STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155363	A. BUILDING 00 B. WING	12/21/2023

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 19, 20, 21, 2023 Facility number: 000254 Provider number: 155363 AIM number: 100266270 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Type: Medicare: 1 Medicaid: 18 Other: 9 Total: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 8, 2024.	F 0000	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 1/22/24.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristy Denton	HFA	01/19/2024

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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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to insure care plan conferences were completed quarterly for 4 of 10 residents reviewed for care plans. (Resident 2, Resident 3, Resident 15, Resident 22) Findings include: 1. On 12/20/23 at 9:22 A.M., Resident 3's clinical record was reviewed. Resident 3 was admitted on 12/12/16. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dysphagia. The most recent quarterly MDS (minimum data set) Assessment was completed on 9/20/23. Resident 3's cognitive level was moderately impaired, and required extensive assistance for mobility and eating, and total dependence for toileting and bathing. Care plan conferences during the past 12 months	F 0657	It is the intent of the facility to ensure that care plan conferences are conducted quarterly according to schedule and as needed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Residents 2,3,15 and 22 have had care conferences completed. ·An audit was conducted for each resident's last assessment and care plan conferences were scheduled and conducted if needed. ·Education provided to social services and the interdisciplinary team (IDT) on care plan conferences scheduling and process.	01/19/2024

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	were held on 3/3/23, 3/31/23, and 7/5/23. 2. On 12/20/23 at 10:07 A.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 6/23/22. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dementia. The most recent quarterly MDS Assessment was completed on 11/18/23. Resident 22's cognitive level was moderately impaired, and required extensive assistance for mobility and transfers, maximal assistance for toileting, and was dependent on staff for bathing. Care plan conferences during the past 12 months were held on 5/31/23 and 12/18/23. 3. On 12/20/23 at 10:59 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, unspecified dementia, Type II diabetes mellitus, anxiety and major depressive disorder. The most recent quarterly MDS Assessment, dated 11/4/23, indicated Resident 15 had severe cognitive impairment, required extensive assistance of two for bed mobility and toilet use, and was totally dependent on two staff members for transfers, and one staff member for bathing. Resident 15's most recent care plan conference was completed on 8/31/23. The clinical record lacked a care plan conference, or an invitation to one since 8/31/23. During an interview on 12/21/23 at 1:10 P.M., the administrator indicated she was unable to find a care plan conference or an invitation to one after 8/31/23 in Resident 15's clinical records. 4. During an interview on 12/19/23 10:11 A.M., Resident 2 indicated she had not received a care plan conference.		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Audits will be conducted to ensure compliance with conducting care plan conferences by 1/19/24. ·IDT education provided by the administrator on 1/16/24 related to care plan meeting scheduling and processes. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·IDT education provided by the administrator on 1/16/24 related to care plan meeting scheduling and processes. ·The Social Service designee will ensure care plan conferences are conducted quarterly according to schedule by 1/19/24. ·Schedule will reflect upcoming conferences to ensure invitations are sent and conferences are held at least quarterly for each resident, this will be overseen by the IDT. **How the corrective action(s) will be monitored to ensure the**	

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	On 12/20/23 at 9:33 A.M., Resident 2's clinical record was reviewed. The most recent significant change MDS Assessment, dated 11/15/23 indicated Resident 2 had a moderate cognitive impairment. Resident 2 failed to receive a care plan conference between 6/16/23 and 12/21/23. The care plan conference form indicated Resident 2 received an observation on 12/20/23 and the form was completed on 12/21/23. During an interview on 12/21/23 at 10:07 A.M., the Social Services Director indicated care plan conferences should be completed quarterly or if there is a significant change, and the facility completed the care plan conferences when the resident was due for a MDS Assessment. She indicated several residents failed to receive their care plan conferences as they should have. She further indicated that the observation date on the form was when the form was opened and the completed date was when the care plan conference was completed with the facility. On 12/21/23 at 12:34 P.M., the Infection Preventionist provided the Comprehensive Care Plan Policy, revised 8/2023 that indicated, "Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment." 3.1-35(c)(2)(C)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Social Service Director/ designee will complete a care plan audit weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee. ·Regional social service/ designee will complete the audit review monthly to ensure and monitor compliance. ·If 90% threshold is not achieved, an action plan will be developed to ensure compliance.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to ensure proper storage of medications in 1 of 2 medication carts. The narcotic box was not locked in the medication cart. (West Hall) Finding includes: On 12/20/23 at 7:23 A.M., the narcotic box in the West Hall Medication Cart was observed unlocked. On 12/20/23 at 9:56 A.M., the narcotic box in the West Hall Medication Cart was observed unlocked.	F 0761	It is the intent of the facility to ensure medications are locked with access only to authorized personnel. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · ·The medication cart on West Hall is now locked. ·An audit was conducted to ensure that all medications are secured with access only to	01/19/2024

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	During an interview on 12/20/23 at 10:00 A.M., Registered Nurse (RN) 20 indicated the narcotic box should be locked. During an interview on 12/20/23 at 10:10 A.M., RN 35 indicated narcotic boxes in the medication cart should be locked anytime the nurse was not in it. On 12/21/23 at 10:15 A.M., a current Controlled Substance Policy, dated November 2015, was provided by the Administrator and indicated " ... 1. All controlled substances prescribed for all residents must be double locked in a secure container in the community ... " 3.1-25(m)		authorized personnel and that controlled medications listed as Schedule II are separately locked. ·Education provided to nursing on proper storage of medications and controlled medications listed as Schedule II. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Audits will be conducted to ensure compliance with proper medication storage by 1/19/24. ·IDT education provided by the Director of Nursing/ designee by 1/19/24 related to proper medication storage. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Nurse education provided by the Director of Nursing/ designee by 1/19/24 related to proper medication storage. ·The Director of Nursing/ designee will ensure medications are properly stored per medication storage policy. ·DNS/ designee will round each shift to ensure medication carts are locked at all times.	

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			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? ·The Director of Nursing/ designee will complete a medication storage audit weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee. ·Regional nurse support/ designee will complete the audit review monthly to ensure and monitor compliance. ·If 90% threshold is not achieved, an action plan will be developed to ensure compliance.	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section			

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	with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including			

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	the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.			

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	(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice:			

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	(A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.			
	Based on interview and record review, the facility failed to ensure a communication process with hospice personnel was developed and implemented, including how the communication will be documented between the LTC (long term care) facility and the hospice provider, and to ensure that the needs of the resident were addressed. The clinical record lacked	F 0849	It is the intent of the facility to ensure proper documentation of communication with hospice and facility personnel. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/19/2024

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	documentation of ongoing communication between facility staff and hospice staff for 1 of 1 residents reviewed for hospice. (Resident 3) Findings include: On 12/20/23 at 9:22 A.M., Resident 3's clinical record was reviewed. Resident 3 was admitted on 12/12/16. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dysphagia. The most recent quarterly MDS (minimum data set) Assessment was completed on 9/20/23. Resident 3's cognitive level was moderately impaired, and required extensive assistance for mobility and eating, and total dependence for toileting and bathing. Current physician orders included, but were not limited to, [admission to] (hospice company) with diagnosis of COPD (chronic obstructive pulmonary disease) dated 3/27/23. During an interview on 12/21/23 at 11:41 A.M., LPN 12 indicated Resident 3 did not have a hospice communication binder, or any other source of communication, and hospice would verbally communicate any changes or hand write any new orders on a telephone order sheet. During an interview on 12/21/23 at 12:01 P.M., the DON (director of nursing) indicated nurses working the floor do not have access to (hospice company) charting system, and medical records has to print (hospice company) notes from their charting system and upload them in to the patient's chart in the facility's charting system, and that should be done each time hospice has completed a visit. The DON was unable to provide documentation that any notes had been uploaded from (hospice company) charting		**practice?** ·Resident 3 communication binder has been implemented to ensure communication occurs between the hospice provider and the facility. ·Coordination with hospice providers to use binders for each resident receiving hospice services for documentation to be available for nursing staff responsible for the care of that resident. ·Education provided to nursing staff and nurse leadership on documentation availability. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·Audits will be conducted to ensure compliance with hospice documentation and to ensure communication binders are present for all hospice residents by 1/17/24. ·IDT education provided by the Administrator/ designee by 1/19/24 related to proper hospice documentation and communication. **What measures will be put into place or what systemic changes you will make to**	

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WILLOWDALE VILLAGE	404 W WILLOW RD DALE, IN 47523

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	system to the facility's charting system. During an interview on 12/21/23 at 12:29 P.M., the Hospice Nurse indicated all of the charting completed by hospice is entered into their charting system, was not accessible by floor nurses but was accessible by administrative staff, and when hospice faculty are in the facility they verbalize any changes of Resident 3 to the nurse working the floor at that time. On 12/19/23 a document titled "Hospice Services Agreement", dated 2/11/15, was provided. This document served as a contract between the facility and Resident 3's current contracted hospice company, and indicated "2. Responsibilities of the Facility: (f) Maintain an accurate medical record that includes all services and events provided. Required documentation provided by Hospice will be included in a designated area/section." A current hospice policy, dated 1/2016 revised 8/19, was provided by the DON on 12/21/23 at 2:20 P.M. and indicated "Recommend using the Hospice Initiation observation in Matrix for documentation. 3. For resident's who have elected the hospice benefit, there will be e. Hospice documentation available at the facility."		**ensure that the deficient practice does not recur?** ·Nurse education provided by the Administrator/ designee by 1/19/24 related to proper hospice documentation and communication. ·The Administrator/ designee will ensure hospice documentation is available to staff responsible for care of the resident receiving hospice services by 1/17/24. **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?** ·The Administrator/ designee will complete a hospice documentation audit weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the QAPI Committee. ·Regional nurse support/ designee will complete the audit review monthly to ensure and monitor compliance. ·If 90% threshold is not achieved, an action plan will be developed to ensure compliance.	