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	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHANDLER PLACE	2879 S LIMA RD KENDALLVILLE, IN 46755

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 3rd and 4th, 2024 Facility number: 004440 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 10, 2024	R 0000		
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Farrah Elwood	Director of Health & Wellness	05/09/2024

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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	(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to			

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	appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review the facility failed to ensure the resident was provided notice of transfer, appeal rights, long term care ombudsman contact information, protection and advocacy services contact information or a facility bed hold policy for an interfacility transfer for 1 of 2 residents reviewed (Resident 6).	R 0045	**R045** **What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** **The Wellness Director will review documentation for all affected residents and confirm**	05/15/2024

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	Findings include: A facility Move-In/Move-Out record was reviewed on 4/3/24 at 10:30 AM. The Move-In/Move-Out record indicated Resident 6 had moved from the facility to a higher level of care on 3/15/24. Resident 6's record was reviewed on 4/3/24 at 11:20 AM. Diagnoses included Alzheimer's dementia, diabetes and reactive depression. A Resident Transfer Form indicated Resident 6's diagnoses at the time of transfer included hypertension, diabetes, weakness, Alzheimer's dementia, reactive depression and was very hard of hearing. The Resident Transfer Form did not indicate the date, time or the name of the accepting facility Resident 6 was transferred to. An undated Notice of Transfer or Discharge indicated it was necessary to transfer Resident 6 to meet the resident's needs that could not be met in the facility. The Notice of Transfer or Discharge included the previous local long-term ombudsman contact information. Resident 6's physician orders did not include an order to discharge the resident from the facility. An untimed resident service note dated 2/19/24 indicated Resident 6 was very anxious and displayed increased confusion. A resident service note dated 2/29/24 at 12:30 PM indicated Resident 6 was transferred to the hospital due to confusion, uncontrolled anxiety and constant yelling for help. A resident service note dated 2/29/24 at 6:00 PM		**that it is completed properly. WD will follow proper procedures to ensure all records are compliant.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** The facility will ensure compliance by creating a system for all residents transferred out of the facility. A transfer packet has been put into place that consist of the transfer form, ombudsman info and bed hold policy. Three copies will be made. One placed in resident record, a copy to the resident or their representative, and a copy to the facility in which will be receiving the resident The information within the packet will include: Physicians order to discharge from facility Reason for the discharge or transfer Effective date Location to where the resident will be transferred Ensuring that there is a statement on the form stating "You have the right to appeal the facilities decision to transfer" **What measures will be put**	

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	indicated Resident 6 returned from the hospital. Resident 6 had received a psychiatric evaluation. Resident 6 had received intravenous antibiotics for a urinary tract infection. A resident service note dated 3/14/24 at 10:00 AM indicated Resident 6 had left the facility in a local nursing facility's company van. The progress note indicated Resident 6's family had been in the facility removing the resident's belongings. In an interview on 4/3/24 at 2:50 PM the Director of Nursing (DON) indicated Resident 6 had been transferred to a skilled nursing facility due to increased confusion. The DON indicated the facility did not use transfer forms. The DON indicated they had documented the events surrounding Resident 6's transfer in the administrative notes. The DON indicated the facility obtained a physician order prior to transferring a resident to a higher level of care. Resident 6's administrative notes were reviewed on 4/4/24 at 9:20 AM. An untimed administrative note dated 2/27/24 indicated the facility nursing staff had reported Resident 6 had displayed confusion and anxiety. The note indicated Resident 6 had voiced thoughts of self-harm. The note indicated the facility would discuss a higher level of care or memory care with Resident 6's family as soon as possible. An untimed administrative note dated 3/7/24 indicated Resident 6 had been accepted at a local skilled nursing facility. An administrative note dated 3/14/24 (no time) indicated Resident 6 had been discharged to a local skilled nursing facility memory care unit. The		**into place or systemic changes to occur to ensure that the deficient practice does not reoccur?** All Nurses will be in serviced on April 24, 2024, by the WD. In serving review will include The proper procedure in order to transfer The proper paperwork required for the transfer What information is required to be on the form The Wellness Director will review documentation and confirm that it is completed properly. ="" p=""> **How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place** The Director of wellness will have sustained compliance. The wellness director or designee will audit all transfers daily for 6 weeks, weekly for 6 weeks, then monthly for 8 weeks. Then on going bi- monthly audits to ensure 100% compliance going forward. **By what date will the systemic changes be completed** Completion by 5/15/2024 -	

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	note indicated the skilled nursing facility company van was to pick the resident up and the resident's family was to meet the resident at the nursing facility. In an interview on 4/4/24 at 9:50 AM Licensed Practical Nurse (LPN) 2 indicated the facility nursing staff used Notice of Transfer or Discharge forms when a resident was transferred to the hospital. LPN 2 indicated the facility nursing staff did not use Notice of Transfer or Discharge forms for transfers to a skilled nursing facility. LPN 2 indicated transfers to a skilled nursing facility were considered a discharge from the facility. An undated current facility policy provided by the DON on 4/3/24 at 12:15 PM indicated the facility would establish guidelines for discharge based on state regulations and community service offerings. The policy objective indicated the discharge process would follow state regulations for determining discharge. The policy procedure included the following: -The facility would routinely monitor resident condition to ensure their needs could be met, routine monitoring would meet state regulations. -Assessments would be completed annually and more often if required by state guidelines -If need for a discharge is identified, a placement plan would be initiated as soon as possible -Reasons for discharge or transfer included: 1. Danger to self or others 2. Physician determination of need for higher level of care 3. Facility determination of need for transfer or discharge; if resident/family disagrees, a physician would determine the need for higher level of care		-	

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	4. If meeting resident needs would be disruptive to the facility 5. Resident failure to pay 6. Facility closure 7. Resident violation of house rules 8. Resident exceeds level of care identified by state regulations An undated current facility policy provided by the Operations Specialist on 4/4/24 at 10:15 AM indicated the facility would establish guidelines for discharge that were compliant with state regulations and would vary by state and community. The policy objective indicated the discharge process would follow community/company/state standards. The policy procedure included the following: -The facility would routinely monitor resident condition to ensure their needs could be met, routine monitoring would meet state regulations and community guidelines. -If need for a discharge is identified, a placement plan would be initiated as soon as possible -Reasons for discharge or transfer included: 1. Danger to self or others 2. Physician determination of need for higher level of care 3. Facility determination of need for transfer or discharge; if resident/family disagrees, a physician would determine the need for higher level of care 4. If meeting resident needs would be disruptive to the facility 5. Resident failure to pay 6. Facility closure 7. Resident violation of house rules			
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance			

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	(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to ensure 2 of 6 pets living with residents in the facility had their required immunizations. Findings include: During an interview on 4/4/24 at 9:15 AM, the Director of Health and Wellness (DHW) indicated documents contained veterinary visit and vaccination records for each pet residing in the facility. During an record review on 4/4/24 at 10:04 AM of veterinary records provided by the Director of Health and Wellness, a veterinary record for a dog belonging to Resident 4 indicated the dog received vaccinations including a rabies vaccine on 9/7/21 and was due to receive a rabies booster on 9/7/22. No additional records for Resident 4's dog were available for review. A veterinary record for a cat belonging to Resident 11 indicated the cat received a rabies vaccine on 11/28/22. The record indicated the rabies vaccine should be repeated annually.. No additional records for Resident 10's cat were available for review. During an interview on 4/3/24 at 10:04 AM, the Administrator indicated she was missing some pet vaccination records as she was new to the facility and had not had the opportunity to audit the records. A review of the current facility policy, Addendum B- Pet Addendum, dated July 2023, provided by	R 0151	**R151** **What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** On 4/24/2024, Residents or representatives were notified and corrective action to become compliant have been initiated **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **The Executive Director or designee will audit all documentation for all residents that home pets to ensure 100% compliance on a monthly basis for 6 months. Then quarterly thereafter to ensure compliance.** ="" p="">"> **What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur** **The Executive Director will track all new move ins with pets and conduct audits on those resident files quarterly.**	05/15/2024

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	the Administrator on 4/3/24 at 10:55 AM, indicated the pet must be licensed, registered, and vaccinated in accordance with applicable state and local regulations, rules, and ordinances.		**How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place.** **The Executive Director is responsible for sustained compliance. Residents will be reviewed at the Quality Assurance monthly meetings. Monitoring will be on going.** ="" p="">**By what date will the systemic changes be completed** Completion date by 5/15/2024	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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			

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	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 a current signed and dated service plan was completed for 4 of 5 residents reviewed. (Resident 2, Resident 3, Resident 4, and Resident 7). Findings include: 1) Resident 2's record was reviewed on 4/2/24 at 10:23 am. Diagnoses included multiple sclerosis, hypertension, hyperlipidemia, and heart disease. Resident 2's current service plan dated 12/17/23 was not signed or dated by the resident and/or responsible party. 2) Resident 3's record was reviewed on 4/3/24 at 10:11 AM. Diagnoses included type 2 diabetes mellitus, hyperglycemia, urinary frequency, cystitis, and dementia with mood disturbance. Resident 3's current service plan dated 3/23/24 was not signed and dated by the resident and/or responsible party. 3) Resident 4's record was reviewed on 4/2/24 at 1:32 pm. Diagnoses included diagnoses hypertension, osteoporosis, history of right retinal hemorrhage, hypothyroidism, and urinary	R 0217	**R217** **What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** All Service plans deficient of a signature will be made compliant by 5/15/2024 **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** ="" span="">**On 4/12/2024, an audit of completed service plans for all residents was conducted by the Wellness Director identifying missing signatures. All deficient Service plans will be signed and compliant by 5/15/2024** **What measures will be put into place or systemic changes to occur to ensure that the**	05/15/2024

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	stress incontinence. Resident 4's current service plan dated 3/23/24 was not signed or dated by the resident and/or responsible party. 4) Resident 7's record was reviewed on 4/3/24 at 1:55 PM. Diagnoses included cardiac arrythmia, dementia hyperlipidemia and depression. Resident 7's current service plan dated 2/28/24 was not signed and dated by resident and/or responsible party. In an interview on 4/4/24 at 3:00 PM, the Director of Health and Wellness (DHW) indicated service plans should have been signed and dated each time the service plan was reviewed and updated by the resident and/or responsible party and DHW indicated the service plans should had. A current policy titled "Care Plan", revised 10/1/22 and provided by the Operations Specialist on 4/4/24 at 12:44 PM, indicated every resident at the facility was required to have a Care Plan/Service Plan reviewed and revised every 6 months. The policy indicated the Care Plan/Service Plan would be signed by both the nurse, resident and/or responsible party.		**deficient practice does not reoccur** All resident care plans upon completion will be reviewed and discussed with facility and resident or representative at assigned CP meeting within 7 days of assessment completion. A signature will be obtained at that time. If Representative declines meeting, a discussion will occur, and a copy of the completed service plan will be mailed to obtain signature. A Resident tickler system was put into place and a monthly list will be created. Weekly audits will be completed by Wellness Director to ensure service plans are compliant per policy. **How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place** **The Wellness Director or designee will audit random Service Plans monthly for 6 months. The monthly list will be reviewed at the QI meeting monthly to ensure 100% compliance. Findings suggestive of compliance will result in cessation for monitoring plans at that time** ="" span="">	

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			By what date will the systemic changes be completed Completion by 5/15/2024	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview the facility failed to ensure complete and accurate emergency files were maintained for 4 of 5 residents reviewed. (Resident 2, Resident 3 and Resident 4, and Resident 7). Findings include: 1) Resident 2's record was reviewed on 4/2/24 at 10:23 am. Diagnoses included multiple sclerosis, hypertension, hyperlipidemia, and heart disease. Resident 2's current emergency file did not include	R 0356	**R356** **What corrective actions will be accompanied for those residents found to have been affected by the deficient practice?** On 4/18/2024 those residents with deficient information were corrected and brought to compliance **How the facility will identify other residents having**	05/15/2024

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	a photograph of the resident and her physician's phone number. 2) Resident 3's record was reviewed on 4/3/24 at 10:11 AM. Diagnoses included type 2 diabetes mellitus, hyperglycemia, urinary frequency, cystitis, and dementia with mood disturbance. Resident 3's current emergency file did not include her physician's phone number and her hospital preference. 3) Resident 4's record was reviewed on 4/2/24 at 1:32 PM. Diagnoses included hypertension, osteoporosis, history of right retinal hemorrhage, hypothyroidism, and stress urinary incontinence. Resident 4's current emergency file did not include a photograph of the resident. 4) Resident 7's record was reviewed on 4/3/24 at 1:55 PM. Diagnoses included cardiac arrythmia, dementia hyperlipidemia, and depression. Resident 7's current emergency file did not include her physician's phone number. In an interview on 4/4/24 at 2:33 PM the Director of Health and Wellness (DHW) indicated emergency files should contain all state required information including a photograph of the resident, their physician's name and phone number, and their hospital preference and the DHW indicated the emergency files did not. In an interview on 4/4/24 at 12:44 PM the Operations Specialist indicated the facility did not have a policy for emergency records.		**the potential to be affected by the same deficient practice and what corrective action will be taken** b="">
="" p="">
On 4/18/2024, The Wellness Director conducted an audit of all residents' charts to determine missing emergency information. Those residents with missing or incorrect information were updated to reflect compliance. **What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur?** An emergency binder was created on 4/18/2024 to reflect the most current resident information including name, sex, age or DOB, apt #, phone number hospital and funeral home preference, emergency contact, Physician information, allergies & Photo. The Wellness Director will re-educate staff by 5/15/2024 on the proper use of the emergency binder and pertinent information that is required so that when a change may occur- the correct information can be updated. **How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put**	

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		A. BUILDING 00 B. WING	04/04/2024

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			into place b="">
="" span="">
The Wellness Director is responsible for sustained compliance. The wellness Director and or designee will audit all documentation for all new admissions weekly for 6 weeks then monthly for 6 months to ensure the Emergency information is correct and compliant per policy and regulations. Monitoring monthly will be on going. **By what date will the systemic changes be completed** **Completion date: 5/15/2024** ="" p="">	
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			

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	with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review the facility failed to ensure tuberculosis testing was completed for 3 of 5 residents reviewed. (Resident 2, Resident 3, and Resident 4). Findings include: 1) Resident 2's record was reviewed on 4/2/24 at 10:23 AM. Diagnoses included diagnoses multiple sclerosis, hypertension, hyperlipidemia, and heart disease. Resident 2 had an admission tuberculosis test administered on 5/24/23 at 8:00 PM. The test was recorded as read on 5/26/23 at 9:00 PM. No documentation of administration of a second step was available for review. 2) Resident 3's record was reviewed on 4/3/24 at 10:11 AM. Diagnoses included diabetes mellitus, type 2, hyperglycemia, urinary frequency, cystitis, and dementia with mood disturbance. Resident 3 had a tuberculosis test administered on 8/31/23 with no time of administration noted. The test was recorded as read on 9/2/23 at 1:45, AM or PM was not indicated on the form. A second step tuberculosis test was performed on 10/8/23 with no time of administration recorded. The test was recorded as read on 10/11/23 with no time recorded. 3) Resident 4's record was reviewed on 4/2/24 at	R 0410	**R410** ="" p="">**What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** The Wellness Director will re-administer all residents or staff that have not been time stamped or missing the second step of the two step to ensure accuracy by 5/15//2024 **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** **On 4/6/2024 an audit was conducted by the Wellness Director comparing resident service notes and TB forms to confirm that TB testing was performed in a timely manner per corporate policy and state regulations.** ="" p="">Wellness Director will re-educate staff by 4/24/2024 on corporate policy and state regulations of TB testing to ensure compliance.	05/15/2024

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	1:32 pm. Diagnoses included diagnoses hypertension, osteoporosis, history of right retinal hemorrhage, hypothyroidism, and stress urinary incontinence. Resident 4's tuberculosis testing records indicated an annual tuberculosis test was administered on 10/17/23 with no time of administration recorded. The test was recorded as read on 10/18/23 with no time of reading recorded. In an interview on 4/3/24 at 2:55 PM, the Director of Health and Wellness (DHW) indicated a two-step tuberculosis skin test should be performed within 7 days and annually thereafter. She indicated each skin test should be read between 48 and 72 hours after the test was administered and the date and time of administration and reading should be recorded. A current policy dated 7/7/23 provided by the DHW on 4/4/24 at 9:15 AM indicated tuberculosis testing should be completed per state regulations residents.		**What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur** ="" p="">A TB tracking sheet has been instituted to track due dates for reading TB skin tests that were administered and to track due dates for second step TB testing for all employees. This will b reviewed by the Wellness Director weekly. The Wellness Director will maintain TB testing per corporate policy by ensuring the two-step testing is complete and accurate for all new admissions, current residents and all staff by writing them in the MAR, time stamping and reading within 48-72 hours **How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place** **The Executive Director or Wellness Director will audit 4 random files monthly for 6 months. Findings suggestive of compliance will result in cessation for monitoring plan at that time.** **By what date will the systemic changes be completed** **Completion by: 5/15/2024** ="" p="">	

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