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	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALKER PLACE	2216 N RILEY HWY SHELBYVILLE, IN 46176

(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. Survey dates: December 30 and 31, 2024 Facility number: 004444 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 6, 2025.	R 0000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of any conclusions set forth in this allegation by the survey agency.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to ensure a food temperature measuring device was properly cleaned and sanitized while retrieving food temperatures from the steam table. This had the potential to affect 31 of 31 residents in the facility. Findings include: A tour of the kitchen was conducted on 12/30/24 at 12:20 p.m. During the tour, the DM (Dietary Manager) retrieved food temperatures of hot foods from the steam table with a thermometer. He	R 0273	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by this deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**	03/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn	Steele	01/16/2025

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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	first retrieved the temperature of beef, then wiped the needle of the thermometer on his apron. He then retrieved the temperature of gravy and wiped the needle of the thermometer on his apron. He then retrieved the temperature of chicken soup and wiped the needle of the thermometer on his apron. He then retrieved the temperature of corn and wiped the needle of the thermometer on his gloved hand. He then retrieved the temperature of mashed potatoes and wiped the needle of the thermometer on his apron. He did not clean or sanitize the needle of the thermometer during food temperature retrievals. An interview was conducted with the DM on 12/31/24 at 10:54 a.m. He indicated he didn't usually wipe the needle of the thermometer on his apron between temperature retrievals. He used a sanitizer solution or alcohol wipes. The RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS TITLE 410 IAC 7-24, effective November 13, 2004, indicated, "Equipment food-contact surfaces and utensils; cleaning frequency Sec. 296. (a) Equipment food-contact surfaces and utensils shall be cleaned as follows: ... (4) Before using or storing a food temperature measuring device. (5) At any time during the operation when contamination may have occurred."		All residents have the potential to be affected by the deficient practice. The corrective action will be that all culinary staff and all new culinary hires will be in serviced on proper cleaning of thermometers per facility policy and procedure. **What measure will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Executive Director will re-educate all culinary staff on proper thermometer cleaning. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur.** Executive director will monitor thermometer cleaning 5 times per week for 4 weeks, then three times per week for 4 weeks, then 1 time per week for 4 weeks then on-going as needed. Results will be reviewed in Monthly QI and reevaluated as needed.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on interview and record review, the facility failed to ensure complete and systematically organized documentation regarding pharmacy recommendations and follow up for 3 of 5 residents reviewed for pharmacy services. (Residents 8, 16 and 31)	R 0349	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Five residents were found to be	03/17/2025

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	Findings include: 1. The clinical record for Resident 8 was reviewed on 12/31/24 at 10:45 a.m. Diagnoses included, but were not limited to, gout, urinary retention, diabetes mellitus, and brain shunt. A Consultant Pharmacy Review Summary for October 2024 provided by the Executive Director (ED), on 12/31/24 at 1:51 p.m., indicated Resident 8 had pharmacy recommendations to discontinue ascorbic acid, zinc sulfate, multi-vitamin with mineral, and start Stress Formula tab with zinc daily. There was also a recommendation to decrease allopurinol from 300 milligrams (mg) twice a day to 300 mg once a day. The prescriber response section on the form was not addressed by the physician and left empty. The December 2024 Medication Administration Record (MAR) provided by the ED, on 12/31/24 at 2:00 p.m., indicated Resident 8 was still on zinc sulfate and a multi-vitamin but no ascorbic acid or Stress Formula tab. Allopurinol continued to have a 300 mg dose twice a day. During an interview with the ED on 12/31/24 at 1:05 p.m., they indicated October had pharmacy recommendations and some orders were changed, but no documentation on how that happened. Some orders were not changed, so they were not sure if the physician said no to the recommendation, or it just wasn't addressed. 2. The clinical record for Resident 16 was reviewed on 12/30/24 at 1:45 p.m. Diagnoses included, but were not limited to, bipolar disorder, chronic obstructive pulmonary disease (COPD), and fibromyalgia.		affected by this deficient practice. **How will the facility 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 deficient practice. The corrective action will be that all nurses will be re-educated on getting pharmacy recommendations reviewed by resident's provider. **What measure will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Upon Pharmacy exit Director of Health and Wellness will ensure all recommendations are sent to providers a minimum of three times until a response is received and documented in nurses notes that recommendations were sent . Nurses and DHW will write on recommendation the date and time it was sent, each time it was sent. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur.** Executive Director or Director of Health and Wellness will monitor pharmacy recommendations upon receiving them to ensure they sent and will track them on a	

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	A Consultant Pharmacy Review Summary for October 2024 provided by the ED, on 12/31/24 at 1:51 p.m., indicated Resident 16 received several supplements that could be combined into a single therapy and reduce medication burden. Recommendations were to discontinue Apple Cider Vinegar, Biotin, Calcium/Magnesium/Zinc tablet, Hair Skin Nails tablet, Turmeric, Vitamin B12, and Vitamin C and to start Resident 16 on Dailyvite Supreme D daily. The prescriber response section on the form was not addressed by the physician and left empty. The December 2024 MAR provided by the ED, on 12/31/24 at 2:00 p.m., indicated Resident 16 was still prescribed Apple Cider Vinegar, Biotin, Calcium/Magnesium/Zinc, Hair Skin Nails tablet, Turmeric, Vitamin B12, and Vitamin C. During an interview with the ED on 12/31/24 at 1:05 p.m., indicated October had pharmacy recommendations and some orders were changed, but no documentation on how that happened. Some orders were not changed, so we are not sure if the physician said no to the recommendation, or it just wasn't addressed. 3. The clinical record for Resident 31 was reviewed on 12/30/24 at 2:00 p.m. Diagnoses included, but were not limited to, anxiolytic dependence, major depression, diabetes mellitus, and asthma with COPD. A Consultant Pharmacy Review Summary for September 2024 provided by the ED, on 12/31/24 at 1:51 p.m., indicated Resident 31 was currently using citalopram 40 milligrams (mg) daily and the maximum dose recommended for persons over the age of 60 was 20 mg daily due to increased risk of		monitoring form.	

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	adverse cardiovascular effects. The prescriber response section on the form was not addressed by the physician and left empty. The December 2024 MAR provided by the ED, on 12/31/24 at 2:00 p.m., indicated Resident 31 was still prescribed citalopram 40 mg daily. A Consultant Pharmacy Review Summary for October 2024 provided by the ED, on 12/31/24 at 1:51 p.m., indicated Resident 31 was currently receiving allopurinol 100 mg twice a day. Due to the risk of drug-induced nephrotoxicity (a poisonous effect of some substances to the kidney), allopurinol should be administered in the lowest most effective dose and recommended decreasing allopurinol to 100 mg daily. The prescriber response section on the form was not addressed by the physician and left empty. The December 2024 MAR provided by the ED, on 12/31/24 at 2:00 p.m., indicated Resident 31 was still prescribed allopurinol 100 mg twice a day. During an interview with the ED on 12/31/24 at 1:05 p.m., indicated September and October of 2024 had pharmacy recommendations and some orders were changed, but no documentation on how that happened. Some orders were not changed, so we are not sure if the physician said no to the recommendation, or it just wasn't addressed. A Medication Services Policy was provided by the ED on 12/31/24 at 1:10 p.m. The policy did not reference that clinical records for each resident must be complete, accurately documented, and systematically organized.			

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R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on interview and record review, the facility failed to utilize a transfer form that included the name of the receiving institution, the resident's personal property, information related to the resident's functional abilities and physical limitations, nursing care, current diet, condition on transfer, and date of chest x-ray and skin test for tuberculosis for 1 of 1 resident whose closed record was reviewed. (Resident 33) Findings include: The closed clinical record for Resident 33 was reviewed on 12/31/24 at 12:05 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility, on 11/15/24, and discharged to the hospital on 11/20/24. The 11/20/24, 11:00 p.m. resident services note indicated, "Resident was sent to hospital by ambulance to be check [sic] for UTI [urinary tract infection....]" The note did not specify what documentation or clinical information was sent to the hospital with Resident 33. There was no information in the clinical record to indicate what documentation or clinical information was sent to the hospital with Resident 33. An interview was conducted with the ED (Executive Director) on 12/31/24 at 12:24 p.m. She indicated when a resident was sent to the hospital, they sent the face sheet, medication list, and code status with the resident. They did not utilize a specific transfer form when a resident was sent to the hospital. She reviewed Resident 33's	R 0354	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** One resident was found to be affected by this deficient practice **How will the facility 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 deficient practice. The corrective action will be that all nurses and QMA's will be reeducated on transfer forms and proper documentation when sending to the hospital or discharged. **What measure will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Director of Health and Wellness will re educate nurses and QMAs on proper transfers and discharge documentation. Transfer packets are assembled and ready for use upon the need to send someone out to hospital or discharged. **How the corrective action (s) will be monitored to ensure the deficient practice will not**	03/17/2025

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	closed clinical record at this time, and indicated she did not see any documentation of what information was sent with Resident 33 to the hospital. On 12/31/24 at 2:00 p.m., the ED provided a copy of Resident 33's face sheet and medication list. They did not include the name of the receiving institution, the resident's personal property, information related to the resident's functional abilities and physical limitations, nursing care, current diet, condition on transfer, and date of chest x-ray and skin test for tuberculosis. An interview was conducted with the DON (Director of Nursing) on 12/31/24 at 12:26 p.m. She indicated the facility did not utilize transfer forms when a resident was sent to the hospital. On 12/31/24 at 12:57 p.m., an interview was conducted with the ED, who provided a blank copy of a Resident Transfer/Discharge form at this time. The ED indicated this form was not used when Resident 33 was sent to the hospital. The form did not include current diet or date of last chest x-ray and skin test for tuberculosis.		**recur.** Executive director will monitor all transfers 5x per week times 4 weeks, then 3xs per week for 4 weeks, then weekly there after.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on interview and record review, the facility failed to analyze and track infections for 5 of 12 months. This had the potential to affect all 31 residents residing in the facility. Findings include: The infection control binder provided by the Executive Director (ED), on 12/31/24 at 12:00 p.m., included verification, tracking, and analyzing	R 0407	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this deficient practice **How will the facility identify other residents having the potential to be affected by the**	03/17/2025

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	infections for the months of January, July, August, September, October, November, and December 2024. An infection control log provided by the Director of Nursing (DON) on 12/31/24 at 1:11 p.m., indicated no tracking or analyzing of infections for February, March, April, May, and June 2024. August through November had a tracking log, but no analysis to go with them. During an interview with the DON on 12/31/24 at 1:10 p.m., indicated she found the August through December 2024 logs in the medication room, but no maps and the information did not make its way into the binder for analyzing. The DON indicated she would look for February through June logs but was unable to locate them. An Infection Disease Management Policy provided by the DON, on 12/31/24 at 1:11 p.m., indicated the policy did not reference that a system was in place to analyze patterns of known infectious symptoms.		**same deficient practice and what corrective action will be taken** All residents have the potential to be affected by the deficient practice. We will track all infections using our Company Infection Control Policy and Colored coded facility map. **What measure will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Director of Health and Wellness will re educate nurses and QMAs on notifying her on all infection control concerns. Director of Health and Wellness will track these using the Company Infection Control Policy and color coded facility map. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur.** We will monitor all residents for infections 3x weekly for 4 weeks then 2x weekly for 4 weeks , then weekly thereafter.	