagnoses included, but were not limited to: dementia, depression, and hypertension. The clinical record lacked the documentation to show that the resident had received a second step 3 weeks after admission.6. A clinical record review for Resident G was completed on 1/25/2023 at 1:27 P.M. Diagnoses included, but were not limited to: congestive heart failure, chronic obstructive pulmonary disease, and major depressive disorder. An Immunization Record was blank with no entries written on the form. A tuberculin skin test was performed on 10/17/2019. There was no other tuberculosis skin test documented in the medical record. A Checklist of Signs and Symptoms of TB (tuberculosis) Disease was completed on 10/17/2019. There was no other checklist completed in the medical record. During an interview on 11/26/2023 at 11:16 A.M., the Director of Nursing indicated that all resident's should have tuberculin skin testing done before admission and then annually thereafter. She indicated a questionnaire for symptoms should be completed upon admission and then quarterly.7. A clinical record review was completed, on 1/26/2023 at 1:44 P.M., and indicated Resident 2 was admitted on 8/11/2020 with diagnoses of :			

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	Malignant neoplasm of brain, hypertension, chronic obstructive pulmonary disease, disorder of bone density and structure and hyperglycemia. A record review was completed, on 1/26/2023 at 1:52 P.M., and indicated Resident 2 did not have a documented yearly tuberculin skin test completed. 8. A clinical record review was completed on, 1/24/2023 at 10:54 A.M., and indicated Resident C was admitted on 4/8/2022 with diagnoses of: Malignant neoplasm of colon, hypothyroidism, hyperlipidemia, major depressive disorder, insomnia, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease and osteoarthritis. A record review was completed, on 1/24/2023 at 11:03 A.M., and indicated Resident C did not have a second step Mantoux documented in the medical record. 9. A clinical record review was completed, on 1/24/2023 at 2:00 P.M., and indicated Resident B was admitted on 8/10/2020 with diagnosis of: Unspecified dementia, psychotic disturbance, mood disturbance, anxiety, hypothyroidism, major depressive disorder, hypertension and osteoarthritis. A record review was completed, on 1/24/2023 at 2:14 P.M., and indicated Resident B did not have a documented yearly tuberculin skin test completed. On 1/27/2023 3:49 P.M., the Administrator in Training provided the policy titled, "Infection Control-13-Resident Tuberculosis Testing", dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...Prior to admission, each resident shall			

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	be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. All residents will have a tuberculin skin test accomplished through use of the Mantoux intradermal method {5 TU PPD} administered at the time of admission or within three months prior to admission, unless there is documented history of a positive skin test. This statement is included on the Medical Evaluation form. All Mantoux administration and results will be documented on the Resident Tuberculosis Screening Record. The Resident Tuberculosis Screening Record will be updated annually for each resident after administration of the one-step Mantoux test...."			