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	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLISS PLACE	3008 SHAWNEE DR S BEDFORD, IN 47421

(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: March 27, 28 and 29, 2023 Facility number: 004011 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 3, 2023.	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 the 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 correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Lay-Wolf	RN, RDCS	04/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on interview and record review, the facility failed to attempt to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. This had the potential to affect 35 residents. Findings include: On 3/27/23 at 11:45 a.m., the Fire Drill Documentation indicated the following: - On 4/29/22 at 2:00 p.m., the fire department was not in attendance or directed the drill. - On 5/23/22 at 5:15 p.m., the fire department was not in attendance or directed the drill. - On 6/29/22 at 10:09 p.m., the fire department was not in attendance or directed the drill. - On 7/14/22 at 10:08 a.m., the fire department was not in attendance or directed the drill. - On 8/25/22 at 3:06 p.m., the fire department was not in attendance or directed the drill. - On 9/30/22 at 4:55 a.m., the fire department was not in attendance or directed the drill. - On 10/28/22 at 1:15 p.m., the fire department was not in attendance or directed the drill. - On 11/29/22 at 9:17 p.m., the fire department was not in attendance or directed the drill. - On 12/15/22 at 10:41 p.m., the fire department was not in attendance or directed the drill.	R 0092	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Executive Director (ED) called the local fire department on 3/31/23 and invited them to the next fire drill on 4/12/23. **1.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?** An audit of last 6 months of fire drill logs was completed on 3/31/23 by ED with no additional findings than those noted on SOD. Going forward a fire drill will be held in conjunction with the	04/15/2023

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	- On 1/12/23 at 10:18 a.m., the fire department was not in attendance or directed the drill. - On 2/28/23 at 3:28 p.m., the fire department was not in attendance or directed the drill. - On 3/22/23 at 5:38 a.m., the fire department was not in attendance or directed the drill. The Fire Drill Documentation lacked documentation of any attempts to involve the local fire department in fire and disaster drills. During an interview on 3/27/23 at 11:55 a.m., the Administrator indicated she had no documentation of any attempts to involve the local fire department in fire and disaster drills. On 3/30/23 at 3:30 p.m., the Administrator provided a copy of the facility policy, "Fire, Wildfire, Explosion, Natural Gas Leak, and Hazardous Spill," dated 2019, and indicated it was the policy currently being used. A review of the policy did not indicate local fire department involvement.		local fire department at least every six months. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by Regional Director of Clinical Services (RDCS) on 4/10/2023 regarding fire drill regulation requirement (Attachment 1). The maintenance Tech (MT) was re-trained by ED on 4/10/2023 regarding fire drill regulation requirement (Attachment 2). **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director is responsible for sustained compliance. The Executive Director or designee will audit the fire drill log monthly for 3 months, then bi-monthly for 2 months to ensure fire drills are completed per regulatory requirement. The	

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			audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure a Qualified Medication Aide (QMA) license was current for 1 of 17 licenses reviewed (QMA 1). This had the potential to affect 35 residents. Finding includes:	R 0123	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** QMA 1 is no longer employed with	04/15/2023

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	On 3/29/23 at 2:15 p.m., the Director of Nursing (DON) presented the License Binder. On the front cover of the License Binder was a list of the employees' license expiration dates. The list indicated QMA 1 license expired on 2/28/23. QMA 1's license inside binder indicated it expired on 2/28/23. During an interview on 3/29/23 at 2:30 p.m., the Administrator (ADM) indicated QMA 1 had not renewed her license until 3/29/23. QMA 1 had resigned and her last day of employment was on 3/15/23. At this time, the ADM presented the schedule for 2/28/23 through 3/15/23. The schedule indicated she worked on 3/1/23, 3/6/23, 3/7/23, 3/8/23, 3/13/23, 3/14/23, and 3/15/23 with an expired QMA license. On 3/29/23 at 3:41 p.m., the ADM indicated they did not have a policy on maintaining current personnel records and renewing licenses.		Bliss Place. The Executive Director (ED) audited current staff files for current licensures on 3/30/23 (Attachment 3). Current staff found without an active license will be pulled from the schedule immediately until the license is active. **1.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?** The ED or designee will ensure that all clinical staff have a valid, active license, prior to working floor. Current staff found without an active license will be pulled from the schedule immediately until the license is active. **1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by Regional Director of Clinical Services (RDCS) on 4/10/2023 regarding licensure requirements (Attachment 1). **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place? The ED is responsible for sustained compliance. Beginning 4/14/2023 the ED and/or designee will audit 5 staff licenses weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure appropriate licensure. The ED and/or designee will also audit the staffing schedule weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure appropriate licensure prior to be placed on the schedule. Results will be reviewed monthly during QI meeting. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	