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	02/15/2023

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00401239 and IN00401136. Complaint IN00401239 - Substantiated. State deficiencies related to the allegation are cited at R0090. Complaint IN00401136 - Unsubstantiated due to lack of evidence. Survey dates: February 14 and 15, 2023 Facility number: 002858 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 17, 2023.	R 0000	Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement by the provider of the truth of statement of deficiency. The Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
April Haggerty, HFA	Executive Director	03/03/2023

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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	twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (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 interview and record review, the facility failed to ensure an incident of alleged resident abuse was reported to the State Survey Agency	R 0090	**R 090 410 IAC 16.2-5-1.3(g) (1-6) Administration and Management – Deficiency** **What correction action will be**	03/17/2023

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	for 1 of 1 resident reviewed for abuse. (Resident E) Finding includes: During an interview on 2/15/23 at 10:30 a.m., the Administrator indicated on 1/11/23 Resident E was experiencing behavioral issues including, but not limited to, agitation and screaming. Resident E's family was notified and arrived at the facility. QMA (Qualified Medication Aide) 2 reported to the Director of Nursing 3 (Director of Nursing at the time of the incident) that Resident E's Family Member was yelling "SSHHH" and then placed two fingers near the Resident's mouth. QMA 2 indicated Resident E's Family Member had abused the resident. The Administrator indicated the abuse allegation was not reported to the State Survey Agency as the facility's investigation did not substantiate any abuse had occurred. During an interview on 2/15/23 at 2:30 p.m., the Regional Director of Operations indicated the incident was not reported to the State Survey Agency because the facility's internal investigation determined no abuse had occurred During an interview on 2/15/23 at 3:00 p.m., QMA 2 indicated on the evening of 1/11/23 Resident E was very anxious and agitated. Resident E's Family Member was notified of Resident E's behaviors and arrived at the facility around 9:00 p.m. Shortly after the Family Member arrived at the facility, QMA 2 observed the Family Member put her right hand over Resident E's mouth. The Family Member's fingers were pressed firmly against Resident E's cheeks. At that same time, the Family Member said in a very loud, demeaning, and forceful voice "SSHHH STOP MOM STOP STOP." Resident E's response was		**accomplished for those residents found to have been affected by the deficient practice:** On 2/15/2023, the Executive Director (ED) was re-educated by the Regional Director of Operations on the guidelines of reporting allegations of abuse to state and local officials based on timeframes surrounding the allegation per the company policy and procedure, and the state and federal regulation. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. The Executive Director (ED) was re-educated by the Regional Director of Operation on 2/15/2023, and all staff members will be re-educated by the Executive Director (ED) and the Director of Nursing (DON) on the prevention of abuse and neglect, and reporting allegations of abuse and neglect per the state and federal guidelines and regulation, and per the company policy and procedure. All newly hired staff members will be educated on the guidelines and federal regulation on preventing and reporting allegations of abuse of neglect during their orientation process. The training	

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	"Stop you're hurting me." QMA 2 indicated that interaction occurred 2-3 times within "a short period of time." QMA 2 indicated the "Family Member's behavior was abusive." At 9:30 p.m., the Director of Nursing 3 and the Memory Care Activity Program Director arrived at the facility and QMA 2 reported the incident to the managers. On 2/15/23 at 2:00 p.m., the Administrator provided a copy of a document written by the Director of Nursing 3. A review of the document indicated, "1/11/23 at approximately 9 p.m...facility staff stated that POA [Power of Attorney/Family Member] covered resident's mouth with her hand and yelled again for her to shut up...writer arrived to facility at approximately 9:30 p.m., writer could hear POA yelling at resident from the hall. Upon entering the room POA was standing at resident's bedside bending over resident...writer explained to [Family Member] that raising your voice to resident and covering her mouth can be interpreted as abuse and absolutely cannot happen..." On 2/15/23 at 2:00 p.m., the Administrator provided a copy of a document written by the Administrator. A review of the document indicated, "...1/11/23...Director of Nursing [3] discussed with us [Resident E's] behaviors and [Family Member] had a raised tone voice and put her hand over resident's mouth due to Resident's yelling out repeatedly behavior..." On 2/15/23 at 2:00 p.m., the Administrator provided a copy of the Investigating Suspected Abuse, Neglect or Exploitation policy, dated 12/3/15, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...The Executive Director is responsible for reviewing and understanding his or her state's		documentation will be kept in their employee file. **What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:** The Executive Director (ED) was re-educated on the abuse policy including prevention and reporting allegations of abuse. The Regional Director of Operations and/or Regional Director of Nursing will re-educate the Executive Director (ED) 1 x per month for 3 months, then 1 x quarterly for the next two quarters, then annually. The documentation of the training with the Executive Director by the Regional Director of Operations and/or Regional Director of Nursing will be reviewed with the QAPI committee each month. Any concerns or lack of compliance will be addressed by re-education and/or discipline of this by plan by the Regional Director of Operations and/or Regional Director of Nursing. **How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place:** The Regional Director of Operations and/or Regional Director of Nursing will review all incidents with the Executive Director (ED) prior to making the decision for reporting the concern	

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	reporting regulations, along with the reporting timeframe requirements...Abuse includes both physical and emotional abuse. It may involve residents, family members...Any alleged abuse, neglect, and/or exploitation of a resident by an associate, family member or other person must be reported to the Executive Director...The Executive Director will, when required by law, immediately refer the incident to the applicable state-licensing agency within the state required reporting timeframe..." This State Residential finding relates to Complaint IN00401239.		and/or allegation of abuse to the local and state agencies to ensure all guidelines and timeframes are being met per the federal regulation and the company policy a timeframes are being met per the federal regulation and the company policy and procedure. Completion Date 3/17/23	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually			

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	thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure a newly hired staff member received dementia training for 1 of 5 staff reviewed for training. (Dietary Cook 4) Findings include: On 2/15/23 at 3:00 p.m., the employee record of Dietary Cook 4 was reviewed. The record indicated Dietary Cook 4 was hired on 4/28/22. Dietary Cook 4's training records were reviewed. The employee record lacked documentation of any dementia training. During an interview on 2/15/23 at 4:30 p.m., the Administrator indicated new hires were required to complete dementia training (upon hire) and then again annually. The facility was unable to provide any dementia training documentation for Dietary Cook 4 who began her employment with the facility on 4/28/22. On 2/15/23 at 3:50 p.m., the Administrator provided a copy of the Orientation Policy, dated	R 0120	**R120 410 IAC 16.2-5-1.4(e) (1-3) Personnel** **What correction action will be accomplished for those residents found to have been affected by the deficient practice:** The Executive Director (ED) and/or Director of Nursing (DON) will ensure that we have an organized education program for all personnel in all departments at least annually and for all newly hired personnel pertaining to Dementia Training. Audits were conducted immediately on all employee files for compliance. Staff re-education regarding Dementia Training, Abuse/Neglect Reporting was initiated immediately upon discovery and our Relias Dementia Training for new hires has been addressed. New hires will be required to complete their Relias training during the orientation period. The	03/17/2023

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	10/1/11, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...To provide an organized needs-based approach to orientation of associates within the 90 day introductory period ...The community's minimum requirements of hew hire orientation are outlined in the discipline specific Orientation Guide ..." The policy lacked any required dementia training. During an interview at that time, the Regional Director of Operations indicated the facility lacked a specific policy regarding dementia training.		Corporate Director Memory Care completed 3 hours of Dementia training in our community on March 1st and 2nd, 2023 for annual staff education. Associates will also have additional Dementia courses throughout the year per in-service calendar. **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.** No other residents were found to be affected by this practice. **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** Audits will occur at the end of each month by the Business Office Manager (BOM), Director of Nursing (DON) and/or Executive Director (ED) to ensure Relias compliance. All newly hired associate audits will be performed bi-weekly for two months, then once a month for 4 months, then bi-annually thereafter. Employee audits will be reviewed during our QAPI meetings for 6 months, with adjustments being made if indicated and addressed at meetings. Any issues with lack of compliance will be addressed by employee re-education and /or discipline or revision to this plan by the Executive Director (ED)	

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			and/or Director of Nursing (DON). **How will the facility monitor the performance to ensure the deficient practice will not reoccur, and what quality assurance program will be put into place:** Audits will occur at the end of each month by the Business Office Manager (BOM), Director of Nursing (DON) and/or Executive Director (ED) to ensure Relias compliance. All newly hired associate audits will be performed bi-weekly for two months, then once a month for 4 months, then bi-annually thereafter. Employee audits will be reviewed during our QAPI meetings for 6 months, with adjustments being made if indicated and addressed at meetings. Any issues with lack of compliance will be addressed by employee re-education and /or discipline or revision to this plan by the Executive Director (ED) and/or Director of Nursing (DON). Completion Date 3/17/23	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the dumpster	R 0155	**R155 410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards**	03/17/2023

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	container's lids and a sliding panel door were kept closed when not in use and failed to ensure the ground surrounding the dumpster area was free of debris for 4 of 4 observations. Findings include: 1. During the initial facility tour with the Dietary Manager, on 2/14/23 from 9:45 a.m. to 9:50 a.m., observed a wooden enclosure that contained one large dumpster. The dumpster area was located to the left of the facility's front door. The dumpster had two separate top lids and two sliding panel doors. The dumpster was approximately 1/2 full of filled trash bags. The right sliding panel door and both top lids were observed to not be closed. Next to the dumpster was a large white colored mattress leaning against the wooden enclosure. No staff were visible in the area at that time. 2. On 2/14/23 from 3:25 p.m. to 3:30 p.m., observed a wooden enclosure that contained one large dumpster. The dumpster area was located to the left of the facility's front door. The dumpster had two separate top lids that were observed to not be closed. No staff were visible in the area at that time. 3. On 2/15/23 from 8:20 a.m. to 8:25 a.m., observed a wooden enclosure that contained one large dumpster. The dumpster area was located to the left of the facility's front door. The dumpster had two separate top lids that were observed to not be closed. No staff were visible in the area at that time.		**What correction action will be accomplished for those residents found to have been affected by the deficient practice:** The facility will ensure that it has an effective garbage and waste disposal program. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** No residents were found to be affected by this practice. **What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** The sliding panel doors were closed upon discovery of being open. All staff were re-educated on the requirements to close the door promptly after each use. Attached re-education has been provided for review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Food Service Director and/or Executive Director will be responsible for monitoring the dumpster area 5 days per week, 3 times a day for two months, then 4 days per week, 2 times a day for	

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	4. During a facility tour with the Maintenance Director, on 2/15/23 from 11:15 a.m. to 11:25 a.m., observed a wooden enclosure that contained one large dumpster. The dumpster area was located to the left of the facility's front door. The dumpster had two separate top lids that were observed to not be closed. Next to the dumpster was a large white colored mattress leaning against the wooden enclosure. No staff were visible in the area at that time. During an interview 2/14/23 at 9:55 a.m., the Dietary Manager indicated the dumpster lids and sliding panel doors were to be kept closed. During an interview on 2/15/23 at 11:30 a.m., the Maintenance Director indicated the dumpster lids and sliding panel doors were to be kept closed. The dumpster area should be kept free of debris. On 2/15/23 at 8:45 a.m., the Administrator provided copy of the Housekeeping - Trash Pick-up and Recycling policy, dated 11/1/13, and indicated it was the current policy in use by the facility. The policy was reviewed and lacked specific requirements regarding receptacles and waste handling units for refuse. During an interview at that time, the Administrator indicated the facility lacked a policy regarding dumpster receptacles and waste handing units for refuse. On 2/15/23 at 4:00 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are		two months, then 3 days a week, 1 time a day for two months. The Executive Director (ED) and/or Food Service Director (FSD) will monitor for compliance. Any deficiencies discovered will be discussed at daily morning meetings, with instructions to inform all staff promptly of the non-compliance. R155 will be presented and reviewed at Quality Assurance Monthly Meetings for 6 months. All new associates will be educated upon hire in the requirements of proper garbage disposal. Any issues with lack of compliance will be addressed by employee re-education and has discipline or revision of this plan by the Executive Director (ED) and/or Director of Nursing (DON). Completion Date 3/17/23	

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	minimized...effective cleaning is facilitated around...the unit..."			