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	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KEYSTONE WOODS	2335 N MADISON AVE ANDERSON, IN 46011

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: 2/28/24-2/29/24 Facility number: 010409 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 6, 2024.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Keystone Woods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindi Cooper	Executive Director	03/18/2024

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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Bldg. 00	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure the service plan was signed by the resident for 1 of 7 residents reviewed for service plans (Resident 4). Finding includes: Resident 4's clinical record was reviewed on 2/29/24 at 10:21 a.m. The most current service plan, dated 7/11/23, was not signed by the	R 0217	F217 Resident #4 no longer resides at the Community. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. Wellness Director was in serviced to review the assessment	04/18/2024

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	resident or a representative. During an interview, on 2/29/24 at 3:01 p.m., the DON indicated she was unable to locate a signed service plans for the resident. A current facility document, dated 8/2023, titled "The Service Planning Process," provided by the DON on 2/29/24 at 4:53 p.m., indicated "...Have all involved parties sign the finalized Resident Service Plan...."		and service planning process including the requirement that all service plans be signed by the resident, power of attorney, or guardian as applicable. The Executive Director or designee will audit the service plans to ensure they are signed by the appropriate party monthly for 3 months, then quarterly thereafter. Date the systemic changes 4/18/24.	
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to notify the physician of pharmacy medication recommendations for 1 of 2 residents for pharmacist drug regimen review (Resident 10). Findings include: Resident 10's clinical record was reviewed on 2/28/24 at 12:10 p.m. Diagnoses included stage 4 dementia and altered mental status. Her current physician orders included quetiapine 25 milligram, give one tablet by mouth at bedtime (an antipsychotic used to treat schizophrenia and bipolar disorder). Review of the clinical record indicated the pharmacist provided recommendations on 8/22/23 for the physician to complete an AIMS (abnormal involuntary movement scale) assessment.	R 0299	F299 Resident #10's physician was notified regarding the pharmacy's medication recommendations. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The Wellness Director received training from the regional clinical nurse regarding notifying a physician of pharmacy medication recommendations. The Wellness Director or designee will follow up with the physician every other week to ensure that deficient practice does not reoccur. The Wellness Director or	04/18/2024

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	Her clinical record lacked AIMS assessment and documentation of physician notification. On 10/23/23, the pharmacist recommended updating her order and diagnosis list with an appropriate diagnosis to support the use of quetiapine. Her clinical record lacked updated diagnoses and documentation of physician notification. On 12/11/23, the pharmacist recommended updating her PRN (as needed) medication orders to include pain levels and when each should be administered (mild, moderate, severe pain). Her clinical record lacked updated medication orders and documentation of physician notification. During an interview, on 2/29/24 at 2:57 p.m., the DON indicated she was unable to find documentation of physician notification of pharmacy recommendations prior to her employment date of 1/2/24. A facility policy, provided by the DON, on 2/29/24 at 4:52 p.m., titled "Communicating with Resident Physicians," indicated "...Document in the Resident's Service Notes all contact with the Resident's physician and/or office nurse...."		designee will audit the pharmacist drug regimen review monthly for three months to ensure that all medication recommendations are communicated to the resident's physician. Date the systemic changes 4/18/24.	
R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following:			

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	(1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia. (B) Schizoaffective disorder. (C) Mood (bipolar and major depressive type) disorder. (D) Paranoid or delusional disorder. (E) Panic or other severe anxiety disorder. (F) Somatoform or paranoid disorder. (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual.			
	Based on record review and interview, the facility failed to ensure mental health screenings were performed for 2 of 7 sampled residents (Resident 4 and 57). Findings include: Resident 57's clinical record was reviewed on 2/28/24 at 11:57 a.m. Diagnoses included major depressive disorder. The clinical record lacked a mental health screening. Resident 4's clinical record was review on 2/29/24 at 10:21 a.m. Her diagnoses included depression. The resident received Medicaid benefits. The clinical record lacked a mental health screening. During an interview, on 2/29/24 at 3:04 p.m., the DON indicated she had not seen anything on	R 0378	F378 The Community will ensure all residents have received a mental health screening and, where appropriate, are enrolled in a mental health care plan. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The mental health screening requirement has been added to the new resident pre-admission checklist and the Wellness Director received training from the regional clinical nurse on completing the mental health	04/18/2024

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	mental health screening for Residents 4 and 57. The facility had not been doing mental health screening. During an interview, on 2/29/24 at 3:48 p.m., the Administrator indicated she would look for a policy on mental health screening. During an interview, on 2/29/24 at 4:44 p.m., the Administrator indicated the DON would provide the mental health screening policy. A policy on behavior management plans was provided on 2/29/24 at 4:53 p.m. by the DON. She reviewed the policy and indicated the policy was for mental health screening. Review of the policy indicated the policy did not address mental health screening.		screening for all new residents. The Wellness Director or designee will audit all new resident move-ins to ensure they have received a mental health screening. Said audits will be conducted weekly for 8 weeks. Date the systemic changes 4/18/24.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to			

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	have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a second-step tuberculin (TB) skin test was completed for 1 of 3 residents reviewed for completion of the TB screening process (Resident 10). Resident 10's clinical record was reviewed on 2/28/24 at 12:10 p.m. The record indicated a chest x-ray was performed on 12/27/22. A negative first step TB test performed on 1/30/23. The record lacked a second step TB skin test. On 2/29/24 at 11:30 a.m., the DON indicated there was no second step TB skin test completed for Resident 10. Review of a document titled "TB Testing", dated August 2017, and provided by the DON on 2/29/24 at 4:53 p.m., indicated "... Follow the state licensing regulation requirements on TB tests for Residents and Community Team Members to include for Resident move-in requirements, Community Team Members new hire requirements, and ongoing testing...."	R 0410	F410 The Community will ensure a TB skin test is completed with 2nd step on all new residents. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The Wellness Director or designee will ensure all residents receive the 1st. and 2nd. Step TB skin test. The two step TB skin test has been added to the new resident and new employee checklist. The Wellness Director or designee will audit all new resident files weekly for 8 weeks to ensure all TB skin tests have been completed. Date the systemic changes 4/18/24.	04/18/2024