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	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEACOAST AT SUMMERS POINTE LLC	1 SUNSET DRIVE WINCHESTER, IN 47394

(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: February 22 and 23, 2023 Facility number: 013838 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 1, 2023.	R 0000	The Lodge at Summers Pointe submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. This provider respectfully requests that the 2567 Plan of Correction (POC) be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review.	
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 of the service plan shall be given to the resident upon request.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Staci	Keen	03/16/2023

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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	(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 interview and record review, the facility failed to ensure the review of services provided by the facility for each individual resident were discussed with, and signed by, the resident or their representative for 7 of 7 resident records reviewed (Resident 2, 3, 5, 11, 12, 14, and 28). Findings include: Resident 12's record was reviewed on 2/22/23 at 12:45 p.m. The service plans for 10/3/22 and 12/20/22 lacked a resident or resident representative signature. Resident 11's record was reviewed on 2/22/23 at 1:49 p.m. The service plans for 11/30/22 and 12/14/22 lacked a resident or resident representative signature. Resident 28's record was reviewed on 2/22/23 at 2:30 p.m. The initial service plan for admission on 1/3/23 lacked a lacked a resident or resident representative signature. Resident 14's record was reviewed on 2/23/23 at 10:22 a.m. The service plans for 9/30/22 and 1/18/23 lacked a resident or resident representative signature. Resident 5's record was reviewed on 2/23/23 at 11:03 a.m. The service plans for 11/1/22 and	R 0217	1. Nursing staff will be in-serviced and all Resident Service Plans will be signed by the resident/representative within 3 days of move in, according to facility policy. 2. All residents have the potential to be affected. The Director of Nursing will audit all service plans for signatures and will obtain signatures on the current service plans for all residents that do not currently have a signature. 3. The Director of Nursing/designee will audit the resident service plans 1x weekly for 4 weeks, 2x's monthly for 3 months, and 1x monthly thereafter. 4. The results of these audits and any corrective actions will be reviewed during the facility's monthly QA meetings and the frequency of the monitoring will be increased or decreased according to the findings. Systematic changes will be effective: 3/17/2023	03/17/2023

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	2/15/23 lacked a resident or resident representative signature. Resident 2's record was reviewed on 2/23/23 at 12:22 p.m. The service plans for 8/1/22 and 10/5/22 lacked a resident or resident representative signature. Resident 3's record was reviewed on 2/23/23 at 12:56 p.m. The service plans for 9/22/22 and 12/29/22 lacked a resident or resident representative signature. During an interview, on 2/22/23 at 3:17 p.m., the Director of Nursing indicated she was unaware the service plans should be signed. She had not discussed the service plans, nor had them signed by the residents or their representatives since she had started the Director of Nursing position (11/17/20).			
R 0328 Bldg. 00	410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.			
	Based on interview and record review, the facility failed to employee an Activity Director who was either qualified by education or certification. This deficient practice had the potential to impact 28 of 28 residents who resided in the facility. Review of a facility - completed "Employee Record" form, dated 2/22/23, indicated the	R 0328	1. No residents were affected by the alleged deficient practice. 2. No residents had the potential to be affected by the alleged deficient practice due to the Licensed Activity Consultant is employed by the community. Activity Director Consultant is	03/17/2023

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	Activity Director's employment start date was 11/27/20. During a 2/22/23 employee record review, the Activity Director did not have a certification to qualify them as an Activity Director. During an interview, on 2/22/23 at 2:19 p.m., the Administrator indicated the Activity Director also functioned as the Business Office Manager. She indicated the Activity Director did not possess the required education or certification for the Activity Director position. The facility had recently been taken over by a new company. She had waited to enroll the Activity Director in training to see if the Activity Director/Business Office Manager position might become two positions. If this change occurred, a new Activity Director would be hired while the current Activity Director would be responsible for Business Office Manager duties only. During an interview, on 2/23/23 at 9:05 a.m., the Activities Director indicated she had started the Activity Director position in November of 2020. She had not completed a training program, but she had a consultant come in two times a month to go over the activities schedule and discuss new ideas for activities to involve the residents.		assuming the role of Activity Director effective 3/1/2023. 3. The ED was reeducated on licensing requirements by COO. The ED will audit credentials of all new hires and 5 current employees to ensure employees are qualified by certification or education. The auditing will occur weekly x 4 weeks, bi-weekly x 4 weeks, then monthly. 4. The results of these audits and any corrective actions will be reviewed during the facility's monthly QA meetings and the frequency of the monitoring will be increased or decreased according to the findings. Systematic changes will be effective: 3/17/2023	