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	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE CITY PLACE	425 CHINWORTH CT WARSAW, IN 46580

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 11 and 12, 2023 Facility number: 011389 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/17/23	R 0000		
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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Shirey	Care Services Manager/Director of Nursing	04/27/2023

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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	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 staff person was working every shift. Finding includes: A nursing schedule dated 4/9/2023 through 4/15/2023 indicated there were no CPR certified staff on third shift on 4/9/2023. There were no first aid certified staff on 4/9/2023 on third shift. During an interview on 4/12/2023 at 1:57 P.M., the Executive Director indicated she followed state regulations. On 4/12/2023 at 2:09 P.M., the Executive Director provided the policy titled, "First Aid Policy", dated 3/1/22, and indicated the policy was the one currently used by the facility. The policy indicated"...Staff members will be required to be first aid certified in states which requires employees to obtain and maintain certification based on the state regulatory requirements...." On 4/12/2023 at 2:59 P.M., the Executive Director provided the policy titled, "Cardiopulmonary Resuscitation (CPR) Policy", dated 3/1/22, and indicated the policy was the one currently used by the facility. The policy indicated"...If a resident is found without pulse and/or is not breathing, staff will respond to the emergency following established first aid procedures and in compliance with state regulations...."	R 0117	**R 117 Personnel – Deficiency** /b> First aid and CPR training will be completed for current third shift staff by 4/28/2023 by the Executive Director (ED) and Care Services Manager (CSM). **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** /p> **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The ED was re-trained on 4/12/2023 by Regional Director of Care Services regarding the needto ensure one awake staff person, with current first aid and CPR certification, is on site at all times. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 5/1/2023, the ED or designee will audit the staffing	04/28/2023

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			schedule weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure a first aid and CPR certified employee is on site at all times. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed:** Completion date: 5/12/2023 **R 0356 Clinical Records – Noncompliance** /b> The emergency information file for resident 3 was updated with all required documents, including photo, on 4/24/2023 by the Care Services Manager (CSM). The emergency information file for resident 5 was updated with allergy status on 4/20/2023 by the CSM. The emergency information file for resident 6 was updated with all required documents, including photo, on 4/24/2023 by the CSM. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and**	

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			what corrective action will be taken: An audit of emergency information files for current residents was completed on 4/21/2023 by the CSM to ensure all required information is provided in the emergency information file. Results reviewed by the Executive Director and concerns identified were corrected. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was re-trained on 4/12/2023 by the Regional Director Clinical Services (RDCS) on the need to ensure an emergency information file for each resident is complete with the required information. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 5/1/2023, the CSM or designee will audit emergency files weekly for 4 weeks, biweekly for 4 weeks, then monthly for 4 weeks to ensure required information is included in the emergency information file. Results will be discussed in monthly QI meeting. The QI Committee will determine if	

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			continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 5/12/2023	
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 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 and interview, the facility failed to provide required information for the resident emergency information file for 3 of 5 residents reviewed for emergency file information. (Residents 3, 5, & 6) Findings include: 1. A record review was completed on 4/11/2023 at	R 0356	**R 0356 Clinical Records – Noncompliance** /b> The emergency information file for resident 3 was updated with all required documents, including photo, on 4/24/2023 by the Care Services Manager (CSM). The emergency information file for	04/24/2023

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	2:04 P.M. for Resident 3. Diagnoses included, but were not limited to: congestive heart failure, atrial fibrillation, and diabetes mellitus type 2. She admitted on 3/24/2023. Resident 3 did not have any information in the emergency information file, including a photograph, when the emergency information file was reviewed. 2. A record review was completed on 4/11/2023 at 10:59 A.M. for Resident 5. Diagnoses included, but were not limited to: bladder cancer, anemia, and hypertension. The allergies section in the emergency information file for Resident 5 was blank. 3. A record review was completed on 4/11/2023 at 10:26 A.M. for Resident 6. Diagnoses included, but were not limited to: dementia, asthma, and insomnia. She admitted on 3/23/2023. Resident 6 did not have any information in the emergency information file, including a photograph, when the emergency information file was reviewed. On 4/11/2023 at 2:28 P.M., the Director of Nursing indicated the emergency information file should contain CPR (cardiopulmonary resuscitation) decision, insurance cards, and the resident's face sheet. A policy for emergency file information was requested on 4/12/2023 at 1:45 P.M. The Administrator indicated on 4/12/2023 at 1:57 P.M., the facility does not have a policy for the emergency information file. The facility follows the state regulations.		resident 5 was updated with allergy status on 4/20/2023 by the CSM. The emergency information file for resident 6 was updated with all required documents, including photo, on 4/24/2023 by the CSM. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of emergency information files for current residents was completed on 4/21/2023 by the CSM to ensure all required information is provided in the emergency information file. Results reviewed by the Executive Director and concerns identified were corrected. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was re-trained on 4/12/2023 by the Regional Director Clinical Services (RDCS) on the need to ensure an emergency information file for each resident is complete with the required information. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: Effective 5/1/2023, the CSM or designee will audit emergency files weekly for 4 weeks, biweekly for 4 weeks, then monthly for 4 weeks to ensure required information is included in the emergency information file. Results will be discussed in monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 5/12/2023	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to complete a system to analyze patterns of known infections within the facility. This practice affected had the potential to affect 40 of 40	R 0407	**R 407 Infection Control – Noncompliance** /b>	04/24/2023

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	residents. Finding includes: During the entrance conference, on 4/11/2023 at 9:11 A.M., the facility was requested to provide information on the infection control program. On 4/11/2023 at 11:07 A.M., the Director of Nursing indicated that infection control and antibiotic usage had not been documented and tracked for the year of 2023. She indicated the last time infection control and antibiotic usage was tracked was in 2022, and she couldn't find the time to get all the paperwork completed. A review of the infection control binder on 4/11/2023 at 11:14 A.M., indicated no documentation on the papers titled, "Infection Control Log", and the facility map for mapping of infections for January, February, March, and April of 2023. On 4/12/2023 at 2:06 P.M., a policy titled, "Preventing Transmission of Infection Policy" was provided by the Administrator. The policy did not indicate analyzation or surveillance of facility infections. A more specific policy regarding analyzation or surveillance of facility infections was requested. On 4/12/2023 at 2:07 P.M., the Administrator indicated the facility did not have a policy for analyzation or surveillance of facility infections.		/p> **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of current resident records for the past 30 days was completed on 4/24/2023 by the CSM to identify and analyze patterns of known infections within the community. /p> 3 **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**: The CSM was retrained on 4/12/2023 by the Regional Director of Care Services on the need to identify and analyze patterns of known infections within the community. /p> 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Effective 5/1/2023, the CSM and/or designee will complete an audit of the medication administration records and infection control log to identify and	

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			analyze patterns of known infections within the community. The audit will occur weekly for 4 weeks, biweekly for 4 weeks, then monthly for 4 weeks. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 5/12/2023	