PRINTED:	05/26/2023
FORM APP	ROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 04/12/2023	
	PROVIDER OR SUPPLIE	R		425 CH	ADDRESS, CITY, STATE, ZIP COD INWORTH CT AW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PF	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
R 0000							
Bldg. 00	This visit was for a Survey. Survey dates: Apri	State Residential Licensure	R 000	0			
	Facility number: 0	11389					
	Residential Census	:: 40					
	These State Reside accordance with 41	ntial Findings are cited in 10 IAC 16.2-5.					
	Quality review con	npleted on 4/17/23					
R 0117 Bldg. 00	qualifications, and applicable state la twenty-four (24) h unscheduled nee services provided and training of sta required to provid the residents. A n staff person, with certificates, shall fifty (50) or more regularly receive or administration least one (1) nurs site at all times. F over one hundred receiving resident administration of have at least one	iency sufficient in number, d training in accordance with aws and rules to meet the nour scheduled and ds of the residents and l. The number, qualifications, aff shall depend on skills le for the specific needs of ninimum of one (1) awake current CPR and first aid be on site at all times. If residents of the facility residential nursing services of medication, or both, at sing staff person shall be on Residential facilities with d (100) residents regularly tial nursing services or medication, or both, shall (1) additional nursing staff					
	person awake an	d on duty at all times for					

Kristina Shirey

Care Services Manager/Director of Nursing

04/27/2023

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

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			04/12/2023	
NAME OF	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD		
_AKE C	ITY PLACE				HNWORTH CT AW, IN 46580		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	I		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG				IAU			DATE
		ifty (50) residents. Personnel					
	-	l only those duties for which					
	-	o perform. Employee duties					
	shall conform wit	h written job descriptions.	DA	117	D 447 Dave annal Deficience		04/20/2022
	Doord on recent	view and interview, the facility	R 0	11/	R 117 Personnel – Deficienc	У	04/28/2023
		•			1		
		CPR (Cardiopulmonary			/b>	h .	
	,	ified and first aid certified staff			First aid and CPR training will		
	person was workin	ig every shift.			completed for current third sh	ift	
	T 1 1 1				staff by 4/28/2023 by the		
	Finding includes:				Executive Director (ED) and C	Care	
					Services Manager (CSM).		
	-	e dated 4/9/2023 through				_	
		d there were no CPR certified			2 How the facility will ident	ify	
		on $4/9/2023$. There were no first			other residents having the		
	aid certified staff of	on 4/9/2023 on third shift.			potential to be affected by the	ie	
					same deficient practice and		
	e	w on 4/12/2023 at 1:57 P.M., the			what corrective action will b	e	
		indicated she followed state			taken:		
	regulations.				/p>		
					3 What measure will be put		
		09 P.M., the Executive Director			into place or what systemic		
		y titled, "First Aid Policy",			changes the facility will mak	е	
		ndicated the policy was the one			to ensure that the deficient		
		he facility. The policy			practice does not recur:		
		nembers will be required to be			The ED was re-trained on	-	
		n states which requires			4/12/2023 by Regional Directo	or of	
		in and maintain certification			Care Services regarding the	~~	
	based on the state	regulatory requirements "			needto ensure one awake sta		
					person, with current first aid a		
		59 P.M., the Executive Director			CPR certification, is on site at	all	
		y titled, "Cardiopulmonary			times.		
		R) Policy", dated 3/1/22, and			4 How the corrective action(
	-	y was the one currently used			will be monitored to ensure	the	
		e policy indicated"If a resident			deficient practice will not		
	-	ulse and/or is not breathing,			recur, i.e., what quality		
	-	to the emergency following			assurance program will be p	ut	
		d procedures and in compliance			into place:		
	with state regulation	ons"			Effective 5/1/2023, the ED or		
					designee will audit the staffing	9	

Event ID: OOPY11 Facility ID: 011389 If continuation sheet Page 2 of 9

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		04/12/2023
NAME OF PI	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
LAKE CIT	Y PLACE			HNWORTH CT AW, IN 46580	
(X4) ID		STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
				schedule weekly x 4 weeks,	
				biweekly x 4 weeks, then mont	hly
				to ensure a first aid and CPR	- 11
				certified employee is on site at times. The audits will be	all
				discussed at monthly QI	
				meetings. The QI Committee	will
				determine if continued auditing	
				necessary based on 3 consecu	
				months of compliance. Monito	ring
				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	
				resident 3 was updated with al	1
				required documents, including photo, on 4/24/2023 by the Ca	ro
				Services Manager (CSM).	le
				The emergency information file	e for
				resident 5 was updated with	
				allergy status on 4/20/2023 by	the
				CSM.	
				The emergency information file	
				resident 6 was updated with al required documents, including	
				photo, on 4/24/2023 by the CS	
				2 How the facility will identif	iv .
				other residents having the	,
				potential to be affected by the	e
				same deficient practice and	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING B. WING	00		pleted 2/2023
NAME OF P	ROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP	COD	
LAKE CI	Y PLACE			HINWORTH CT SAW, IN 46580		
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION SHOULD BE	(X5) COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG			DATE
				 what corrective active active taken: An audit of emergence files for current reside completed on 4/21/20 CSM to ensure all requision is provide emergency information is provide emergency information. 3 What measure will into place or what sy changes the facility to ensure that the depractice does not retere. The CSM was re-traine 4/12/2023 by the Reg Clinical Services (RD need to ensure an emisiformation. 4 How the corrective will be monitored to deficient practice will be solve will be will be will be will be whet we for 4 weeks, then moweeks to ensure requision will be discuss monthly QI meeting. 	cy information ents was D23 by the quired ed in the on file. the Executive is identified I be put ystemic will make eficient focur: ned on gional Director DCS) on the mergency the resident is quired e action(s) ensure the ill not lity will be put he CSM or mergency eks, biweekly inthly for 4 uired ed in the on file. ssed in	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 04/12/2023
	PROVIDER OR SUPPLIE	R	425 C	T ADDRESS, CITY, STATE, ZIP COD CHINWORTH CT	
LAKE CI	TY PLACE		WAR	SAW, IN 46580	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE
				continued auditing is necessar based on 3 consecutive month compliance. Monitoring will be on-going.	ns of
				5 By what date the systemic changes will be completed Completion date: 5/12/2023	
R 0356	410 IAC 16.2-5-8				
Bldg. 00	be immediately a in case of emerg following: (1) The resident apartment numbe date of birth. (2) The resident (3) The name an legally authorized	rgency information file shall ccessible for each resident, ency, that contains the s name, sex, room or er, phone number, age, or s hospital preference. d phone number of any d representative. d phone number of the			
	 (5) The name and family members of contacted in the of death. (6) Information of (7) A photograph resident). (8) Copy of adva 	d telephone number of the or other persons to be event of an emergency or n any known allergies. (for identification of the nce directives, if available.			
	failed to provide re resident emergency	view and interview, the facility equired information for the y information file for 3 of 5 for emergency file information. 6)	R 0356	R 0356 Clinical Records – Noncompliance /b> The emergency information file resident 3 was updated with all required documents, including photo, on 4/24/2023 by the Ca	ll
	-	was completed on 4/11/2023 at		Services Manager (CSM). The emergency information file	

	'EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 04/12/2023	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD HINWORTH CT	-		
_AKE C	ITY PLACE				AW, IN 46580			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	2:04 P.M. for Resi	dent 3. Diagnoses included, but			resident 5 was updated with			
	were not limited to	o: congestive heart failure, atrial			allergy status on 4/20/2023 by	/ the		
	fibrillation, and dia	abetes mellitus type 2. She			CSM.			
	admitted on 3/24/2				The emergency information fil	le for		
		have any information in the			resident 6 was updated with a	all		
	emergency inform			required documents, including	-			
	photograph, when was reviewed.			photo, on 4/24/2023 by the C	SM.			
					2 How the facility will ident	ify		
		was completed on 4/11/2023 at			other residents having the			
		sident 5. Diagnoses included,			potential to be affected by the	ne		
		ed to: bladder cancer, anemia,			same deficient practice and			
	and hypertension.				what corrective action will b	е		
					taken:			
	-	The allergies section in the emergency information			An audit of emergency inform	ation		
	file for Resident 5			files for current residents was				
					completed on 4/21/2023 by th	e		
		was completed on 4/11/2023 at			CSM to ensure all required			
		sident 6. Diagnoses included,			information is provided in the			
		ed to: dementia, asthma, and			emergency information file.			
	insomnia. She adm	nitted on 3/23/2023.			Results reviewed by the Exec Director and concerns identified			
	Resident 6 did not	have any information in the			were corrected.			
		ation file, including a			3 What measure will be put			
	.	the emergency information file			into place or what systemic			
	was reviewed.	_ `			changes the facility will mak	e		
					to ensure that the deficient			
	On 4/11/2023 at 2	:28 P.M., the Director of Nursing			practice does not recur:			
	indicated the emer	gency information file should			The CSM was re-trained on			
	contain CPR (card	iopulmonary resuscitation)			4/12/2023 by the Regional Dir	rector		
	decision, insurance	e cards, and the resident's face			Clinical Services (RDCS) on t	he		
	sheet.				need to ensure an emergency	/		
					information file for each reside	ent is		
		gency file information was			complete with the required			
	*	2023 at 1:45 P.M. The			information.			
		cated on 4/12/2023 at 1:57 P.M.,						
		ot have a policy for the			4 How the corrective action(s)		
		ation file. The facility follows			will be monitored to ensure	the		
	the state regulation	18.			deficient practice will not			
					recur, i.e., what quality			

State Form

Event ID: OOPY11 Facility ID: 011389 If continuation sheet Page 6 of 9

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 04/12/2023	
NAME OF	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD	-	
LAKE CI	TY PLACE			WARS	AW, IN 46580		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TON D BE OPRIATE	(X5) COMPLETION DATE
R 0407 Bldg. 00	 410 IAC 16.2-5-1 Infection Control (b) The facility m control program t (1) A system that analyze patterns symptoms. (2) Provides oriel education on infe including univers (3) Offering healt including, but not transmission and (4) Reporting cor public health auth Based on record re failed to complete known infections of 	2(b)(1-4) - Noncompliance ust establish an infection hat includes the following: enables the facility to of known infectious ntation and in-service and precautions. h information to residents, ilimited to, infection immunizations. nmunicable disease to	R 04		assurance program will I into place: Effective 5/1/2023, the CS designee will audit emerg files weekly for 4 weeks, the for 4 weeks, then monthly weeks to ensure required information is included in a emergency information file Results will be discussed monthly QI meeting. The 4 Committee will determine continued auditing is nece based on 3 consecutive m compliance. Monitoring w on-going. 5 By what date the syste changes will be complete Completion date: 5/12/202 R 407 Infection Control – Noncompliance	SM or ency biweekly for 4 the e. in QI if essary nonths of <i>r</i> ill be mic ed 23	04/24/202

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN B. WING	G <u>00</u>		COMPLETED 04/12/2023	
				EET ADDRESS, CITY, STATE, ZIP (_	2/2020	
NAME OF	PROVIDER OR SUPPLIE	R		5 CHINWORTH CT			
LAKE C	ITY PLACE		WA	ARSAW, IN 46580			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAC			DATE	
	residents.			/p>			
	Finding includes:			2 How the facility wi other residents havin	-		
	Finding includes.			potential to be affected	-		
	During the entrance	e conference, on 4/11/2023 at		same deficient practi	-		
	e e	ility was requested to provide		what corrective actio			
		infection control program.		taken:			
				An audit of current res	sident		
	On 4/11/2023 at 1	1:07 A.M., the Director of		records for the past 30) days was		
	Nursing indicated	that infection control and		completed on 4/24/202			
	-	nd not been documented and		CSM to identify and a	nalyze		
		r of 2023. She indicated the last		patterns of known infe	ctions within		
		trol and antibiotic usage was		the community.			
		22, and she couldn't find the time		/p>			
	to get all the paper	work completed.		3 What measure will	-		
				into place or what sy			
		fection control binder on		changes the facility v			
		A.M., indicated no the papers titled, "Infection		to ensure that the det			
		the facility map for mapping of		practice does not rec	ur:		
	-	ary, February, March, and April		The CSM was retrained	ad on		
	of 2023.	ary, reordary, waren, and repri		4/12/2023 by the Regi			
	0120201			of Care Services on th			
	On 4/12/2023 at 2	:06 P.M., a policy titled,		identify and analyze p			
	"Preventing Trans	mission of Infection Policy"		known infections withi			
	was provided by the	ne Administrator. The policy		community.			
		alyzation or surveillance of		/p>			
	facility infections.						
	A	lion monutine		4 How the corrective	• •		
		olicy regarding analyzation or ility infections was requested.		will be monitored to e deficient practice will			
		:07 P.M., the Administrator		recur, i.e., what quali			
		ity did not have a policy for		assurance program v	-		
		veillance of facility infections.		into place:			
				Effective 5/1/2023, the	e CSM		
				and/or designee will c			
				audit of the medication	-		
				administration records			
				infection control log to	identifv and		

State Form

	OF HEALTH AND HU					RM APPROVED
	MEDICARE & MEDIC					B NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	or contraction	IDENTIFICATION NONIDER	B. WING	<u></u>	04/12/	
	ROVIDER OR SUPPLIEF	•	425 C	ADDRESS, CITY, STATE, ZIP COD HINWORTH CT		
LAKE CI	TY PLACE		WARS	AW, IN 46580		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				 analyze patterns of known infections within the commu The audit will occur weekly weeks, biweekly for 4 weeks monthly for 4 weeks. Result be reviewed at monthly QI meeting. The QI Committee determine if continued intern are necessary based on 3 consecutive months of compliance. Monitoring will on-going. 5 By what date the system changes will be completed Completion date: 5/12/2023 	for 4 s, then s will views be ic	