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	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR RESIDENCES OF NORTHWOODS	2501 FRIENDSHIP BLVD KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. This visit included the Investigation of Complaint IN00361901. Complaint IN00361901 - Substantiated. No State Residential Findings related to the allegations were cited. Survey dates: September 9 and 10, 2021 Facility number: 014019 Residential Census: 62 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 15, 2021	R 0000	This plan of Correction constitutes Five Star Residences of North Woods written allegation of compliance for the alleged deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to have staff who were CPR (Cardiopulmonary Resuscitation)and First Aid certified for 6 of 7 night shifts reviewed for staff certifications. Finding includes: During a review of the staffing schedule for the week of September 3 through the 9, 2021, no staff on the night shift had CPR or First Aid training on the following dates: a. 9/3/21 b. 9/4/21 c. 9/5/21 d. 9/6/21 e. 9/8/21 f. 9/9/21 During an interview, on 9/10/21 at 3:15 p.m., the Director of Nursing (DON) indicated the facility had 9 nursing staff quit recently due to not wanting to get the mandatory Covid vaccination. Some of the staff who quit had worked the night shift. The staff working night shift were new and had not been certified in CPR or First Aid. During an interview, on 9/10/21 at 4:45 p.m., the Executive Director (ED) indicated the facility	R 0117	1. No residents were affected by the deficient practice. The two new employees working the night shift will attend CPR and first aid training classes on 10/01/2021. 2. No other residents have the potential to be affected by the deficient practice. 3. HR to complete an audit of current and new nursing employee files to identify employees that may need CPR and first aid training. Those that are identified as needing CPR and/or first aid training shall be enrolled in a class within 30 days of identifying the need. HR shall utilize a monthly checklist to keep track of CPR and first aid trainings as well as renewal dates. 4. This monthly checklist will be reviewed by the ED or designee to ensure facility staff are in compliance with CPR and first aid requirements. 5. 10/26/2021	10/26/2021

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	did not have a policy on staff CPR and First Aid certification and followed the state guidelines for certification.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			

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	Based on record review and interview, the facility failed to ensure employees received complete orientation for 2 of 5 employees reviewed for orientation training (Dietary Aide 3 and Certified Nursing Assistant 5). Findings include: 1. Dietary Aide (DA) 3 was hired on August 9, 2021. DA 3 did not have references checked, did not receive job specific orientation or resident rights training. 2. Certified Nursing Assistant (CNA) 5 was hired on July 23, 2021. CNA 5 had not received general orientation, job specific orientation or resident rights. During an interview, on 9/10/2021 at 4:45 p.m., the ED (Executive Director) indicated Dietary Aide 3 did not have a reference check, job specific orientation or resident rights training documented. CNA 5 did not have general orientation, job specific orientation or resident rights training documented. A current policy, titled "Orientation," dated as effective 8/1/2018 and received from ED on 9/10/2021 at 4:30 p.m., indicated "...a comprehensive general orientation program ("General Orientation") for all newly hired and certain rehired team members within the first ten days of their employment/reemployment. All team members also participate in a specific department orientation ("Department Orientation")...." A current policy, titled "Resident Rights," dated as effective 9/1/2019 and received from ED on 9/10/2021 at 4:30 p.m., indicated "...Five Star	R 0119	1. No residents were affected by the deficient practice. DA3 and CNA5 will have missing reference checks, resident rights training, general orientation and job specific orientations completed by 10/26/2021. 2. No other residents have the potential to be affected by the deficient practice. 3. HR to complete an audit of current and new employee files to identify employees with any missing orientation items required to be included in the employee file. Those employees that are identified as missing or needing orientation items shall have the missing items completed and put in the employee file within 30 days of identifying the deficiency. HR shall utilize a monthly checklist to keep track of required orientation paperwork. 4. This monthly checklist will be reviewed by the ED or designee to ensure facility staff are in compliance with required orientation paperwork. 5. 10/26/2021	10/26/2021

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	team members are provided, at orientation...."			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of			

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	active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure staff had the required health screening and tuberculin skin test for 1 of 5 staff reviewed for health screenings. (LPN 6) Finding includes: The staffing record for LPN 6 was reviewed on 9/10/21 at 1:15 p.m. There was no health screening and no tuberculosis (TB) testing or screening in the record. LPN 6 had a hire date of 1/27/2021. During an interview, on 9/10/21 at 4:15 p.m., the Executive Director (ED) indicated LPN 6 did not have a health screening or a TB test or screening. A current policy, titled "Workplace Safety," dated 9/1/18 and received from the ED on 9/10/21 at 4:30 p.m., indicated "...Five Star is committed to the health and safety of its team members and promotes various programs to minimize the risk of team member illness and injury. including the risk of exposure to infectious disease in the workplace...The provisions of this policy apply to all team members and volunteers who have regular contact with residents...Health Screens...Where required by law or state regulation, a post-offer, pre-employment health screen is completed for all applicants/team members and volunteers with resident contact, by a physician, nurse practitioner or physician assistant...The health screen includes...Past medical history...Physical assessment...Presence/absence of signs and symptoms of communicable disease...A	R 0121	1. No residents were affected by the deficient practice. LPN6 shall have health screen completed and TB test completed by 10/26/2021. 2. No other residents have the potential to be affected by the deficient practice. 3. HR to complete an audit of current and new employee files to identify employees that may need health screenings and/or TB tests. Those that are identified as needing health screenings and/or TB tests shall have them completed within 30 days of identifying the need. HR shall utilize a monthly checklist to keep track of health screenings and/or TB tests of employees. 4. This monthly checklist will be reviewed by the ED or designee to ensure facility staff are in compliance with health screening and TB tests requirements. 5. 10/26/2021	10/26/2021

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	determination of the team member's ability to safely perform the essential functions of the job...."			