STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaints IN00449458 and IN00450780. Complaint IN00449458 - No deficiencies related to the allegations are cited. Complaint IN00450780 - Federal/state deficiencies related to the allegations are cited at F921. Survey dates: February 10, 11, 12, 13, 14, and 17, 2025 Facility number: 002667 Provider number: 155678 AIM number: 200300090 Census Bed Type: SNF/NF: 39 NF: 45 Residential: 42 Total: 126 Census Payor Type: Medicare: 25 Medicaid: 36 Other: 23 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 19, 2025.	F 0000	**R000** The submission of this plan of correction does not indicate an admission by Waterford Place Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Waterford Place Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Rife	Area Executive Director	02/27/2025

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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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure the physician's orders for a medication hold parameter was followed, hospice was notified of low blood glucose readings, and staff obtained a blood glucose reading as ordered for 3 of 3 residents reviewed for quality of care. (Resident 30, 54 and 24) Findings include: 1. The clinical record for Resident 30 was reviewed on 2/10/25 at 2:38 p.m. The diagnoses included, but were not limited to, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus with diabetic chronic kidney disease and neuropathy, and nonrheumatic aortic valve stenosis. a. A physician's order, dated 1/4/25, indicated to give metoprolol tartrate (a medication used to treat high blood pressure) 25 milligrams (mg) twice a day with special instructions to hold the medication for a systolic blood pressure less than 100. A Medication Administration Record (MAR), dated 1/1/25 through 1/30/25, indicated metoprolol tartrate 25 mg was given with a recorded systolic blood pressure of less than 100 on the following dates: On 1/13/25, with a systolic blood pressure of 84. On 1/16/25, with a systolic blood pressure of 88. On 1/18/25, with a systolic blood pressure of 96. On 1/19/25, with a systolic blood pressure of 97. On 1/20/25, with a systolic blood pressure of 93. On 1/24/25, with a systolic blood pressure of 89. On 1/30/25, with a systolic blood pressure of 99.	F 0684	**F684 – Quality of Care** 1 Residents #30, 54, and 24 were affected by the alleged deficient practice. Assessments were completed immediately. Notifications completed to provider and appropriate interventions in place for all residents. 2 All residents potentially affected by the alleged deficient practice. All like residents have been assessed with no signs of adverse effects. All licensed nursing staff in-serviced on blood glucose policy and holding parameters. 3 As a measure of on-going compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 residents to ensure hold parameters, low blood glucose call orders, and obtaining blood glucose accurately, 3 X weekly X 4 weeks; then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. 4 Results of audits will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue past 6 months, if warranted, until 100% compliance is attained.	03/16/2025

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	During an interview, on 2/12/25 at 10:30 a.m., LPN 5 indicated vital signs should be checked and hold parameters should be followed. b. A physician's order, dated 1/31/25, indicated to call hospice if the resident's blood glucose reading was greater than 250. A MAR, dated 1/31/25 through 2/11/25, indicated Resident 30 had the following blood glucose readings greater than 250: On 2/1/25, the resident's blood glucose reading was 256. On 2/5/25, the resident's blood glucose reading was 273. On 2/9/25, the resident's blood glucose reading was 307. There was no documentation hospice was notified of the resident's blood glucose readings greater than 250 in the medical record. During an interview, on 2/13/25 at 10:11 a.m., the Clinical Support Nurse indicated the facility did not have any documentation of hospice being notified of the elevated blood sugars and the nurse should have called the hospice provider per the order.2. The clinical record for Resident 54 was reviewed on 2/12/25 at 2:26 p.m. The diagnoses included, but were not limited to, dementia, psychotic disturbance, mood disturbance, and anxiety. A care plan, dated 11/29/23, indicated the resident had the potential for cardiovascular distress related to a diagnosis of hypertension. Interventions included, but were not limited to, administer medications as ordered and obtain vital signs as ordered.			

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	A physician's order, dated 10/24/24, indicated to give metoprolol tartrate (a medication used to treat high blood pressure) 12.5 milligrams (mg) twice a day with special instructions to hold the medication for a systolic blood pressure less than 110. A Medication Administration Record (MAR), dated 11/1/24 through 11/30/24, indicated metoprolol tartrate 12.5 mg was given with a recorded systolic blood pressure of less than 110 on the following dates: On 11/1/24, the morning dose was given with a systolic blood pressure of 105. On 11/1/24, the evening dose was given with a systolic blood pressure of 107. On 11/6/24, the morning dose was given with a systolic blood pressure of 100. On 11/12/24, the morning dose was given with a systolic blood pressure of 107. On 11/14/24, the morning dose was given with a systolic blood pressure of 104. On 11/17/24, the morning dose was given with a systolic blood pressure of 103. On 11/17/24, the evening dose was given with a systolic blood pressure of 108. On 11/18/24, the morning dose was given with a systolic blood pressure of 109. On 11/19/24, the morning dose was given with a systolic blood pressure of 100. On 11/22/24, the morning dose was given with a systolic blood pressure of 100. During an interview, on 2/12/25 at 10:30 a.m., LPN 5 indicated vital signs should be checked and hold parameters should be followed.3. The clinical record for Resident 24 was reviewed on 2/12/25 at 9:42 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertension, and			

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	depression. A care plan, dated 4/22/21, indicated the resident was at risk for hypoglycemia and hyperglycemia related to diabetes mellitus. Interventions included, but were not limited to, monitor blood sugar, give medications as ordered, and observe the resident for signs of hypoglycemia or hyperglycemia. A physician's order, dated 5/8/22, indicated to check the resident's blood glucose reading at 4:00 a.m. to prevent hypoglycemia (low blood sugar). There was no documentation in Resident 24's Electric Health Record the 4:00 a.m. blood glucose readings were obtained, or the physician was notified the order was not completed. During an interview, on 2/14/25 at 12:00 p.m., the Clinical Support Nurse indicated the nurse entered the physician's order wrong and the 4 a.m. blood glucose reading was never obtained and recorded as ordered. During an interview, on 2/17/25 at 11:43 a.m., LPN 8 indicated when a physician gave a verbal order she would repeat the order back to the physician, go straight to the computer, and enter the order into the computer. The management team verified the new orders and made sure they were entered into the computer correctly. During an interview, on 2/17/25 at 12:25 p.m., RN 9 indicated verbal orders needed to be entered into the computer and the pharmacy made aware of the new orders. The management team reviewed the orders to ensure they were checked twice. During an interview, on 2/17/25 at 12:35 p.m., the			

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	Director of Nursing indicated he did not look at the residents' orders on the Medication Administration Record (MAR). The only reason he would check the orders was if the residents' blood glucose readings were triggered high or low. The facility did not have a policy for blood glucose monitoring. A current facility policy, titled "Guidelines for Medication Orders," dated as reviewed 12/17/24 and received by the Clinical Executive Director Support on 2/12/25 at 9:15 a.m., indicated "...A current list of orders will be maintained in the electronic clinical record of each resident...Standing orders...The admitting nurse shall review the standing order list with the physician when verifying admission orders...The physician shall inform the admitting nurse if any of the standing orders should be eliminated, modified and/or other standing orders added for the specific resident...Standing orders shall be in the medical record with the other physicians orders...." 3.1-37(a)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure oxygen was administered at the physician's ordered level and to obtain an order to administer oxygen for 4 of 4 residents reviewed for oxygen. (Resident 118, 51, 9 and 58) Findings include:	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** 1 Residents #118, 51, 9, and 58 were affected by the alleged deficient practice. Assessments were completed immediately. Notifications completed to provider and appropriate interventions in	03/16/2025

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	1. During an observation, on 2/10/25 at 12:49 p.m., Resident 118 was sitting on her recliner wearing oxygen. The oxygen concentrator was set on 0.5 liters via nasal cannula. During an observation, on 2/11/25 at 3:30 p.m., the resident was sitting on her recliner wearing oxygen. Her oxygen concentrator was set on 1 liter via nasal cannula. During an observation, on 2/14/25 at 10:20 a.m., the resident was lying in bed eating her breakfast. The resident's oxygen concentrator was set on 3 liters via nasal cannula. During an interview, on 2/14/25 at 10:25 a.m., LPN 5 indicated Resident 118's concentrator was set on 3 liters, and she was not sure of the resident's oxygen order. The clinical record for Resident 118 was reviewed on 2/12/25 at 10:01 a.m. The diagnoses included, but were not limited to, chronic obstruction pulmonary disorder (COPD), congestive heart failure (CHF), hypertension, depression, dementia, and anxiety disorder. A physician's order, dated 2/7/25, indicated to administer oxygen at 2 liters when needed. A care plan, dated 2/10/25, indicated the resident had the potential for shortness of breath while lying flat. The interventions included, but were not limited to, administer oxygen per physician's order and elevate head of bed or place in upright position when needed. A care plan, dated 2/10/25, indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory		place for all residents. 2 All residents have the potential to be affected by the alleged deficient practice. All like residents have been assessed with no signs of adverse effects. All licensed nursing staff were in-serviced on correct oxygen settings. A house-wide audit has been completed in the Health Center to ensure that all residents requiring supplemental Oxygen, have the appropriate settings per the physician order. 3 As a measure of on-going compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 residents to ensure oxygen settings are accurate, 3 X weekly X 4 weeks; then two times weekly X 4 weeks; then weekly X 4 weeks, then monthly X 3 months. 4 Results of audits will be reported, reviewed, and trended for compliance through the campus QAPI (Quality Assurance Performance Improvement) Committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue past 6 months, if warranted, until 100% compliance is attained.	

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	failure. The interventions included, but were not limited to, administer oxygen per physician's order and to monitor lung sounds. During an interview, on 2/13/25 at 9:50 a.m., LPN 7 indicated that when a resident wore oxygen, she would check the Medication Administration Record (MAR) and verify the liter flow the resident was ordered. When a resident was wearing oxygen without an order, she would call the physician a get the order. During an interview, on 2/14/25 at 10:36 a.m., LPN 7 indicated the resident's oxygen should be set on 2 liters. 2. During an observation, on 2/10/25 at 10:43 a.m., Resident 51 was sitting in a Broda chair wearing oxygen. His oxygen concentrator was set on 3 liters per nasal cannula. The clinical record for Resident 51 was reviewed on 2/13/25 at 10:48 a.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, interstitial pulmonary disease, sick sinus syndrome, atrial fibrillation, and chronic systolic congestive heart failure. A physician's order, dated 1/9/25, indicated the resident was to receive oxygen at 2 liters continuously. A care plan, dated 1/23/25, indicated the resident had the potential for complications related to congestive heart failure. The interventions included, but were not limited to, administer oxygen according to the physician's order. A care plan, dated 1/23/25, indicated the resident had the potential for cardiovascular distress. Interventions included, but were not limited to, administer oxygen according to the physician's			

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	order. On the following dates, the resident was documented on the vitals report to have been on oxygen at 3 liters per nasal cannula: On 2/3/25 at 4:32 p.m. On 2/4/25 at 7:23 p.m. On 2/5/25 at 3:59 p.m. On 2/6/25 at 7:30 p.m. On 2/7/25 at 3:41 p.m. On 2/8/25 at 8:19 a.m. On 2/8/25 at 4:23 p.m. On 2/11/25 at 3:36 p.m. On 2/12/25 at 3:11 p.m. On 2/8/25 at 8:19 a.m., the resident was documented to be on oxygen at 1.5 liters. 3. During an observation, on 2/10/25 at 11:04 a.m., Resident 9 was lying in bed wearing oxygen. His oxygen concentrator was set on 4 liters per nasal cannula. During an observation, on 2/11/25 at 4:29 p.m., the resident was sitting up in his bed wearing oxygen. His oxygen concentrator was set on 3.5 liters per nasal cannula. The clinical record for Resident 9 was reviewed on 2/11/25 at 1:32 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, systolic (congestive) heart failure (CHF), atrial flutter, emphysema, nicotine dependence- cigarettes, and pulmonary fibrosis. A care plan, dated 1/6/25, indicated the resident had the potential for cardiovascular distress.			

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	Interventions included, but were not limited to, administer oxygen per the physician's order. A care plan, dated 1/6/25, indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory disease. Interventions included, but were not limited to, administer oxygen per the physician's order. There was no physician's order for Resident 9 to receive oxygen until after the survey start date. On the following dates, the resident was documented on the vitals report to have been on the following oxygen liters: On 1/27/25 at 4:58 p.m., the resident was on 4 liters of oxygen. On 1/28/25 at 9:09 a.m., the resident was on 4 liters of oxygen. On 1/28/25 at 09:05 p.m., the resident was on 6 liters of oxygen. On 1/29/25 at 4:07 p.m., the resident was on 4 liters of oxygen. On 1/30/25 at 10:41 a.m., the resident was on 7 liters of oxygen. On 1/30/25 at 4:47 p.m., the resident was on 4 liters of oxygen. On 1/31/25 at 4:54 p.m., the resident was on 4 liters of oxygen. On 2/2/25 at 8:09 p.m., the resident was on 4 liters of oxygen. On 2/3/25 at 3:37 p.m., the resident was on 4 liters of oxygen. On 2/4/25 at 3:06 p.m., the resident was on 4 liters of oxygen. On 2/5/25 at 3:57 p.m., the resident was on 4 liters of oxygen. On 2/6/25 at 7:40 p.m., the resident was on 4 liters of oxygen.			

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	On 2/7/25 at 8:48 a.m., the resident was on 2 liters of oxygen. On 2/9/25 at 09:01 p.m., the resident was on 4 liters of oxygen. On 2/10/25 at 8:46 p.m., the resident was on 4 liters of oxygen. On 2/11/25 at 3:35 p.m., the resident was on 4 liters of oxygen.4. During an observation, on 2/10/25 at 11:07 a.m., Resident 58 was sitting in his room wearing 3.5 liters of oxygen via a nasal cannula. During an observation, on 2/11/25 at 11:02 a.m., the resident was sitting in his room wearing 3.5 liters of oxygen. The clinical record for Resident 58 was reviewed on 2/12/25 at 9:57 a.m. The diagnoses included, but were not limited to, Parkinson's disease, pneumonia, acute respiratory failure with hypoxia (low oxygen), and heart failure. There was no physician's order for Resident 58 to receive oxygen until after the survey start date. During an interview, on 2/12/25 at 10:54 a.m., LPN 8 indicated the resident now had a physician's order for 2 liters of oxygen. She would check the physician's order to verify how much oxygen to give a resident when she was adjusting the flow rate. The resident should have had an order for the oxygen administration. A current facility policy, titled "Administration of Oxygen," dated 12/13/24 and provided by the Clinical Support Nurse on 2/11/25 at 4:54 p.m., indicated "...Verify physician's order for the procedure...Adjust the oxygen delivery device so that...the proper flow of oxygen is administered...." A current facility policy, titled "Guidelines for			

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	Medication Orders," dated as reviewed 12/17/24 and received by the Clinical Executive Director Support on 2/12/25 at 9:15 a.m., indicated "...A current list of orders will be maintained in the electronic clinical record of each resident...Oxygen orders..When recording oxygen orders specify...The rate of flow, route and rationale (i.e: 02, 2L/min per nasal cannula PRN for SOB)...." 3.1-47(a)(6)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to ensure resident rooms and hallways were maintained and kept in clean and sanitary condition for 3 of 8 rooms (room 101, 106 and 107) and 3 of 3 hallways (hallway 100, 200 and 300) reviewed for environment. Findings include: During room observations, starting on 2/10/25 at 11:18 a.m., the following were observed: a. The 100-hallway had a very strong urine and bowel movement odor. b. Room 101 had a large uneven area with peeling paint and cracks on the wall next to the bathroom. c. Room 106 had an unsecured outlet on the wall at the foot of the resident's bed. The outlet was pulled away from the wall with black cords plugged into the outlet. The room had a very strong urine and bowel movement odor. d. Room 107 had a large basketball-size dried blood smear on the wall by the first bed near the door. The resident's sheets had dried blood on both sides of the resident. The bed by the window had two little black bugs flying around the resident and in the bathroom, there was one little	F 0921	**F921 – Safe/Functional/Sanitary/Comfortable Environment** 1 Resident rooms for 101, 106 and 107 were immediately cleaned, repairs made, and odors addressed by environmental, nursing and plant ops staff. 2 All residents are potentially affected by the alleged deficient practice. Environmental staff audited all Health Center rooms for proper cleaning and maintenance. All EVS and Plant ops staff were in-serviced on room cleaning and maintenance for room readiness. 3 As a measure of on-going compliance, the EVS manager or designee will audit resident rooms for readiness 2 X's weekly for 4 weeks, then weekly for 4 weeks, then monthly x's 4 months or until 100% compliance is achieved and report to the campus QAPI committee.	03/16/2025

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	155678	A. BUILDING 00 B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

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	black bug sitting on the toilet paper mounted on the wall. The room had a very strong urine and bowel movement odor. e. The 200-hallway had multiple mechanical lifts lined down the hall and resident wheelchairs were stored in the hallway. During an observation, on 2/12/25 at 11:05 p.m., Room 106 had an unsecured outlet on the wall at the foot of the resident's bed. The outlet was pulled away from the wall and black cords were plugged into the outlet. During an observation, on 2/17/25 at 8:20 a.m., the 100-hallway had a strong urine and bowel odor. There was a very strong urine and bowel odor in rooms 106 and 107. During an interview, on 2/10/25 at 11:10 a.m., LPN 5 indicated he was aware the resident in Room 107 had blood smeared on the wall and his sheets. The CNA was busy with another resident and had not cleaned the resident up yet. During an interview, on 2/10/25 at 11:28 a.m., the Regional Support Executive Director indicated the dialysis sewer backed up and went into Room 107's bathroom. He indicated there were little flying bugs in the room. During an interview, on 2/12/25 at 2:13 p.m., the Maintenance Director indicated he had fixed the outlet in room 106 once before. The cover had been pulled away from the wall when the nursing staff pushed the bed against the wall and lifted the bed up and down. During an interview, on 2/13/25 at 10:59 a.m., the Regional Support Executive Director indicated the 200-hallway had multiple mechanical lifts lined		4 Results of audits will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue past 6 months, if warranted, until 100% compliance is attained.	

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	down the halls. The residents' wheelchairs were stored in the hallway when the residents were in bed. The facility had no other place to store the equipment and the residents' rooms were too small to store wheelchairs. The facility did not have an environmental policy, and the facility followed the state guidelines. A current facility policy, titled "Resident Rights," dated as reviewed on 12/17/24 and received from the Clinical Support nurse on 2/17/25 at 4:12 p.m., indicated "...To ensure resident rights are respected and protected and provide an environment in which they can be exercised...Our residents have a right to...be treated with dignity and respect...Personalize their apartment...." This citation relates to Complaint IN00450780. 3.1-19(f)(4) 3.1-19(f)(5)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00449458 and IN00450780. Complaint IN00449458 - No deficiencies related to the allegations are cited. Complaint IN00450780 - Federal/state deficiencies related to the allegations are cited at F921. Survey dates: February 10, 11, 12, 13, 14, and 17, 2025	R 0000	**R000** The submission of this plan of correction does not indicate an admission by Waterford Place Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Waterford Place Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient	

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	Facility number: 002667 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 19, 2025.		manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on record review and interview, the facility failed to ensure job specific orientation was completed and a copy was maintained in the employee's record for 2 of 10 staff members reviewed for orientation. (RN 3 and 4) Findings include: 1. The employee record for RN 3 was reviewed on 2/12/25 at 1:15 p.m. The employee's job specific orientation was not located in her employee file. 2. The employee record for RN 4 was reviewed on 2/12/25 at 1:20 p.m. The employee's job specific orientation was not located in her employee file. During an interview, on 2/17/25 at 2:40 p.m., the Executive Director (ED) indicated he could not locate the completed job specific orientation for RN 3 or 4. The facility did not have a policy and followed the state regulations.	R 0119	**R119 – Personnel – Noncompliance** 1 No residents were directly affected by the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficient practice. All staff records were audited for presence of Job Specific Orientation. 3 As a measure of ongoing compliance, the Employee Experience Manager (EXM) or designee will review 5 staff personnel files for presence of Job Specific Orientation 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least	03/16/2025

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			quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure annual in-service education was completed for 2 of 10 staff members reviewed for annual in-services. (CNA 1 and LPN 2) Findings include: 1. The employee record for CNA 1 was reviewed on 2/12/25 at 1:05 p.m. The employee's resident rights, abuse and 3-hour dementia training were not completed. 2. The employee record for LPN 2 was reviewed on 2/12/25 at 1:10 p.m. The employee's resident rights, abuse and 3-hour dementia training were not completed. During an interview, on 2/13/25 at 11:05 a.m., the Executive Director (ED) indicated he could not locate any of the missing annual training required for these employees. A current facility policy, titled "Regulatory Training," undated and received from the ED on 2/12/25 at 1:40 p.m., indicated "...ensures compliance with federal, state, and local regulation, while maintaining a high standard of care...Annual: Assigned annually on the first day of the month prior to anniversary (hire) date with a	R 0120	**R120 – Personnel - Noncompliance** 1 No residents were directly affected by the alleged deficient practice. 2 All residents have the potential to be affected by this alleged deficient practice. An audit was done of all required training for annual in-services for all employees. 3 As a measure of ongoing compliance, EXM or designee will review 5 personnel records to ensure training requirements are met 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until	03/16/2025

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	due date of 60 days following assignment date. i. Example: Anniversary date 5/17; assignment date: 4/1; due date 6/1...It is the responsibility of the employee's leader to ensure regulatory training is completed timely...Employees who fail to complete the required training within the specified timeframes will receive corrective action...."		100% compliance is maintained.	