STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OI	F CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WI	NG		09/26/2024	
			<u> </u>	CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF PR	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DDENT\\/C							
BRENTWO	OOD AT HOBART			HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
		State Residential Licensure	R 00	000	This Plan of Correction is not t	o be	
	•	ncluded the Investigation of			construed as an admission of, or		
	Complaints IN0044	3613 and IN00443702.			agreement with the findings ar	nd	
					conclusions in the statement o	f	
	-	613 - State deficiencies related			deficiencies. This Plan of		
	to the allegations are	e cited at R0240.			Correction is being submitted	as	
	S 11 . P 700 110				required by the regulation.		
	•	702 - State deficiencies related					
	to the allegations are	e cited at R0240.					
	Survey dates: Septer	mber 25 and 26, 2024					
	Facility number: 002	2627					
	Residential Census:	119					
	These State Residen accordance with 410	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review com	pleted on 10/4/24.					
R 0030	410 IAC 16.2-5-1.2	2(e)(1-6)					<u>'</u>
	Residents' Rights	, , , ,					
Bldg. 00	Č	•					
			R 00)30	Administrator completed an		10/25/2024
	Based on record rev	iew and interview, the facility			Alzheimer's and Dementia Spe	ecial	
		ent disclosure form for the			Care Unit disclosure form and		
		tia Special Care Unit. This had			submitted it via US Mail. The		
	•	et all residents residing on the			administrator was informed that	at	
	Dementia Care unit.				the information is now submitte	ed	
	Finding includes:				online. After completing the Housing Services Unit Disclosure		
	-				Form, an Alzheimer's/Dementi		
		ementia Special Care Unit			Special Care Unit form was		
		requested on 9/25/24 and was			submitted. The		
	not provided by the	facility.			Alzheimer's/Dementia Specia	l	
					Care unit was approved on		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Verna Meacham **Executive Director** 11/04/2024

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.

State Form Event ID: Y1Q811 Facility ID: 002627 Page 1 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 09/26/2024			/2024		
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER		1420 ST MARYS CIRCLE					
BRENTW	OOD AT HOBART		HOBART, IN 46342					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	on 9/26/24 at 1:48 p.m., the			October 18, 2024.			
		ated she had filled out a new			The Dementia Disclosure form			
		and she was unable to locate			submission shall be monitored	•		
	any previous disclos	sure forms.			the Administrator at least twice			
					during the year - when auditing	_		
					availability of documents need for the Annual Survey, and ag			
					by November 1st of each year			
				allowing sufficient time to subr	-			
				any forms needed to assure				
					compliance. This shall be don	ne		
					on an ongoing basis each yea			
					and is a part of the Administra			
					routine responsibilities. Dates			
					review are noted on the calend			
					the Administrator.			
R 0216	410 IAC 16.2-5-2(c)(1-4)(d)						
	Evaluation - Nonc							
Bldg. 00		p						
	Based on record rev	view and interview, the facility	R 02	216	An audit was completed to en	sure	10/25/2024	
	failed to ensure a re	sident had the ability to			that all residents that			
	self-administer med	ications for 1 of 1 resident			self-administer medications ha	ave		
	reviewed for self-ad	lministration of medications.			physicians' orders and			
	(Resident 5)				self-administration assessmer	ıts.		
					Self-administration assessmer	nts		
	Finding includes:				will be completed for each res			
	m 10 5 1	1 . 5			that self-administers medication			
		dent 5 was reviewed on 9/25/24			on a monthly basis to ensure t	hat		
		oses included, but were not			they have the ability to			
	iimited to, heart fail	ure and high blood pressure.			self-administer their medicatio	ns		
	The resident's assume	nt Service Plan indicated she			accurately. All nursing staff			
		nt Service Plan indicated she			in-serviced on self-medication assessments.			
		fills independently and was			assessments. Self-administration assessmer	nte		
		elf-administration of			will be completed upon admiss			
	medications.	in administration of			for each resident and monthly			
	mountains.				thereafter. DON or designee w			
	The September 2024	4 Physician's Order Summary			monitor for accuracy and			
	-	resident received the			completion of assessments,			

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 2 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE S' COMPLE 09/26/2	TED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARYS CIRCLE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	softener) 100 millig needed, furosemide labetalol (treatment mg tablet twice dail milligram/milliliter as needed, meclizin mg tablet four times medication) 100 mg needed, ondansetror mg tablet four times chloride 20 millieque daily, and xarelto (bonce daily). There were no Physical self-administration of the daily and the daily and the self-administration of the daily, and ondansetror twice daily, potassing daily, and ondansetror there were no Self-related to docusate and morphine. During an interview Director of Nursing self-administered all should have been a			weekly for 3 months, monthly months, and then monthly indefinitely to ensure compliar			
R 0217 Bldg. 00	410 IAC 16.2-5-2(Evaluation - Defici	, ,					
2.49.00	Based on record rev	riew and interview, the facility	R 0217	An audit was completed for al	ı	10/25/2024	

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	00	COMPL	ETED
			B. WING	ì		09/26/	/2024
		l	1	TDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			MARYS CIRCLE		
BDENIT\A	OOD AT HOBART	-			T, IN 46342		
DKENIV	OOD AT HODAKT			IUBAK	11, IIN 40342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
		vice Plans were signed by the			resident service plans requiring	g	
	•	esentative, and revised and			review, and signatures to ensu	ıre	
	-	residents reviewed for Service			compliance.		
	Plans. (Residents 2	, 6, 8, 10, 7, 3, and 14)			DON or designee will monitor		
					service plans for completion to		
	Findings include:				ensure they are updated, revie	ewed	
					and signed by Resident/ POA		
		or Resident 2 was completed on			upon admission, any change of	of	
		m. Diagnoses included, but			condition, and quarterly.		
		, dementia with behaviors,	1		A tracking tool will be used to		
	diabetes mellitus, glaucoma, legal blindness,				audit service plans, twice a we		
	hypertension and heart failure. The resident was				for one month, once a week for		
	admitted to the facility on 11/1/23.				months, and quarterly to ensu	re	
					compliance.		
		ed 11/4/23, indicated the					
		ate dementia with significant					
	-	and possibly long-term					
	-	resident was visually impaired					
	_	ance with bathing and					
	medications.						
		as not signed by the					
	responsible party.						
	Daning - ' ('						
	-	v on 9/25/24 at 3:26 p.m., the					
		g (DON) indicated she was	1				
	unable to locate a s	igned Service Plan.					
	2 Decord ravious fo	or Dasidant 6 was completed on					
		or Resident 6 was completed on Diagnosis included, but were					
		or depressive disorder, chronic					
			1				
	obstructive pulmonary disease, congestive heart failure, diabetes mellitus, end stage renal disease, and legal blindness. The resident was admitted to						
	the facility on 8/30/						
	uie tachity on 8/30/	43.	1				
	A Samijaa Dlan dat	ed 8/28/23, indicated the					
	· ·	nd oriented. The resident was					
		na oriented. The resident was					
	regainy billid and ur	iadie to administer fils OWII	1				

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 4 of 24

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP COD ST MARYS CIRCLE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		esident required orientation to nd required dialysis for renal			
	There was no docur	as not signed by the resident. mentation to indicate the ad and explained to the as legally blind.			
	DON indicated the because the residen provide any docume explained and read for Resident 8 was p.m. Diagnoses inc	or on 9/26/24 at 3:50 p.m., the Service Plan was not signed t was blind. She could not entation the Service Plan was to the resident. 3. The record reviewed on 9/26/24 at 1:20 cluded, but were not limited to, isorder, and hyperlipidemia.			
	There was no signa	as last updated on 4/18/24. ture of the resident and or indicate the Service Plan had accepted.			
	· ·	on 9/26/24 at 9:45 a.m., the would look for the signed			
	DON indicated she	on 9/26/24 at 4:10 p.m., the was unable to find any signed urther information was			
	reviewed on 9/26/2- included, but were	rd for Resident 10 was 4 at 9:04 a.m. Diagnoses not limited to, dementia, ype 2 diabetes mellitus.			
		as last updated on 9/3/23. ture of the resident and or			

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 5 of 24

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 09/26/2024			2024	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			Γ MARYS CIRCLE		
BRENTW	OOD AT HOBART	•			T, IN 46342		
			1	<u> </u>	,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION responsible party to indicate the Service Plan had			TAG	DE ICERCI I		DATE
	been reviewed and accepted.						
	been reviewed and	accepted.					
	During an interview	v on 9/26/24 at 9:45 a.m., the					
	_	would look for the signed					
	service plans.	would look for the signed					
	service plans.						
	During an interview	v on 9/26/24 at 4:10 p.m., the					
	_	was unable to find any signed					
	service plans. No f	urther information was					
	provided.5. Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and encephalopathy. The resident was						
	admitted to the faci	lity on 5/1/23.					
		as last updated on 8/30/24 and					
		he resident and/or responsible					
	party.						
	D						
	_	on 9/26/24 at 3:45 p.m., the facility staff mailed the service					
		few months ago, but had no					
	-	ne plan being sent to, received					
		e family member. 6. On 9/27/24					
		ent 3 was observed in a hospital					
	_	it. He was wearing a nasal					
		en at 2.5 liters per minute. He					
		he nasal cannula with oxygen					
		sometimes he would wake up					
		se from moving around at					
	night. He was able to put it back in place independently when needed.						
	- -						
	Resident 3's record	was reviewed on 9/25/24 at					
	1:26 p.m. Diagnose	es included, but were not limited					
	to, diabetes mellitus	s, high blood pressure, and					
	chronic kidney dise	ease.					
	A Service Plan was	last updated on 9/24/24. The					

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 6 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
			B. WING		09/26/2024		
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD			
			1420 ST MARYS CIRCLE				
BRENTW	OOD AT HOBART	•	HOBA	HOBART, IN 46342			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
	-	Service Plan on 9/20/24. It nt was cognitively intact. The					
	Service Plan did not address oxygen use.						
	-	y on 9/26/24 at 9:52 a.m., the					
		resident had oxygen as needed					
		om the hospice company and					
	the Service Plan sho	ould have been updated.					
	7. Resident 14's record was reviewed on 9/25/24 at						
	9:55 a.m. Diagnoses included, but were not limited						
	to, dementia, Parkinson's disease, and an enlarged						
	heart. The resident admitted to the facility on						
	8/24/24.						
	The Service Plan, d	ated 8/24/24, was not signed					
		or responsible party.					
	During an interview	v on 9/25/24 at 9:45 a.m., the					
		had no further information to					
	provide.						
R 0240	410 IAC 16.2-5-4((d)					
110270	Health Services -	• •					
Bldg. 00		Delicioney					
		on, record review, and	R 0240	An audit was completed to en			
	· ·	ty failed to assess a resident		accuracy for all incident report	ts		
		ician and responsible party		related to falls. All Nursing sta	aff		
	-	d failed to monitor oxygen use		in-serviced on fall protocol,			
	for 2 of 11 residents	s reviewed. (Residents B and 3)		including assessment and documentation policy, along w	uith		
	Findings include:			proper notifications to include			
				notification of physician and			
		rd for Resident B was reviewed		responsible party/ POA.			
		a.m. Diagnoses included, but		DON or designee will use a			
		hypertension and chronic		tracking tool to audit fall			
	obstructive pulmon	ary disease.		documentation weekly for 3			
	The Service Plan d	ated 6/13/23, indicated the		months, and then monthly indefinitely to ensure compliar	nce		
				I			

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 7 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/26/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARYS CIRCLE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	gait problems. A Progress Note, daindicated the resider follow up, was not land required staff as of daily living (ADI lack of any docume occurred, assessment the fall, notification notification of the resider follow up and was rediscomfort related the any documentation assessment of the resident's responsibular print off the incident During an interview Director of Nursing print off the incident print off the incident print off the incident print off the incident away. She had conticulated the DOI incident reports because. She had conticulated the door indicated away as observed in a He was wearing and to a flow rate of 2.5 he kept the oxygen sometimes he would	for falls related to balance and atted 8/26/24 at 3:30 p.m., and was being monitored for fall having any pain or discomfort, assistance of one for activities (Ls) and transfers. There was a matation of when the fall att of the resident at the time of of the Physician, or esident's responsible party. Atted 8/6/24 at 12:46 p.m., and the was being monitored for fall not having any pain or to the fall. There was a lack of of when the fall occurred, asident at the time of the fall, thysician, or notification of the let party. Attended 18/25/24 at 3:47 p.m., the (DON) indicated she would at reports for the falls. At on 9/26/24 at 4:41 p.m., QMA at was unable to print off the ause the resident had passed facted corporate to see if they as the reports. No further to on 9/27/24 at 1:30 p.m., a sign doxygen was in use. Resident hospital bed in his apartment. asal cannula with oxygen set liters per minute. He indicated on all of the time, but it wake up without it in his around at night. He was able to		An audit was completed to en all residents that require oxyg are entered on service plan a pos orders are entered in PCC All Nursing staff in-serviced or proper documentation of order oxygen use. Clinical documentation will be monitor daily indefinitely by DON or designee to ensure proper documentation is obtained.	en nd C. n rs for			

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 8 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARYS CIRCLE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION when needed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Resident 3's record 1:26 p.m. Diagnose to, diabetes mellitus chronic kidney dise A Service Plan was	was reviewed on 9/25/24 at s included, but were not limited s, high blood pressure, and					
	indicated the resider Service Plan did nor The September 202	nt was cognitively intact. The t address oxygen use. 4 Physician's Order Summary rders for oxygen or monitoring					
	Director of Nursing	on 9/25/24 at 9:45 a.m., the (DON) indicated the resident ed order for oxygen, but never knowledge.					
	by the DON on 9/26	er, dated 2/20/24, was provided 6/24 at 3:30 p.m., which a oxygen concentrator 2-4 at as needed.					
	DON indicated oxy addressed on the Se	y on 9/26/24 at 9:52 a.m., the gen should have been rvice Plan and it should have a for monitoring purposes.					
	This citation relates and IN00443702.	to Complaints IN00443613					
R 0273 Bldg. 00		nal Services - Deficiency					
	review, the facility	on, interview, and record failed to maintain proper food unlabeled and undated food.	R 0273	Corrective action All staff have been educated of 10/14/2024 by the food service			

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 9 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
			B. W	ING		09/26	/2024	
		l .		CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARYS CIRCLE				
BRENIT/A	OOD AT HOBART			HOBART, IN 46342				
DIVEINIV	TANGOLI IL GONT			HODAR				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	ial to affect the 119 residents			manager on labeling and datir	ng		
	who received food	from the kitchen.			per facility policy.			
	Findings include:				Measures put in place			
					All staff were educated on			
					10/14/2024 by the food service			
		a.m., on the initial tour of the			manager on labeling and datir	ng		
		tchen Manager, the following			per facility and state board of			
	was observed:				health policy,			
					All food service areas will be			
	a. In the refrigerator, there was a tray with 11 cups				monitored daily by the food ar			
	of watermelon, unlabeled and undated. There was				service manager/designee x 6			
	an opened, undated bottle of Worcestershire sauce.b. In the freezer, the following items were opened				months to assure compliance	is		
					maintained.			
					Corrective actions monitored			
		of diced chicken, a box of			Ongoing compliance with			
	chicken nuggets, a	box of pork fritters, a box of			corrective action will be monitor	ored		
	egg rolls, a box of t	aco meat, a box of pasta			via the facility QA program, ar	nd a		
	sheets, and 3 large	containers of ice cream. There			monthly meeting will be held b	у		
	was a tray with 13 s	serving dishes of sherbet,			the food service			
	unlabeled and unda	ted.			manager/designee.			
	Duning on interview	y on 0/25/24 at 0.25 a m tha						
	_	on 9/25/24 at 9:25 a.m., the ndicated the food items should						
	have been labeled a							
	nave occii iaucieu a	ma aaca.						
	A Facility Policy ti	itled "Food Storage" received						
		d, "All products should be						
	· ·	and quality and be dated						
	-	open, and when prepared"						
		* *						
R 0298	410 IAC 16.2-5-6((c)(2)						
	Pharmaceutical S	ervices - Deficiency						
Bldg. 00								
		view and interview, the facility	R 0	298	All Pharmacy reviews requiring	g	10/25/2024	
	_	rmacy drug regimen reviews			signatures were submitted to			
		ery 60 days for 9 of 11 residents			Physicians.			
	•	aceutical services. (Residents			Pharmacy reviews will be			
	6, 4, 8, 10, B, 7, 3,	5, and 11)			completed every 60 days and	-		
					in binder, DON or designee w	ill		

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PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 09/26/2024	
	ROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	9/26/24 at 9:36 a.m. not limited to, majo obstructive pulmona failure, diabetes me and legal blindness. the facility on 8/30/	ed medications through the		audit pharmacy reviews on a monthly basis indefinitely to ensure completion and accura of orders.	icy
	documentation to in	dicate a pharmacy drug been completed every 60 days			
	Director of Nursing not provide any doc drug regimen review days since the resid- for Resident 4 was a p.m. Diagnoses inc	or on 9/26/24 at 3:50 p.m., the (DON) indicated she could cumentation the pharmacy whad been completed every 60 ent's admission. 2. The record reviewed on 9/25/24 at 2:16 cluded, but were not limited to, 2 diabetes mellitus, and ase.			
	There was a lack of reviews had been co	documentation any pharmacy ompleted for 2024.			
	_	on 9/26/24 at 9:45 a.m., the would look for the pharmacy			
	DON indicated she	on 9/26/24 at 4:10 p.m., the was unable to find any No further information was			
	3. The record for R	esident 8 was reviewed on			

State Form Event ID: Y1Q811 Facility ID: 002627 If continuation sheet Page 11 of 24

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	_	. Diagnoses included, but were entia, anxiety disorder, and			
	There was a lack of reviews had been co	documentation any pharmacy ompleted for 2024.			
	_	on 9/26/24 at 9:45 a.m., the would look for the pharmacy			
	DON indicated she	w on 9/26/24 at 4:10 p.m., the was unable to find any No further information was			
	reviewed on 9/26/26 included, but were	ard for Resident 10 was 4 at 9:04 a.m. Diagnoses not limited to, dementia, type 2 diabetes mellitus. The ty on 7/11/24.			
	There was a lack of reviews had been co	documentation any pharmacy ompleted for 2024.			
		on 9/26/24 at 9:45 a.m., the would look for the pharmacy			
	DON indicated she	on 9/26/24 at 4:10 p.m., the was unable to find any No further information was			
	on 9/26/24 at 10:36 were not limited to,	rd for Resident B was reviewed a.m. Diagnoses included, but hypertension and chronic ary disease. The resident			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/26/2024
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	reviews had been co	documentation any pharmacy			
	DON indicated she pharmacy reviews. provided. 6. Record review for 9/25/24 at 1:28 p.m. not limited to, demonstrated to.	ne resident was admitted to			
		ed medications through the The record lacked any men reviews.			
	DON indicated they provide at this time reviewed on 9/25/24 included, but were mellitus, high blood	on 9/26/24 at 3:45 p.m., the had no further information to 7. Resident 3's record was 4 at 1:26 p.m. Diagnoses not limited to, diabetes 1 pressure, and chronic kidney at admitted to the facility on			
	facility pharmacy. documentation to in	ed medications through the There was a lack of adicate a pharmacy drug been completed every 60 days			
		on 9/26/24 at 3:50 p.m., the (DON) indicated she could			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	re survey ipleted 26/2024		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARYS CIRCLE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION cumentation the pharmacy w had been completed every 60 lent's admission.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	9/25/24 at 2:55 p.m not limited to, hear	esident 5 was reviewed on Diagnoses included, but were t failure and high blood ent admitted to the facility on						
	facility pharmacy. documentation to in	ed medications through the There was a lack of indicate a pharmacy drug I been completed every 60 days						
	Director of Nursing not provide any do	y on 9/26/24 at 3:50 p.m., the g (DON) indicated she could cumentation the pharmacy w had been completed every 60 lent's admission.						
	9/26/24 at 10:21 a.i not limited to, dem	esident 11 was reviewed on m. Diagnoses included, but were entia, depression, and anxiety ent admitted to the facility on						
	facility pharmacy. documentation to in	ed medications through the There was a lack of indicate a pharmacy drug I been completed every 60 days						
	Director of Nursing not provide any do	y on 9/26/24 at 3:50 p.m., the g (DON) indicated she could cumentation the pharmacy w had been completed every 60						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. W	ING		09/26/	2024
	ROVIDER OR SUPPLIER			1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	days since the reside	ent's admission.					
R 0349 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -						
Diag. 00	Based on observation	on, record review and	R 0	349	Acuity guidelines uploaded on		10/25/2024
		ty failed to maintain clinical	I K U	J T J	gateway:		10/23/2024
	·	omplete and accurately			Nursing staff in-serviced on		
		to urinary indwelling catheter			medication policy, reviews for		
	output documentation	on, duplicate orders for			duplicate orders, and that prop		
	medications, and a l	lack of orders for			verification of physician orders	are	
	self-administering n	nedications. (Residents 3 and			entered correctly in MAR. DOI	N or	
	5)				designee will complete medica	ation	
					reviews monthly in PCC on an	l	
	Findings include:				ongoing basis to ensure		
					medication orders are comple		
		rd was reviewed on 9/25/24 at			accurate, and up to date in the	•	
		s included, but were not limited			MAR indefinitely.		
		s, high blood pressure, and					
	· ·	ase. The resident admitted to			Previous order for catheter ou	tput	
	the facility on 5/1/2.	3.			documentation corrected		
	Tl	Diamindiant data maddant			previously in PCC to reflect ca		
	had an indwelling c	Plan indicated the resident			monitored and maintained by		
	_	atheter and required of the bag.			party services and/ or Hospice		
	assistance with emp	bying the time catheter bag.			Education provided to nursing regarding indwelling catheter		
	A Physician's Order	c, dated 4/29/24, indicated to			and Acuity Guidelines.	Jai C	
		atheter output every shift.			Immediate audit completed on	1	
	assument urmary of	anter output every smit.			residents requiring indwelling	!	
	The September 2024	4 Treatment Administration			catheters to ensure physician		
	-	e urinary catheter output was			orders are followed and are in		
		the day shift on 9/9/24,			compliance according to Acuit		
		0/24 and 9/13/24, and the night			Guidelines.	,	
	-	9/6/24, and 9/8-9/10/24.			Per Acuity Guidelines: residen	ıt	
	ĺ				should be able to perform self-		
	During an interview	on 9/25/24 at 9:45 a.m., the			for indwelling catheters and		
	_	had no further information to			demonstrate the ability to perf	orm	
	provide.				catheter care. If unable to perf		
					self-care, home health or anot		
					third-party, service will perforn		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			B. WING		09/26/2024	
	PROVIDER OR SUPPLIER		1420	T ADDRESS, CITY, STATE, ZIP COD ST MARYS CIRCLE ART, IN 46342		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG R 0354	2. The record for Re 9/25/24 at 2:55 p.m not limited to, heart pressure. The reside 10/31/23. The current Service was cognitively into and self-administer. The September 202 (POS) indicated momilliliter (mg/ml) 0 needed was ordered. There were no Physical self-administration. A Medication Self-dated 4/14/24 at 2:0 was able to safely a thinner) 15 mg table tablet daily, labetal pressure) 50 mg tw meq tablet daily, labetal pressure) 50 mg tw meq tablet daily, an medication) 4 mg table daily, and medication) 4 mg table daily, an an ew order in the discontinue the old.	esident 5 was reviewed on Diagnoses included, but were failure and high blood ent admitted to the facility on Plan indicated the resident act for daily decision making ed medications. 4 Physician's Order Summary orphine 100 milligrams per 25 ml every four hours as 1 twice on 7/27/24 and 8/13/24. Sician's Orders for of medications. Administration Safety Screen, 5 p.m., indicated the resident dminister xarelto (blood et, furosemide (diuretic) 20 mg ol (treatment for high blood ice daily, potassium chloride 10 d ondansetron (anti-nausea ablet as needed. 7 on 9/25/24 at 9:45 a.m., the gindicated the resident all of her medications and there Physician's Order in the POS. filled the medications, they put the POS, but they did not order as they should have. 1(g)(1-7)	TAG		an s y for ns e wed	
Bldg. 00		view and interview, the facility	R 0354	Nursing staff in-serviced on	10/25/2024	
	failed to ensure a tr	ansfer/discharge form was		Transfer/ Discharge policy		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/26/2024
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	completed for 1 of 11 resident records reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 9/25/24 at 1:28 p.m. Diagnoses included, but were not limited to, dementia, cystitis, and including the completion transfer/ discharge form. DON or designee will ma binder created to include resident hospital discharge form and ensure proper documentation is completed in PCC for each completed in PCC f		DON or designee will maintain	na	
				binder created to include each resident hospital discharge/ transfer form and ensure that proper documentation is completed in PCC for each resident transfer or discharge	
	the facility on 5/1/2 A Nurse's Note, dat		DON or designee will monitor this binder each month indefinitely. ated the the hospital.		r this
	Previous Nurse's No the resident going to	otes lacked documentation of the hospital.			
	There was no docur transfer/discharge a completed for the re	ssessment or instructions			
	Director of Nursing	on 9/26/24 at 4:10 p.m., the indicated the facility should ansfer/discharge form, but			
R 0356 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -				
	failed to ensure a cu file was complete fo (Residents 2, 3, 4, 5	riew and interview, the facility arrent emergency information or 8 of 8 residents reviewed.	R 0356	An audit of the emergency bir was completed to determine versidents required hospital preference documentation. DON or designee will ensure	vhich
	9/26/2024 at 11:45	binder was reviewed on a.m. e a hospital preference		hospital preferences are listed new and existing residents. It or designee will complete aud on emergency binder for new existing resident's biweekly for months, weekly for 2months,	OON lits and r 2
ı	l ara not hav	sprim prototoneo		I	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		09/26/	2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARYS CIRCLE HOBART, IN 46342			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAVOE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		oldents 2, 3, 4, 5, 6, 7, 8, and 11.			monthly indefinitely to ensure accuracy and compliance.		
	-	on 9/26/24 at 3:45 p.m., the ated they did not document					
	resident hospital pre						
R 0409	410 IAC 16.2-5-12 Infection Control -						
Bldg. 00	miection Contiol -	1401100111plia110 0					
	failed to ensure residence health statement, for annual health statement, for annual health statement, for annual health statement, for annual health statement, for some statement of the statem	nentation to indicate an nent that the resident was free seases had been completed. To on 9/26/24 at 3:50 p.m., the (DON) indicated she could umentation an annual health	R 04	409	An audit was conducted to determine each resident required a signed annual health statem stating resident is free of communicable disease. DON or designee will ensure enter and existing resident has signed annual health statemer indicating they are free of communicable disease upon admission and annually as required per regulations and with monitored monthly indefinitely ensure compliance.	ent each a nt	10/25/2024
	2. Record review fo 9/26/24 at 9:36 a.m. not limited to, majo obstructive pulmona	r Resident 6 was completed on Diagnosis included, but were r depressive disorder, chronic ary disease, congestive heart Ilitus, end stage renal disease,					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 09/26	ETED
	PROVIDER OR SUPPLIEF		1420 \$	ADDRESS, CITY, STATE, ZIP COD ST MARYS CIRCLE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
		. The resident was admitted to				
	annual health stater	mentation to indicate an nent that the resident was free iseases had been completed.				
	DON indicated she documentation an a the resident was fre had been completed was reviewed on 9/included, but were	v on 9/26/24 at 3:50 p.m., the could not provide any annual health statement that the of communicable diseases d.3. The record for Resident 4 25/24 at 2:16 p.m. Diagnoses not limited to, hypertension, litus, and chronic kidney				
	9/2024, lacked any	der Summary (POS), dated health statement indicating the om communicable disease.				
		v on 9/26/24 at 9:45 a.m., the would look for annual health				
	-	v on 9/26/24 at 4:10 p.m., the was unable provided any				
	9/26/24 at 1:20 p.m	Resident 8 was reviewed on Diagnoses included, but were entia, anxiety disorder, and				
	9/2024, lacked any	der Summary (POS), dated health statement indicating the om communicable disease.				
	During an interview	v on 9/26/24 at 9:45 a.m., the				

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	OF CORRECTION	IDENTIFICATION NUMBER	, ,	JILDING	00	COMPL 09/26/	ETED
	PROVIDER OR SUPPLIER			1420 ST	DDRESS, CITY, STATE, ZIP COD MARYS CIRCLE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	DON indicated she statement.	would look for annual health					
		on 9/26/24 at 4:10 p.m., the was unable provided any					
	reviewed on 9/26/24 included, but were r	rd for Resident 10 was 4 at 9:04 a.m. Diagnoses not limited to, dementia, ype 2 diabetes mellitus. The y on 7/11/24.					
	7/2024, lacked any	der Summary (POS), dated health statement indicating the om communicable disease.					
		on 9/26/24 at 9:45 a.m., the would look for annual health					
		on 9/26/24 at 4:10 p.m., the was unable provided any					
	on 9/26/24 at 10:36 were not limited to,	d for Resident B was reviewed a.m. Diagnoses included, but hypertension and chronic ary disease. The resident 8/24.					
	8/2024, lacked any	ler Summary (POS), dated health statement indicating the om communicable disease.					
		on 9/26/24 at 9:45 a.m., the would look for annual health					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	COM	ie survey ipleted 26/2024
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP C T MARYS CIRCLE RT, IN 46342	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	DON indicated she further information. 7. Record review for 9/25/24 at 1:28 p.m. not limited to, demon encephalopathy. The facility on 5/1/2 The record lacked as the resident was free. During an interview DON indicated she that the resident was diseases. 8. Resident 3's reconducted 1:26 p.m. Diagnose to, diabetes mellitust chronic kidney dise the facility on 5/1/2 There was no docur annual health statem of communicable diseases. During an interview Director of Nursing not provide any doc statement that the recommunicable diseases. 9. The record for Recommunicable diseases. 9. The record for Recommunicable diseases.	or Resident 7 was completed on Diagnoses included, but were entia, cystitis, and he resident was admitted to 3. health statement to indicate the of communicable diseases. or on 9/26/24 at 4:10 p.m., the could not find documentation is free of communicable. In was reviewed on 9/25/24 at it is included, but were not limited its, high blood pressure, and wase. The resident admitted to 3. Inheritation to indicate an inheritation an annual health inheritation an annual health				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLE B. WING 09/26/2				
			B. W.	ING		09/26/	2024
	ROVIDER OR SUPPLIER			1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	annual health staten of communicable di During an interview Director of Nursing	nentation to indicate an nent that the resident was free iseases had been completed. on 9/26/24 at 3:50 p.m., the (DON) indicated she could					
		cumentation an annual health					
	statement that the re communicable disea	esident was free of ases had been completed.					
R 0410	410 IAC 16.2-5-12	2(e)(f)(g)					
	Infection Control -	Noncompliance					
Bldg. 00	Based on record reversal failed to ensure inferplace related to not tuberculosis (TB) of 11 residents reviewed 14) Findings include: 1. Record review for 9/26/24 at 9:36 a.m. not limited to, major obstructive pulmons failure, diabetes me and legal blindness. the facility on 8/30/ The record lacked as	view and interview, the facility ection control measures were in testing residents for n or prior to admission for 5 of ed. (Residents 6, 4, 5, 11, and or Resident 6 was completed on Diagnosis included, but were or depressive disorder, chronic arry disease, congestive heart llitus, end stage renal disease, The resident was admitted to 23.	R O	410	An audit was completed to enall residents requiring their init TB/chest x-ray/ yearly screeni were completed. All new and existing residents have their first and second steadministered upon admission prior to admission. The two stable TB test will be administered, a education will be provided. TB will be documented in PCC and will flag to notify when TB test screenings are due. DON or designee will run immunization report weekly indefinitely to er compliance.	ial ng will p TB or eep ind itest or	10/25/2024
	During an interview Director of Nursing not provide any doc completed for the re was admitted. 2. The	d on or prior to the resident's cility. y on 9/26/24 at 3:50 p.m., the (DON) indicated she could cumentation TB tests had been esident on or prior to when he he record for Resident 4 was 4 at 2:16 p.m. Diagnoses					

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	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 09/26/2024
	PROVIDER OR SUPPLIER		1420 S	ADDRESS, CITY, STATE, ZIP COD T MARYS CIRCLE RT, IN 46342	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	COMPLETION COMPLETION
TAG	included, but were a type 2 diabetes mell disease. The reside on 11/10/23. A Physician's Order aplisol (solution use intradermal solution screening. The Medication Addated 11/2023, indicated 11/2023, indicated states was completed. During an interview DON indicated she further information, was reviewed on 9/2 included, but were a high blood pressure facility on 10/31/23. The record lacked a had been completed admission to the factor of Nursing not provide any documents of the provide any documents.	y on 9/26/24 at 9:45 a.m., the would look for the TB testing. y on 9/26/24 at 4:10 p.m., the was unable provided any 3. The record for Resident 5 25/24 at 2:55 p.m. Diagnoses not limited to, heart failure and . The resident admitted to the . ny documentation a TB test	TAG	DEPALENCE	DATE
		esident 11 was reviewed on n. Diagnoses included, but were			

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PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	 JILDING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIEI		1420 ST	ADDRESS, CITY, STATE, ZIP COD F MARYS CIRCLE T, IN 46342		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	not limited to, dem	entia, depression, and anxiety ent admitted to the facility on	TAG	DEFICIENCY		DATE
		any documentation a TB test don or prior to the resident's cility.				
	During an interview on 9/26/24 at 3:50 p.m., the DON indicated she could not provide any documentation TB tests had been completed for the resident on or prior to when he was admitted.					
	9/25/24 at 9:55 a.m not limited to, dem	Resident 14 was reviewed on Diagnoses included, but were entia, Parkinson's disease, and The resident admitted to the				
		any documentation a TB test d on or prior to the resident's cility.				
	DON indicated she documentation TB	v on 9/26/24 at 3:50 p.m., the could not provide any tests had been completed for rior to when she was admitted.				

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