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	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH WOODS VILLAGE AT EDISON LAKES	1409 E DAY ROAD MISHAWAKA, IN 46545

(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 IN00396551, IN00400668, IN00407549 and IN00411766. Complaint IN00396551 - State deficiencies related to the allegations are cited at R0349 Complaint IN00400668 - No deficiencies related to the allegations are cited. Complaint IN00407539 - No deficiencies related to the allegations are cited. Complaint IN00411766 - State deficiencies related to the allegations are cited at R0349 Survey dates: July 5, 6, & 7, 2023 Facility number: 013236 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 7/19/2023.	R 0000		
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Deejra Lee | Administrator | 07/31/2023

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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	simulation of emergency fire conditions, 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 complete a fire drill every quarter on each shift. Finding includes: On 7/6/2023, the Plant Operations Manager provided 12 months of fire drills completed for the past year. The Fire Drill Report Sheets lacked the documentation to show a Fire Drill had been conducted on the evening shift for the first quarter (January, February & March) and for the third quarter (July, August, & September) and lacked the documentation for the night shift during the second quarter (April, May & June). During an interview, on 7/6/2023 at 10:29 A.M., the Plant Operations Manager indicated he had not completed a fire drill each quarter on a different shift and should have.	R 0092	**Element One:** It is **North Woods Village's** intention to conduct scheduled fire and disaster drills per ISDH guidelines. **Element Two:** Upon review and investigation no residents or staff were found to be harmed by the alleged noncompliance. **Element Three:** The **Regional Nurse/Operations Director** has re-educated the Executive Director and Maintenance Director on the regulations pertaining to fire and disaster drills. As an initial intervention the community will conduct a fire drill on each shift to ensure understanding and compliance by all staff in each department on those said shifts. Each shift will have these drills	08/27/2023

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	On 7/7/2023 at 7:03 A.M., the Administrator provided the policy titled," Fire alarm/Sprinkler Maintenance" ,dated 12/8/2020, and indicated the policy was the one currently used by the facility. The policy indicated"...Fire Drills: The community will periodically conduct fire and disaster drills to ensure that all personnel know out fire safety and disaster preparedness plans. Frequency: Fire drills (once a month/on a different shift each month): and Disaster drill (semiannually)...."		completed no later than **7/31/2023.** Going forward, fire and disaster drills will then be conducted according to the established quarterly schedule. The Maintenance Director will be responsible for completion of safety drills and maintaining records of drills. The Executive Director will be responsible for confirming that these drills take place per schedule and any concerns are addressed and resolved. **Element Four**: The **Executive Director/designee** will review the fire and disaster drill logs monthly for six months. Findings will be reviewed at scheduled QAPI meetings. The Executive Director may also request increased drills or monitoring as needed at any time. Date of Compliance: **8/27/2023**	
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			

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	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 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 first aid certified staff member was working every shift for 6 of the 21 shifts reviewed. Finding includes: A review of the nursing schedule, dated 7/1/2023 through 7/7/2023, indicated there was no first aid certified staff for the following dates: -First shift 7/5 and 7/6/2023. -Second shift 7/4/2023. -Third shift 7/2, 7/5, and 7/7/2023. During an interview, on 7/6/2023 at 2:50 P. M, the Administrator indicated there was not a first aid certified employee working or scheduled to work on the above dates and shifts, but there should have been. On 7/7/2023 at 9:10 A.M., a policy for employee files, and a policy for first aid certification was requested. The Administrator indicated there was no policies for employee files and first aid certification.	R 0117	**Element One:** It is North Woods Villages intentions to ensure that trained staff in first aide/cpr are on duty and are within the guidelines of one staff member for each shift. Those employees identified as missing cpr/first aide training have been offered and scheduled for such training. Upon investigation, no residents have been identified as having harmed caused by deficiency. **Element two**: Administrated staff has audited all current employees records for documentation of cpr/first aide training. First aide and cpr training will be scheduled and/or completed no later than 8/27/23. Training is provided to all staff who choose to attend. Personnel file will be updated with certifications once obtained. **Element Three:** cpr/first aide training classes are being offered	08/27/2023

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			to all staff; nursing staff are required to participate in class and obtain needed certification. All new employees will be scheduled for first aide/ CPR certification in the quarterly class schedule. **Element Four**: Compliance will be monitored by use of an audit process and tracing form. The business office manager/designee will perform a monthly audit of daily schedule templates to ensure compliance of the CPR/first aide staffing rules and regulations. They will also review 10% of the current personnel records to verify for CPR/First aide certification. Those without will be encouraged to take the class; to be offered quarterly at the community. Audits shall be conducted monthly, times six months, and reported to the Quality Assurance Committee. Date of Compliance: **8/27/2023**	
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, the facility failed to ensure the kitchen preparation areas and equipment were maintained sanitary and in good repair for one of one Kitchen's reviewed. This deficient practice had the potential to affect 52 of	R 0273	**Element One:** It is **North Woods Village's** intention to maintain a clean kitchen that meets ISDH sanitary guidelines. The concerns noted by the survey team were	08/27/2023

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	52 residents who received meals out of the kitchen. Finding includes: On 7/5/2023 at 9:43 A.M., during an observation of the kitchen with Dietary Manager, the following was observed: - A microwave with a hard yellow substance inside with paper towel. - A refrigerator with a sticky substance on the shelf. - 2 of 4 trash cans had food and debris on lid. - 2 bottles of ketchup were dented. - Surfaces of prep counters and shelves were dirty with debris. - Crumbs, coffee grounds, food and debris was observed on the floor. During an interview, on 7/6/2023 at 10:08 A.M., the Dietary Manager indicated: the ketchup bottles should have been discarded, the microwave, refrigerator, trash can lids, prep counters, shelves, and floor should have been cleaned. A policy for kitchen sanitation was requested on 7/7/2023 at 1:28 P.M. The Administrator indicated on 7/7/2023 at 1:51 P.M., the facility does not have a policy for the kitchen sanitation.		addressed via cleaning of the kitchen area once items were unpacked from delivery on the day the concern was raised. **Element Two:** No resident was identified as having harm caused by alleged deficiency. **Element Three:** The **Executive Director and Dietary Director** reviewed and revised cleaning schedules and assigned duties of kitchen staff to ensure better cleaning practices. Dietary staff will be re-educated on these changes and cleaning routines no later than **8/27/23**. **Element Four**: Compliance will be monitored by the ED/Dietary Director to observe and evaluate kitchen cleanliness on a weekly basis for one month and ongoing thereafter. Any deficiencies found will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee for review and recommendations. Date of Compliance: **8/27/2023**	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary			

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	instructions and the expiration date. Based on observation, interview, and record review the facility failed to ensure the biohazard refrigerator was free of ice build up, black mold, and free of resident foods and failed to ensure medications were labeled and dated when opened for 1 of 1 medication room and 1 of 1 medication carts reviewed. (Medication room and Glades Medication cart) Findings include: 1. During a medication storage observation, on 7/6/2023 at 2:06 P.M., with LPN 6, the following was observed: -The biohazard refrigerator had a large build up of ice in the freezer section. -Black specs were observed on the dividers in the door. -A protein shake that expired on 12/22/2022. -An opened and undated bottle of blue cheese salad dressing and a bottle of ketchup with no resident identifiers. During an interview, on 7/6/2023 at 2:07 P.M., the Director of Nursing indicated the freezer should have been defrosted the food items should not be in the refrigerator. 2. The Medication refrigerator had an opened and undated Aspart insulin pen with no resident identifiers, and two pedialyte popsicles with no resident identifiers. During an interview, on 7/6/2023 at 2:09 P.M., the Director of Nursing indicated the popsicles should be in the kitchen and the insulin pen should have had a residents name on it.	R 0300	Element One: It is **North Woods Village's** intention to maintain refrigerator maintenance and monitor proper function per ISDH guidelines. Upon the discovery of this allegation of deficiency, all medication and biohazard specimen refrigerators have been defrosted, deep cleaned and labeled appropriately. **Element Two:** No resident was identified as having harm caused by alleged deficiency. **Element Three:** A **weekly cleaning schedule of these refrigerators will be put in place** and used to ensure this deficiency does not reoccur. All Clinical staff responsible for monitoring, scheduled cleaning, handling medication and specimens will be in-serviced and re-educated by the **Director of Nursing** no later than **8/27/2023. (You could add Pharmacy nurse in-service, if Intouch provides)** **Element Four**: The **Director of Nursing/designee** will audit for compliance with proper medication and specimen refrigerator guidelines by completing random audits of the Clinical refrigerators weekly for one month or until 100% compliance is achieved. Findings will be reported to the **Executive Director by the**	08/27/2023

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	3. On a shelf in the medication room the following was observed: -A bin with 2 opened and undated bottles of Nystatin (an anti fungal powder) with the pharmacy label removed. -An opened and undated used tube of hydrocortisone cream (steroid cream) with no resident identifiers. -An opened and undated tube of hydrocortisone and a tube of calazyme (skin cream) for residents who were deceased. During an interview, on 7/6/2023 at 2:11 P.M., the Director of Nursing indicated the creams should have been thrown out and the labels should not have been removed. 4. During a medication cart observation, on 7/6/2023 at 2:13 P.M., on the Glades med cart with the Director of Nursing, the following was observed: - Opened and undated containers of Albuterol (inhaler) - A bottle of eye drops. - A container of Miralax (laxative). - A container of Milk of Magnesium. - 2 bottles of Levetiracetam (anticonvulsant). During an interview, on 7/6/2023 at 2:16 P.M., the Director of Nursing indicated the the pill roll should have been returned to the pharmacy and the other medications should have had opened dates on them. On 7/7/2023 at 6:58 A. M., the Administrator provided the policy titled, "Medication Storage In The Facility', undated, and indicated the policy was the one currently used by the facility. The		**Director of Nursing**/Designee if a deficiency in practice is found and at the next QAPI Committee for review and recommendations. Date of Compliance: **8/27/2023** **Element One:** It is **North Woods Village's** intention to maintain, store and administer medication per ISDH guidelines. All medication identified during the survey process was removed from the current medication supply, destroyed and documented per policy and procedures and a new supply obtained and verification completed for proper labeling. **Element Two:** No resident was identified as having harm caused by alleged deficiency. **Element Three:** All Nursing staff responsible for handling medication will be in-serviced and re-educated by the **Director of Nursing** no later than **8/27/2023.** Element Four: The **Director of Nursing/designee** will audit for compliance with medication labeling and destruction guidelines by completing random cart audits of 1/3 of the community as follows: weekly for one month or until 100% compliance is achieved. Any deficiencies found in the audits will be corrected at the time discovered and retraining or disciplinary actions provided, as	

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	policy indicated"...i. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. (Other foods such as employee lunches, activity department refreshments are not stored in this refrigerator. j. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...." On 7/6/2023 at 6:58 A.M., the Administrator provided the policy titled," Medication Labels", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...Medications are labeled in accordance with facility requirements and state and federal laws. Only the pharmacy can modify or change prescription labels... c. The pharmacy permanently affixes labels to the outside of prescription containers... d. Medication labels are not altered, modified, or marked in any way by nursing personnel... f. Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacy for relabeling or destroyed in accordance with the medication destruction policy...."		appropriate. Findings will be reported to the **Executive Director by the Director of Nursing/**Designee if a deficiency in practice is found and at the next QA Committee for review and recommendations. Date of Compliance: **8/27/2023**	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:			

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	(1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview and record review, the facility failed to ensure medications not being used by a current resident were returned to the pharmacy and or destroyed timely in 1 of 1 medication carts observed. (Glades Medication Cart) Finding includes: During a medication storage observation, on 7/6/2023 at 2:13 P.M., on the Glades medication cart with the Director of Nursing, the following was observed: a roll of medications for a resident who was not currently residing in the facility at this time. During an interview, on 7/6/2023 at 2:16 P.M., the Director of Nursing indicated the the pill roll should have been returned to the pharmacy. On 7/7/2023 at 6:58 A. M., the Administrator provided the policy titled,"Medication Storage In The Facility', undated, and indicated the policy was the one currently used by the facility. The policy indicated"...i. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. (Other	R 0306	**Element one**: Upon careful review, no residents were affected from the deficiency. New policy was obtained from pharmacy and Inservice is set for education for staff. **Element two**: All residents were reviewed, and no residents were affected by the alleged deficiency. **Element three:** Systematic changes that will be made is Inservice for all nursing staff through pharmacy twice a year. Staff will complete discharge checklist for all residents being discharged including deposition of medication and/or medication being returned. This process will then be reviewed by DON/designee to ensure discharge has been done correctly. **Element four:** DON/designee will monitor after all discharges proper procedures have been completed. Designee will schedule in services with Pharmacy in advance for the upcoming 12 calendar year. All corrections will be reviewed at	08/27/2023

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	foods such as employee lunches, activity department refreshments are not stored in this refrigerator. j. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...."		Quality Assurance meetings. To be completed by 8/27/2023	
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 ensure clinical records were completed with resident information and accurately documented for 2 of 9 residents whose clinical records were reviewed. (Residents B and D) Findings include: 1. A record review was completed on 7/6/2023 at 11:03 A.M. Resident B's diagnoses included, but were not limited to: dementia, heart disease, hypertension, depression, and Alzheimer's disease. Resident B's record indicated she had 14 falls documented from 1/24/2023 through 6/24/2023. A Service Plan, dated 5/22/2023 indicated the resident had moderate impairment: Resident has	R 0349	**Element One:** Upon the discovery of this allegation of deficiency, the DON has reviewed all residents who are in need of a skin evaluation to ensure the evaluation is completed and all skin issues documented appropriately in the residents' clinical record. **Element Two:** No resident was identified as having harm caused by alleged deficiency. **Element Three:** The Don has re-inserviced the care staff on the need to complete a Head to Toe skin evaluation upon admission, ensuring Shower/Bathing skin	08/27/2023

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	current or history of occasional disorientation to person, place, time or situation even in familiar surroundings and requires supervision and oversight for safety. During an observation, on 7/7/2023 at 4:49 A.M., Resident B was observed lying in bed with a pillow tucked underneath the bottom sheet along the right side of the bed. A fall mat was on the left side of the bed on the floor with a wedge cushion on the floor also. There was a blue alarm pad on two thirds of the bed with 1/3 of it hanging off the bed. There were pull tabs alarm lying in the recliner. During an interview, on 7/7/2023 at 4:52 A.M., CNA 9 indicated the bed alarm does not sound - it only alerts the staff via the phones that the resident is off the pad. CNA 9 indicated the resident will sometimes take off the tabs alarm. Current physician orders for Resident B included: bed alarm to be placed on night shift at hour of sleep. Bed to be in the lowest position with fall mats in place. Alarm to be attached when resident is in bed at any time. One- hour visual checks per nursing, one- hour visual assessment every night from hour of sleep to 7:00A.M. A safety check form, dated 6/25/2023, lacked the documentation to show the resident had been checked on from 12:00 A.M. through 6:00 A.M. A safety check form, dated 6/27/2023, lacked the documentation to show the resident had been checked on from 12:00 A.M., through 4:00 A.M. A safety check form, dated 6/28/2023, lacked the documentation to show the resident had been checked on from 12:00 A.M., through 6:00 A.M.		sheets are completed and any identified skin issues documented in the resident's medical record no less than weekly. **Element Four**: All new admissions and shower skin sheets will be reviewed to ensure documentation is completed by the **Director of Nursing and/or Executive Director**, weekly for 4 weeks or until 100% compliance is achieved. Findings will be reported to the **Executive Director by the Director of Nursing/Designee** if a deficiency in practice is found and at the next QA Committee for review and recommendations. **Date of Compliance: 8/27/2023**	

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	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	and 10:00 P.M. through 11:00 P.M. A safety check form, dated 7/1/2023, lacked the documentation to show the resident had been checked on from 12:00 A.M., through 6:00 A.M. and 9:00 P.M. through 11:00 P.M. A request for all safety check forms from January through July was requested on 7/7/2023. During an interview, on 7/7/2023 at 12:04 P.M., the Director of Nursing indicated she had no further safety check forms from the times requested, and indicated the forms should have been completed to show the resident had been checked hourly. 2. A closed record review was completed on 7/6/2023 at 1:45 P.M. Resident D's diagnoses included, but were not limited to: anxiety, hypertension, depression, insomnia, dementia, and peripheral vascular disease. A Nurses' Note, dated 10/20/2022 at 7:10 P.M., indicated Resident D was currently at (other facility name) for intravenous antibiotics for severe urinary tract infection with e coli (bacteria) in blood stream. A Nurse's Note, dated 11/2/2022 at 1:44 P.M., indicated Resident D returned to the facility this day. The resident is an assist of 2 staff with all cares and does not ambulate. Uses a broda chair and hoyer lift. A Nurse's Note, dated 11/2/2022 at 2:19 P.M., indicated a head- to- toe assessment was completed upon return from other facility. Excoriation noted to the resident's bottom, with an open area noted to the resident's coccyx. Barrier cream applied by care staff.			

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	A Nurses' Note, dated 11/2/2022 at 9:01 A.M., indicated the resident had an open area to the coccyx with red in the center and painful during cleaning. Requires 2 assist with hoyer for transferring. A Nurses' Note, dated 11/9/2022 at 11:37 A. M. indicated (name of hospice) here today to evaluate resident for possible admission to hospice services. A Nurses' Note, dated 11/12/2022 at 10:30 A.M., indicated the open area to the resident coccyx remains. No signs or symptoms of infection, Barrier cream applied to the coccyx three times a day. A Nurses' Note, dated 11/14/2022 at 5:45 P.M., indicated Resident D was shaking and appears anxious. Blood pressure 97/65, pulse at 97, temperature 96.5, and respirations at 20. Physician was informed and indicated to monitor and update if any change. A Nurses' Note, dated 11/21/2022 4:15 A.M., sent the resident to the emergency room, due to shortness of breath, clammy and hot to the touch. Accessory muscle breathing and unresponsive but awake. Biox at 82 % with 02 at 2 liters via nasal canula. A Nurse's Note, dated 11/21/2022 at 1:00 P.M., the nurse spoke to the hospital nurse and was informed that the resident was being admitted to the hospital for urinary tract infection. The clinical record lacked any documentation to show the resident had been assessed for other skin and or pressure areas and lacked the			

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	documentation to show that skin care was being provided by other providers. During an interview, on 7/7/2023 at 12:58 P.M., the Administrator indicated there was no other documentation of assessing the skin areas and there were no readmission documents for the resident upon return from the other nursing facility and should have been. On 7/7/2023 at 5:50 A.M., the Administrator provided the policy titled, "Admission/discharge Criteria", dated 11/1/2018, and indicated the policy was the one the facility currently uses. The policy indicated"... A community designee will evaluate each resident upon admission and semi-annually in accordance with state licensure rules and regulations as well as the Community's ability to meet the needs of the resident...." On 7/7/2023 at 11:10 A.M., the Administrator provided the policy titled," Significant Change in Condition", dated 2/1/2015, and indicated the policy was the one currently used by the facility. The policy indicated"...Staff will notify the resident, family, or responsible party of a significant change in the resident's condition. Purpose: To ensure the resident and others, as applicable , have accurate and current information...." This Residential tag relates to complaint IN00396551 and IN00411766.			