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	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT CHESTERTON, IN 46304

(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. This visit included the Investigation of Complaint IN00422140. Complaint IN00422140 - No deficiencies related to the allegations are cited. Survey dates: December 19, 20, and 21, 2023. Facility number: 014469 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/29/23.	R 0000	Residences at Coffee Creek (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider herby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on	

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

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			that basis. We are requesting paper compliance for the deficiencies cited.	
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to ensure an allegation of missing money was promptly investigated and reported for 1 of 1 residents reviewed for misappropriation of property. (Resident 5) Finding includes: Resident 5's record was reviewed on 12/20/23 at 10:20 a.m. Diagnoses included, but were not limited to, pulmonary fibrosis and hypertension. The Semi-annual Evaluation, completed on 6/17/23, indicated he was cognitively intact. A Progress Note, dated 12/10/23, indicated the resident had reported $100.00 missing from his room and no longer wanted anyone in his room when he wasn't there. There was no documentation the missing money had been reported to the State Agency or local law enforcement. Interview with the resident on 12/20/23 at 10:00 a.m., indicated he had a money clip that was his	R 0064	Resident #5 met with the ED and disclosed that he was recently at the ER and didn't know exactly when the money went missing. Resident #5 also disclosed that he carries his money around when he goes to the store, etc. The ED asked Resident #5 if she could search his vehicle. Resident #5 agreed, but said he would let her know when she could do it. The morning of the survey, Resident #5 asked the ED to search for the money in his vehicle, but it was not found. The Executive Director had reported the missing money to the ISDH gateway immediately upon this finding. No other residents have reported missing money to the Executive Director after this finding. The Executive Director or designee will report any potential misappropriation within 24 hours to the ISDH gateway. The Executive Director reviewed	12/22/2023

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	father's that had $100.00 in it missing from his room. He had reported it to the staff, but had not heard anything about it since. During an interview on 12/20/23 at 3:00 p.m., the Administrator indicated she had just come inside from searching the resident's car for the missing money. After he reported the money missing, they had searched his room and did not find it. She hadn't reported it because she did not know it was actually missing until she also searched his car, but would report it now. She was unaware allegations needed to be reported prior to the full investigation. The current policy, "Unusual Occurrences/ Reportable Events", was received from the Administrator on 12/20/23 as current. The policy indicated, "The community will investigate all allegations of abuse, neglect, misappropriation of property and unusual occurrences...All substantiated allegations of abuse should be reported...."		with the Director of Resident Services timely reporting to the ISDH. The Executive Director or designee will review any concerns daily for 60 days or until compliance is achieved to ensure that proper reporting is done in a timely manner. These concerns will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be put into place December 19, 2023.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:			

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	(A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to report a COVID-19 outbreak in the facility to the Indiana Department of Health (IDOH) in a timely manner. This had the potential to affect all 83 residents residing in the facility.	R 0090	Executive Director has reported the Covid outbreak to the ISDH immediately upon this finding. The Executive Director or designee will report any outbreak within 24 hours to the ISDH	12/22/2023

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	Finding includes: Review of the facility's COVID-19 line listing was completed on 12/20/23 at 1:15 p.m. The line listing indicated 13 residents and 6 staff were recently COVID positive. The line listing indicated: - 12/14/23: 9 residents tested COVID positive - 12/17/23: 3 resident tested COVID positive - 12/18/23: 1 resident tested COVID positive - 12/13/23: 1 staff member tested COVID positive - 12/14/23: 1 staff member tested COVID positive - 12/15/23: 1 staff member tested COVID positive - 12/18/23: 2 staff members tested COVID positive - 12/20/23: 1 staff members tested COVID positive There was no documentation to indicate the facility's COVID-19 outbreak had been reported to IDOH. Interview with the Administrator on 12/20/23 at 3:25 p.m., indicated she had not reported the COVID Outbreak to the Indiana Department of Health.		gateway. The Executive Director reviewed with the Director of Resident Services on reporting any outbreak to the ISDH in a timely manner. The Executive Director or designee will review the infection control log daily for 60 days or until compliance is achieved to ensure that any outbreak is reported in a timely manner. The infection control log will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be put into place December 19, 2023.	
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			

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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 record review and interview, the facility failed to ensure fire drills were conducted on each shift quarterly as required. This had the potential to affect all 83 residents in the facility. Finding includes: The facilities fire drills for the past 12 months was reviewed on 12/20/23. There was no documentation a fire drill had been completed during the months of April, August, September, October, November or December of 2023. Interview with the Administrator on 12/20/23 at 1:35 p.m., indicated there had been no fire drills completed since July 2023. They were trying to correct the situation.	R 0092	No residents experienced negative outcomes associated with this finding. Due to a change of Directors, a fire drill was not conducted right away by the new Director of Plant Operations. After this survey, a fire drill was conducted on 12/29/23. The Director of Plant Operations or designee will ensure a fire drill is conducted on each shift at least quarterly. The fire drill will be scheduled in advance and documented accordingly. The fire drill documentation will be routinely reviewed at the quality assurance committee as our ongoing compliance. These systematic changes will be put into place December 29, 2023.	12/29/2023
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			

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	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. (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 resident Service Plans were complete and accurate related to unsigned Service Plans, not updated for hospice services or home health, indwelling catheters and therapy for 3 of 7 Service Plans reviewed. (Residents 7, 3 and 6) Findings include: 1. The closed record for Resident 7 was reviewed on 12/19/23. The resident was admitted on 11/15/23. Diagnoses included, but were not limited to, multiple sclerosis and trigeminal neuralgia. There was no Service Plan available for review.	R 0217	No other residents experienced negative outcomes associated with this finding. Resident #3, #6, and #7 did not experience any negative outcomes associated with this finding. The Service plans for residents #3, #6, and #7 will be reviewed and updated. The care plans for resident # 3 and #6 will be reviewed with the resident and signed. Resident #7 was a respite stay and no longer lives at the facility. Nursing staff will complete an in-service on this finding. Director of resident Services or	01/21/2024

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	On 12/20/23 at 10:55 a.m., the Administrator provided a copy of the Service Plan, but indicated it was not signed by the resident or family representative. 2. Record review for Resident 3 was competed on 12/19/23 at 10:32 a.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, and chronic pain syndrome. A Service Plan was completed on 4/18/23. The Service Plan did not included any contracted services. The resident was started on hospice services in October 2023. The record lacked any documentation a Service Plan was completed or updated after the resident was started on hospice services. During an interview on 12/20/23 at 11:30 a.m., the Administrator indicated a Service Plan should have been updated and completed when the resident went on hospice services but it was not completed.3. Resident 6's record was reviewed on 12/20/23 at 9:23 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, and major depressive disorder. The Semi-Annual Resident Assessment, dated 9/25/23, indicated the resident had mild impairment of cognition and needed guidance 1-3 times a day. He had an ostomy that required management. The notes in the Resident Assessment indicated the care was completed by a home health agency and the bag was emptied by the facility staff. The assessment was not signed by the resident and/or responsible party. A Progress Note, dated 6/13/23 at 6:51 p.m., indicated the resident had returned to the facility		designee will review all resident charts to ensure that service plans were updated, reviewed, and signed and no other residents were affected by this finding. As part of the admission process or a significant change in condition, the Director of Resident Services or designee will ensure that the resident service plan is complete, reviewed, and signed by the resident or their representative. Director of Resident Services or designee will audit all new resident charts within 48 hours of admission and as needed until 100% compliance is achieved to ensure ongoing compliance with this requirement. These audits will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be in place January 21, 2024	

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	with a foley catheter intact. Home health services were set up through the social worker at the hospital. A skilled nurse and occupational therapy (OT) would assess the resident tomorrow. Facility staff were to drain urine from the foley. A Progress Note, dated 7/21/23 at 3:03 p.m., indicated the resident had returned to the facility with a foley (urinary) catheter intact. A home health agency was contacted, and a skilled nurse would assess the resident tomorrow to start home health services. The resident had an order for physical therapy, occupational therapy, and speech therapy. A Progress Note, dated 8/1/23 at 11:04 a.m., indicated the resident was evaluated for occupational therapy and would now be seen as a patient regularly. The Resident Service plan was not updated upon return to the facility with a foley catheter or upon receiving home health and therapy services. During an interview on 12/20/23 at 1:15 p.m., LPN 3 indicated the resident had a foley catheter which required care from the staff. They emptied the bag and performed peri-care for the resident. He also had home health services which visited him to care for the foley catheter when it needed to be changed. He did not have an ostomy. A therapist was coming to walk with the resident about once a week. During an interview on 12/21/23 at 3:15 p.m., the Administrator indicated all Resident Service Plans should have been signed by the resident and/or the responsible party and updated to reflect the services that they were receiving.			

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R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure qualified medication aides (QMAs) received authorization from a licensed nurse or physician prior to giving as needed (prn) medications for 2 of 7 records reviewed. (Residents 3 and 6) Findings include: 1. Record review for Resident 3 was competed on 12/19/23 at 10:32 a.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, and chronic pain syndrome. The December 2023 Physician's Order Summary (POS) indicated orders for: - morphine (narcotic pain medication) 20 mg (milligrams)/ml (milliliters); administer 5 mg every 2 hours prn for moderate to severe pain or shortness of breath - lorazepam (for anxiety) 0.5 mg; administer 0.5 mg every 4 hours prn for terminal restlessness/agitation The December 2023 Medication Administration Record (MAR) indicated the prn morphine and lorazepam were administered by a QMA on the following dates and times:	R 0246	No residents experienced negative outcomes associated with this finding. Residents #3 and #6 did not experience any negative outcomes associated with this finding. Nursing staff will complete an in-service on this finding. All Qualified Mediation Assistants will be required to document in the resident chart that they have received prior authorization from a nurse or physician when they give a PRN medication. The Director of Resident Services or designee will randomly audit the resident charts for 60 days and as needed until 100% compliance is achieved. These audits will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be in place January 21, 2024	01/21/2024

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	- 12/13/23 at 4:00 a.m., morphine and lorazepam by QMA 1. - 12/17/23 at 4:05 a.m., morphine and lorazepam by QMA 1. - 12/19/23 at 12:01 a.m., morphine by QMA 1. - 12/19/23 at 4:04 a.m., morphine and lorazepam by QMA 1. During an interview on 12/20/23 at 11:30 a.m., the Administrator indicated she could not provide any documentation the QMA had received prior authorization from a licensed nurse before administering the prn medications. 2. Resident 6's record was reviewed on 12/20/23 at 9:23 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, and major depressive disorder. A Physician's Order, dated 8/2/23 at 12:00 a.m., indicated melatonin 10 milligrams (mg) 1 tablet at bedtime as needed. The December 2023 Medication Administration Record (MAR) indicated melatonin was administered by QMA 1 on 12/3/23 at 2:00 a.m. and 12/18/23 at 1:45 a.m. There was no documentation of nursing staff notified for approval prior to the administration of an as needed medication. A Physician's Order, dated 8/4/23 at 12:00 a.m., indicated albuterol sulfate inhalation aerosol micrograms per actuation three times daily as needed. The December 2023 Medication Administration Record (MAR) indicated albuterol sulfate was administered by QMA 3 on 12/2/23 at 10:05 p.m. QMA 1 administered the medication on 12/11/23 at 10:18 p.m. QMA 2 administered the medication			

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	on 12/15/23 at 10:39 p.m. and 12/19/23 at 4:08 p.m. There was no documentation of nursing staff notified for approval prior to the administration of an as needed medication by the QMAs. During an interview on 12/21/23 at 3:15 p.m., the Administrator indicated she was unable to locate documentation of a nurse being notified of the as needed medications being administered to the resident.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview, the facility failed to ensure residents' meal choices were available as requested. The facility also failed to ensure pureed food was prepared correctly. This had the potential to affect all 83 residents in the facility, and 1 resident who received a puree diet. Findings include: 1. On 12/21/23 at 11:10 a.m., lunch service was observed in the main dining room. Resident 10 was observed getting up from the table and going to an empty table to look for coffee creamer. The condiment basket on her table did not have coffee creamer. An unidentified resident and his guest seated at another table ordered the fried cod and french fries. Minutes later, Server 2 notified them they	R 0270	No residents experienced negative outcomes associated with this finding. 1. The facility goes above and beyond the required meal options to supply residents with an additional full menu to choose from. If a resident requests a meal and it is not on the menu, the facility will accommodate that resident if we have the food supplies. Creamer was available at the facility and at the adjacent table. This particular resident's basket was refilled. Condiment baskets throughout the restaurant were restocked. Due to an unforeseen supply issue, cod was not available. The	01/21/2024

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	did not have fried cod available. The resident ordered shrimp scampi and a baked potato. The server returned and indicated they did not have shrimp scampi or baked potatoes. She offered fried shrimp and french fries instead, which the resident accepted. Resident 9 ordered chicken soup and sweet potato fries. The server indicated they did not have sweet potato fries and offered onion rings instead, which the resident accepted. The resident indicated at that time, it was common they did not have what was ordered. During an interview on 12/21/23 at 9:00 a.m., Resident 11 indicated she felt the biggest issue at the facility was the food and dining services. She and other residents in the Resident Council had spoken to the former Executive Chef (EC) and the Executive Director (ED) several times and would be assured things would improve, but they didn't. The resident indicated some of the Resident Council concerns included condiment baskets weren't stocked, long wait times occurred and menu items were not available. She indicated this had been ongoing for 2 years. During an interview on 12/20/23 at 11:04 a.m., Resident 10 indicated the food and dining service was poor. The facility was frequently out of things, they had long wait times for food, and poor service. During an interview on 12/20/23 at 10:00 a.m., Resident 5 indicated he was moving out soon due to ongoing issues at the facility, one being food service. That morning, he had ordered biscuits and gravy for breakfast. After 55 minutes of waiting, he was told they did not have any. The previous night, he had ordered a pork tenderloin		resident was offered a substitution, which was accepted. Due to an unforeseen supply issue, the sweet potato fries were not available. The resident was offered a substitution, which was accepted. After this survey was completed, The Executive Chef audited the food supply in the kitchen and placed a food order as necessary to ensure that items listed on the always available menu were in stock. If an item is out of stock, the Executive Chef or designee will go to a local grocery store to purchase the items or offer an alternative to the resident. The residents are offered a daily special and also an alternative menu providing them with several options to choose from. If an item is out and not available, the cook or server will notify the resident in a timely manner so they may choose something different off the menu. 2. An in-service was completed by the Executive Chef for the Dining services staff on how to properly puree meals. Recipes from our menu program will be provided for pureed meals and given to the trained dining services staff when the weekly menu is made. All new dining service employees will be trained on how to properly puree food. This training will be added to their orientation checklist. The	

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	sandwich and was told 25 minutes later they did not have any. During an interview on 12/20/23 at 11:40 a.m., the Executive Chef indicated they would have a daily special or residents could order off the menu. A technical issue had prevented him from ordering from the food supplier the past few days, but the facility had accounts at two local grocery stores to purchase items. He indicated they currently did not have about 45% of the menu items available. He was asked if several items from the menu were currently available, he indicated there was no spinach for frittata and no salmon. He had pork tenderloin and biscuits and gravy and didn't know why the resident was told they didn't have them. The menu indicated the following: side dishes included baked potatoes and sweet potato fries. Entrees included pork tenderloin sandwich, spinach and mushroom frittata, fried cod, salmon and shrimp scampi. Breakfast included biscuits and gravy. None of these items were provided when requested by residents. 2. On 12/19/23 at 9:44 a.m., Server 1 was observed preparing pureed sausage patties and two scrambled eggs. Server 1 added 5 sausage patties to the mixer, an unknown amount of water to the mixer, and turned the mixer on. Server 1 poured the pureed mix onto a plate with visible sausage chunks present. Server 1 washed the mixer and reattached the mixing device. Server 1 added two scrambled eggs to the mixer and an unknown amount of water to the mixer. Server 1 turned on the mixer and began pureeing the two scrambled eggs. Once the mixer cycle completed, Server 1 poured the pureed eggs onto the plate. The pureed egg consistency was that of water. Server 1 then put the plate into the microwave for one minute and ten seconds. Server 1 removed the		Executive Chef or designee will randomly audit and observe the dining services staff when making purees. These audits will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be put into place on January 21, 2024	

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	plate of pureed food and indicated the plate was ready to be served to the resident. At that time, the pureed sausage was observed to be chunky, and the pureed eggs was observed to be watery. During an interview on 12/19/23 at 9:58 a.m., Server 1 indicated she had no recipes to follow, she was usually serving the food and not pureeing food, and she did not know how to fix the pureed food. A pureed food policy was requested from the facility, however no policy was provided prior to exit.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain proper wash cycle temperatures for the dishwasher, proper refrigerator temperatures for 1 of 2 refrigerators, and had uncovered and unlabeled beverages in the dining area refrigerator. This had the potential to affect 83 residents in the facility. Findings includes: During the initial tour of the kitchen on 12/19/23 at 8:50 a.m., the following was observed with the Dietary Manager: a. The high temperature dishwasher cycle was observed at 125 degrees Fahrenheit. b. The dining area refrigerator was observed to	R 0273	Areas of concern within the kitchen were corrected immediately by the Executive Chef, Plant Operations Director and additional dining services staff before the surveyors had left for the day on 12/19/23. No residents experienced negative outcomes associated with this finding. The Director of Plant Operations inspected the dishwasher cycle. He revealed that the dishwasher takes time to heat up and the surveyor tested the dishwasher right after it was turned on. When the Director of Plant Operations inspected the dishwasher, it was up to correct	01/21/2024

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	have uncovered, unlabeled, beverages present and the same refrigerator was set at + 6 degrees Celsius. Upon converting Celsius to Fahrenheit, the refrigerator temperature was set at 42.8 degrees Fahrenheit. During an interview on 12/19/23 at 9:19 a.m., the Administrator indicated she would have maintenance look at the fridge and dishwasher temperatures. She understood they were not at the proper levels. A policy titled, "Owner's Manual Installation and Operation for dish washer", was provided by the Maintenance Director as current on 12/19/23 at 11:00 a.m. This manual indicated "...high temp cycle temperatures for washing should be 155-160 degrees Fahrenheit"...		temperature. The Director of Plant Operations inspected the dining area refrigerator the day of this survey and adjusted it to ensure temperatures were maintained appropriately. The uncovered and unlabeled beverages were immediately disposed of and all items in the kitchen were audited for proper coverage and labels. No residents experienced negative outcomes associated with this finding. Temperature logs will be placed by the dishwasher and refrigerators as needed to ensure proper temperatures on a daily basis. A routine audit will be completed by The Executive Chef or designee to ensure all items in the kitchen are covered and labeled appropriately. An in-service was completed for the Dining Services staff addressing all areas of concern. Executive Chef or designee will complete a routine audit of the kitchen until 100% compliance is achieved. These audits will be reviewed routinely at the QA Committee Meeting. These systematic changes will be put into place on January 21, 2024	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records			

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	on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure clinical records were accurate and complete related to blood pressures not checked daily as ordered, no Physician Order for oxygen, no discharge summary for a discharged resident, and no order for an indwelling catheter, home health or therapy for 4 of 7 resident records reviewed. (Residents 2, 5, 7 and 6) Findings include: 1. Resident 2's record was reviewed on 12/19/23 at 11:45 a.m. Diagnoses included, but were not limited to Alzheimer's dementia and COVID-19. A Physician's Order, dated 12/18/23, indicated the resident's blood pressure was to be checked daily for 7 days. The resident's blood pressure was taken twice on 12/18/23. There was no documentation of the blood pressures on 12/19, 12/20 or 12/21/23. During an interview on 12/21/23 at 1:15 p.m., LPN 2 indicated she was unable to locate any additional blood pressures documented. 2. On 12/20/23 at 10:00 a.m., Resident 5 was observed seated in an office. He had a portable oxygen tank hanging around his neck attached to	R 0349	No residents experienced negative outcomes associated with this finding. 1. Resident #2 blood pressure was checked on 12/22/23, 12/23/23, 12/24/23, and 12/25/23 to complete the 7-day order requirements. Resident #2 did not experience any negative outcomes associated with this finding. All nursing staff have been in-serviced on following physician orders and documenting in the resident's chart to ensure it is complete and accurate, including blood pressures. 2. Resident #5 administers and manages his own medications and oxygen. Resident #5 did not experience any negative outcomes associated with this finding. Resident #5 is on palliative services. The facility contacted palliative hospice for the order and told to call the primary physician. Facility called the primary physician for the order which told the facility to contact the pulmonologist for the order. The order will be obtained and entered into the resident record. The	01/21/2024

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	a nasal cannula that was in use. The resident's record was reviewed on 12/20/23 at 10:20 a.m. The resident was admitted on 6/17/23. Diagnoses included, but were not limited to, pulmonary fibrosis and hypertension. There was no Physician's Order for oxygen use or flow rate. During an interview on 12/21/23, the Administrator indicated there was no order in place for the oxygen and they had contacted the Physician to obtain the order. 3. Resident 7's closed record was reviewed on 12/19/23. Diagnoses included, but were not limited to multiple sclerosis and trigeminal neuralgia. The resident was discharged from the facility on 12/11/23. The last Progress Note was dated 11/20/23. There was no documentation the resident had been discharged or to where . During an interview on 12/20/23 at 3:00 p.m., the Administrator indicated there should be a Progress Note entered when a resident was discharged, but there was not one for the resident.4. Resident 6's record was reviewed on 12/20/23 at 9:23 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, and major depressive disorder. The Semi-Annual Resident Assessment, dated 9/25/23, indicated the resident had mild impairment of cognition and needed guidance 1-3 times a day. He had an ostomy that required management. The care was completed by a home health agency, and		record for any new resident admission/readmission will be audited by the Director of Resident Services or designee within 48 hours to ensure orders are recorded in the resident's record. 3. Resident #7 did not experience any negative outcomes associated with this finding. All resident records will be updated with discharge summaries as necessary since the date of this survey. A discharge summary has been competed for resident #7. Within 48 hours, any resident discharged from the facility will have their record reviewed to ensure a discharge summary was complete. 4. Resident #6 did not experience any negative outcomes associated with this finding. Resident #6 was receiving services for therapy, home health, and catheter care at the time of this survey. The orders were not available at the time of this survey. Home health has been contacted for a copy of the orders which will be placed into the resident's chart. The record for any new resident admission/readmission will be audited by the Director of Resident Services or designee within 48 hours to ensure orders are recorded in the resident's record. All current resident records will be audited to ensure all orders are accurate and in place including	

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	the bag was emptied by the facility staff. A Progress Note, dated 6/13/23 at 6:51 p.m., indicated the resident had returned to the facility with a foley catheter intact. Home health services were set up through the social worker at the hospital. A skilled nurse and occupational therapy (OT) will assess the resident tomorrow. Facility staff were to drain urine from the foley. A Progress Note, dated 7/21/23 at 3:03 p.m., indicated the resident had returned to the facility with a foley catheter intact. A home health agency was contacted, and a skilled nurse would assess the resident tomorrow to start home health services. The resident had an order for physical therapy, occupational therapy, and speech therapy. A Progress Note, dated 8/1/23 at 11:04 a.m., indicated the resident was evaluated for occupational therapy and would now be seen as a patient regularly. There were no orders related to the resident's foley catheter, home health services, and therapy services. During an interview on 12/20/23 at 1:15 p.m., LPN 3 indicated the resident had a foley (urinary) catheter that required care from the staff. They emptied the bag and performed peri-care for the resident. He also had home health services who visited him to care for the foley catheter when it needed to be changed. A therapist was coming to walk with the resident about once a week. During an interview on 12/20/23 at 3:05 p.m., the Administrator indicated there should have been orders related to the foley catheter, home health		blood pressures checked as ordered, discharge summary is completed for any discharged resident since this survey, any orders for catheters, home health, or therapy agency have been entered. These audit tools will be brought to the QA committee and reviewed for compliance. These systematic changes will be put into place on January 21, 2024.	

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	services, and therapy services.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to not monitoring or assessing COVID-19 residents per protocol, COVID-19 residents not quarantined for the required amount of time, and not posting signage at the entrance alerting visitors the facility was in outbreak status during the facility Infection Control review. This had the potential to affect all residents residing in the facility. Findings include: 1. Resident 2's record was reviewed on 12/19/23 at 11:45 a.m. Diagnoses included, but were not limited to Alzheimer's dementia and COVID-19. A Progress Note, dated 12/17/23, indicated the resident had tested positive for COVID-19. A Physician's Order, dated 12/17/23, indicated to give Molupiravir, (medication used to treat COVID-19) 800 milligrams every 12 hours for 5 days. The current COVID-19 policy was received from the Executive Director as current on 12/20/23, and indicated residents should be monitored for	R 0406	1.)Resident #2 was assessed, monitored, and vitals documented. All nursing staff have been rein-serviced on monitoring and assessing COVID-19 residents. When a resident becomes positive for COVID-19, the nurse will add an order into the resident chart to monitor vitals and symptoms every shift. 2.)Nursing staff have been rein-serviced on COVID-19 isolation protocols. Resident #12 had since tested negative on two separate occasions and had no symptoms. All nursing staff have been in-serviced on isolation protocols. When a resident becomes positive for COVID-19, the nurse will add an order into the resident chart to monitor vitals and symptoms for 10 days. 3.)Nursing staff have been rein-serviced on COVID-19 isolation protocols. Resident #13 had since tested negative on two separate occasions and had no symptoms. All nursing staff have been in-serviced on isolation	01/21/2024

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	symptoms and vital signs checked every shift. There were two blood pressures recorded on 12/18/23. There were no additional vital signs recorded. There were no progress notes related the resident's condition after testing positive for COVID-19. During an interview on 12/21/23 at 12:35 p.m., LPN 2 indicated she had checked the temperature of all the COVID-19 residents last night, but ran out of time and did not get them entered into the record. She indicated she was unaware she was supposed to monitor all vital signs and resident's condition. 2. On 12/20/23 at 10:45 a.m., Resident 12 was observed in the hallway of the memory care unit. The resident did not have a mask on. Resident 12 record was reviewed on 12/20/23 at 9:00 a.m. Diagnoses included, but were not limited to, dementia. A Progress Note, dated 12/17/23, indicated that Resident 12 tested positive for COVID. A Progress Note, dated 12/18/23, indicated one vital check was completed. There was no more documentation of assessments or COVID symptom monitoring. A Progress Note, dated 12/20/23, indicated Resident 12 was retested for COVID. The results were negative and Resident 12 was removed from isolation for COVID on 12/20/23. The Memory Care COVID-19 Infection Control Log indicated that Resident 12 spent 3 days in isolation. 3. On 12/20/23 at 10:50 a.m., Resident 13 was		protocols. When a resident becomes positive for COVID-19, the nurse will add an order into the resident chart to monitor vitals and symptoms for 10 days. 4. COVID-19 outbreak signage was immediately posted at the time of this survey. Covid numbers were posted at various places throughout the facility at the time of this survey. The Director of Nursing or designee will audit all COVID-19 resident charts within 24 hours of a positive result to ensure the orders were put in for nursing staff to monitor and assess residents for symptoms and vitals are taken, the resident to remain in isolation per protocol. The concierge or designee will be responsible to post COVID-19 outbreak signage on the front entrance if an outbreak was to occur. The signage will be posted immediately. These systematic changes will be put into place on January 21, 2024.	

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	observed. Resident 13 record was reviewed on 12/20/23 at 2:30 p.m. Diagnoses included, but were not limited to, dementia A Progress Note, dated 12/17 /23, indicated Resident 13 tested positive for COVID. There was no documentation of monitoring for symptoms of COVID or vital checks completed for each shift. A Progress Note, dated 12/20/23, indicated Resident 13 was retested for COVID. The results were negative and Resident 13 was removed from isolation for COVID on 12/20/23. The Memory Care COVID-19 Infection Control Log, indicated that Resident 13 spent 3 days in isolation. During an interview on 12/20/23 at 11:12 a.m., LPN 2 indicated the staff retest the residents and check vitals and temperatures one time a day. If a change in condition occurs, they contact the family and the Doctor. During an interview on 12/20/23 at 3:15 p.m., LPN 1 indicated 2 of 11 residents were taken off COVID isolation on 12/20/23, after testing positive on 12/17/23. A current facility policy, titled " COVID PROTOCOL", provided as current by the Administrator on 12/20/23 at 1:00 p.m., indicated staff were to check vitals each shift and monitor for symptoms each shift. 4. On 12/19/23 at 8:40 a.m., the facility was			

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	observed to not have COVID outbreak signage posted on the entry doorways of the facility alerting visitors of the current COVID outbreak. On 12/19/23 the facility had 18 confirmed COVID positive cases, 13 residents and 5 staff members. During an interview on 12/19/23 at 10:00 a.m., the Administrator indicated she didn't know she had to post the COVID outbreak signage for visitors.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure infection control measures were in place related to an annual health statement not completed for 1 of 7 resident records reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 12/20/23 at 10:20 a.m. Diagnoses included, but were not limited to, pulmonary fibrosis and hypertension. The Physician Orders did not contain the required health statement to indicate the resident was free of communicable diseases, including tuberculosis. During an interview on 12/21/23, the Administrator indicated there was no order in place, and they had contacted the Physician to obtain the order.	R 0409	Resident #5 had a chest x-ray done on 4/2/23 before admission indicating free of tuberculosis. All resident charts will be reviewed to ensure each resident has an annual health statement or an order from the physician stating the resident is free of communicable diseases. Prior to or upon admission into the facility, the Director of Nursing or designee will ensure the resident has an annual health statement that the resident is free of communicable disease. All new residents' charts will be audited within 48 hours to ensure an order is put in that the resident is free of communicable disease. These audits will be reviewed	01/21/2024

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			routinely at the QA committee. These systematic changes will be put into place on January 21, 2024.	
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 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 record review and interview, the facility failed to ensure infection control measures were in place related not testing a resident for tuberculosis (TB) or completing a TB assessment on admission for 1 of 7 resident records reviewed. (Resident 7) Finding includes: The closed record for Resident 7 was reviewed on 12/19/23. The resident was admitted on 11/15/23.	R 0410	Resident # 7 was a respite stay and is not currently at the facility for nursing to currently complete the TB test. All residents were audited for TB tests and all TB tests and annual screenings were completed for any resident needing tests. Resident #7 and all other residents did not experience negative outcomes associated	01/21/2024

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	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT CHESTERTON, IN 46304

(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
	Diagnoses included, but were not limited to, multiple sclerosis and trigeminal neuralgia. The record lacked documentation a TB test or assessment had been completed on admission. During an interview on 12/20/23 at 10:55 a.m., the Administrator indicated there was no TB test completed. They had an order on admission for a chest X-ray, but did not have that either.		with this finding. An audit of all resident records was completed at the time of this finding for 1st and 2nd TB test. Director of Resident Services or designee will review all new resident TB results upon admission to ensure that 1st and 2nd step TB tests are done in a timely manner. Licensed staff were in-serviced on completing 1st and 2nd step TB tests for residents in a timely manner. Upon admission, the nurse will schedule the resident's 1st or 2nd step TB test to be completed within the required time frames. Within 72 hours of admission, the Director of Resident Services will audit all new resident admissions to ensure that 1st and 2nd step TB tests were completed in a timely manner. These audits will be reviewed routinely at the quality assurance committee to ensure ongoing 100% compliance. These systematic changes will be in place January 21, 2024.	