DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDALL RESIDENCE AT GATEWAY PARK	6338 WEST QUIET ROAD GREENFIELD, IN 46140

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00450630, IN00450423, IN00449892, IN00448733, IN00448662, IN00448530, and IN00447785. Complaint IN00450630 - State deficiencies related to the allegations are cited at R41, R217, R240, R246 and R356. Complaint IN00450423 - State deficiencies related to the allegations are cited at R41. Complaint IN00449892 - No deficiencies related to the allegations are cited. Complaint IN00448733 - State deficiencies related to the allegations are cited at R41, R217, R240, R246 and R356. Complaint IN00448662 - State deficiencies related to the allegations are cited at R41 and R240. Complaint IN00448530 - State deficiencies related to the allegations are cited at R41, R217, R240 and R246. Complaint IN00447785 - State deficiencies related to the allegations are cited at R354. Survey dates: January 13, 14, 15, and 16, 2025 Facility number: 015521 Residential Census: 34 These State Residential Findings are cited in	R 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melanie Scott	RDHW	02/20/2025

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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	accordance with 410 IAC 16.2-5. Quality review completed on January 22, 2025.			
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency Based on interview and record review, the facility failed to document grievances and follow up timely. This had the potential to affect 34 of 34 residents in the facility. (Resident D) Findings include: On 1/14/25 at 10:55 a.m., the ED (Executive Director) provided the facility's Grievance Log. The first listed grievance was dated 9/24/24. An interview was conducted with the ED on 1/14/25 at 10:55 a.m. She indicated she did not start documenting grievances until 9/24/24, because "We didn't hear a lot of grievances prior to 9/24/24." They only had "little things" prior to 9/24/24. She usually received around five grievances per month. She educated managers that they needed to inform her of grievances voiced to them, so they could be addressed. She started using a grievance box, located in the hallway, and forms in November 2024. They had the grievance form prior, but they weren't being used. Prior to November 2024, the grievance forms were located in a back office. So, residents/family would have to ask for a form to turn in a documented grievance. The Grievance Log indicated a 12/17/24 grievance for Resident D, submitted by Family Member 2, in regards to asking for a care plan meeting. The person responsible section of the grievance	R 0041	***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to documenting grievances and follow up with grievances.*** Resident/ family meeting was conducted on February 11th and grievances were heard by new consulting management company. Family member 2 and 3 were present at the meeting and followed up with regarding grievances. Operation Specialist met with one of the family members also and discussed specific grievances. ***- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put into place to identify potential residents who could be affected by the same deficient practice related to documenting***	02/28/2025

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	indicated the former DON (Director of Nursing), and ED was responsible for addressing this grievance. The resolution section of the grievance indicated Family Member 3 was asked twice about a care plan meeting with no response. The Grievance Log indicated two 12/20/24 grievances for Resident D, submitted by Family Member 3. One was in regards to Resident D found on the floor. The resolution was in-service to staff at all staff meeting regarding bed cane. The other one was that Resident D was put to bed improperly and before receiving her medication. The resolution was aide was spoken to, and informed Resident D was laying in bed when she left the room, and the nurse informed the medications were given. An interview was conducted with Family Member 2 on 1/15/25 at 11:03 a.m. She indicated there was no care plan meeting for Resident D since her 8/29/24 admission. On 12/17/24, there was a meeting with several families, including theirs, on the memory care unit, at which, she asked the ED about having a care plan meeting. All the families were asking about having a care plan meeting. It didn't sound right to her that Family Member 3 wouldn't respond about having a care plan meeting, and one of Family Member 3's complaints was about the ED not responding to grievances. Interviews were conducted with Family Member 3 on 1/14/25 at 1:50 p.m. and 1/15/25 at 11:42 a.m. She indicated she still hadn't received anything back from the ED about the grievances she filed on 12/20/24, and it was not true that she was contacted twice about a care plan meeting. An interview was conducted with the ED on 1/15/25 at 1:10 p.m. She indicated Resident D's family asked about a care plan meeting during a		***grievances and follow up with grievances.*** Executive Director or designee will educate Residents on the process for managing grievances including where the Grievance forms are located. In addition, Charter Chatter that communicates with families will also be sent by the Executive Director or designee and include process for managing grievances going forward. Weekly rounds will be completed by the Executive Director or designee for 2 months to verify availability of Grievance Forms at the front desk and follow up was completed. ***- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for documenting grievances and follow up with grievances.*** Executive Director or designee to educate staff during All Staff Meeting on 2/19/2025 regarding Grievance policy. Executive Director or designee to verify that Grievance forms are readily available at Front Desk, grievances are documented on the Grievance Log and followed up on timely. New employee orientation will include review of Grievance Policy and location of forms.	

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	meeting held on the memory care unit with multiple families. Family Member 3 was "always here," but she didn't see her for a while. When she asked Family Member 3 about having a care plan meeting, Family Member 3 informed the ED that Family Member 3 needed to speak with other family members and would get back with the ED, but Family Member 3 never got back with her. The ED was unsure what dates she asked Family Member 3 about a care plan meeting. She did not consider the 12/17/24 care plan request grievance resolved, as they still needed to have a care plan meeting. The Grievance policy was provided by the ED on 1/14/25 at 10:35 a.m. It read, "What needs to happen...Encourage residents, family members, responsible parties, or interested parties to express their concerns freely, without any fear of retaliation. Address concerns courteously and in a timely fashion. Give residents, families, responsible parties, and interested parties a satisfactory resolution to their concerns. How to make it happen...4. Document a record of the grievance as discussed with the resident, family member, responsible party, or interested party. 5. Investigate the grievance promptly. 6. The Executive Director will respond to the resident, family member, responsible party, or interested party as soon as possible and document the response. 7. The Executive Director will work with the resident, family member, responsible party, or interested party as soon as possible and document the response....10. Final resolution of the grievance will be documented by the Executive Director and will also be logged for the Quality Assurance Committee." This Residential tag relates to Complaints IN00450630, IN00448733, IN00448530, IN00448662,		***- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to documenting grievances and follow up with grievances. If monitoring is for six months or less, please explain the criteria will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.*** Executive Director or designee will bring Grievance Log, documentation of follow up of grievances, and compliance with weekly rounds audit to Quality Committee Meeting for review and verify compliance. Ongoing review of Grievances at Quality Committee Meeting will continue. ="" p="">	

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	and IN00450423.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency			
	Based on interview and record review, the facility failed to complete an accurate elopement assessment for 1 of 1 resident reviewed for elopement (Resident L). Findings include: During an interview with Certified Nurse Aide (CNA) 6 on 1/14/25 at 2:10 p.m., they indicated Resident L was confused and forgetful and wandered throughout the facility frequently. CNA 6 was concerned Resident L would go outside. During an interview with the Executive Director (ED) on 1/14/25 at 3:15 p.m., she indicated she was aware of Resident L wandering around the building and had talked with the resident's family about moving him to the secured memory care unit, but the family had refused to move him. The facility staff had increased supervision for Resident L. During an interview with CNA 7 on 1/15/25 at 1:50 p.m., they indicated Resident L wandered around the facility frequently and the CNA was not able to keep up with the resident. Resident L resided on the third floor of the facility and was on the first floor this morning. CNA 7 brought the resident back up to the third floor and ten minutes later, the resident was wandering again. The clinical record for Resident L was reviewed on 1/15/25 at 2:05 p.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease,	R 0214	="" p=""> ***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to accurate elopement assessment and facility placement.*** Director of Health and Wellness or designee to reassess Resident L including an elopement risk assessment. Care Plan meeting scheduled with family to discuss appropriate placement. On 1/31/2025, resident was placed in Memory Care Neighborhood. ***- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put into place to identify potential residents who could be affected by the same deficient practice related to accurate elopement assessment and facility placement.*** Residents will be re-assessed as the new	03/15/2025

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	and anxiety. The custom level of care assessment for Resident L, dated 10/18/24, indicated the resident did not wander. A progress note for Resident L, dated 10/20/24 at 6:00 a.m. to 6:00 p.m., indicated the resident was wandering around multiple times during the shift. The staff redirected the resident. A progress note for Resident L, dated 10/21/24 at 9:30 a.m., indicated the resident was found going down the stairs by his room. The resident stated he was going home. The staff redirected him back to his room. A progress note for Resident L, dated 11/4/24 at 12:00 a.m., indicated the resident was walking the hallways and stated he did not know where he was going, and he wanted to wander around. The resident was redirected when he approached the exit sign. A progress note for Resident L, dated 11/23/24 at 10:00 p.m., indicated the resident was wandering the hallway. The staff redirected him back to his apartment. A progress note for Resident L, dated 11/26/24 at 9:00 p.m., indicated the resident was wandering the hallway with no shoes on. The resident stated he was going home. The resident was redirected back to his apartment. A progress note for Resident L, dated 12/30/24 at 9:00 p.m., indicated the resident was observed trying to go out the stairway exit. The staff reoriented the resident.		consulting management company will be implementing Electronic Health Record. This will include elopement risk assessments for each Assisted Living and Memory Care resident. Residents identified as an elopement risk will have discussion with resident and responsible party at care plan meeting and verify appropriate placement. ***- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for accuracy of elopement assessments and facility placement.*** Moving to an Electronic Health Record. Elopement risk assessments are required per policy upon admission and every 6 months and with any change in condition. Policy reviewed with Director of Health and Wellness, nurses and Executive Director. ***- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to accuracy of elopement assessment and facility placement. If monitoring is for six months or less, please explain the criteria will be used***	

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	During an interview with the ED on 1/16/25 at 12:20 p.m., she indicated another level of care should have been completed when Resident L started exhibiting wandering behaviors because it was a change in his condition. The Director of Nursing (DON) was responsible to complete the level of care.		***to determine whether further monitoring is necessary or if the monitoring can be stopped.*** Elopement risk assessments are monitored by the Director of Health and Wellness and Executive Director. The EHR has compliance reports to verify completion of assessments. Elopement Risk Assessments will be audited monthly to verify compliance and brought to the Quality Committee Meeting. ***- By what date the systemic changes will be completed?*** 3/15/2025 br="">	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review the facility failed to have an accurate service plan for Resident L and failed to have family involvement in service plan reviews for 5 of 8 residents reviewed for service plans (Resident C, Resident J, Resident K, Resident F and Resident D). Findings include: 1. During an interview with Certified Nurse Aide (CNA) 6 on 1/14/25 at 2:10 p.m., they indicated Resident L was confused and forgetful and wandered throughout the facility frequently. CNA 6 was concerned Resident L would go outside. During an interview with the Executive Director	R 0217	**R 217 Evaluation: Service Plans** - ***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to accuracy of service plans and family involvement in service plan reviews.*** Residents identified not in compliance will have assessments and service plans	03/15/2025

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(ED) on 1/14/25 at 3:15 p.m., she indicated she was aware of Resident L wandering around the building and had talked with the resident's family about moving him to the memory care secured unit, but the family had refused to move him. The facility staff had increased supervision for Resident L.

During an interview with CNA 7 on 1/15/25 at 1:50 p.m., they indicated Resident L wandered around the facility frequently and the CNA was not able to keep up with the resident. Resident L resided on the third floor of the facility and was on the first floor this morning. CNA 7 brought the resident back up to the third floor and ten minutes later, the resident was wandering again.

Review of the record of Resident L, on 1/15/25 at 2:05 p.m., indicated the diagnoses included, but were not limited to, dementia, Alzheimer's disease, and anxiety. The resident's service plan did not address the resident's behavior of wandering.

During an interview with the ED on 1/16/25 at 12:20 p.m., she indicated the Director of Nursing (DON) was responsible to ensure service plans accurately reflected Resident L's status. The ED verified Resident L's service plan did not accurately reflect his behavior of wandering. 2. The clinical record for Resident D was reviewed on 1/13/25 at 12:33 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility, on 8/29/24, and resided on the memory care unit of the facility.

The Custom Level of Care Tool with corresponding service plan indicated a pre-admission evaluation was conducted, on 8/12/24, as Assessment 1 and signed by Resident D's family member. They indicated Assessment 2

completed and reviewed with the responsible parties/ families as appropriate. Care Plan meetings will be scheduled to review service plans, verify agreement with services and obtain signatures.

- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put into place to identify potential residents who could be affected by the same deficient practice related to accuracy of service plans and family involvement in service plan reviews.

Residents will be re-assessed and service plans completed and reviewed with the responsible parties/ families. Care Plan meetings will be scheduled to review service plans and obtain signatures. This is required with the new implementation of the Electronic Health Record.

- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for accuracy of service plans and family involvement in service plan reviews.

Compliance with the

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	was conducted on 8/29/24 but was not signed by Resident D's family. It indicated Assessment 3 was conducted on 9/29/24 but was not signed by Resident D's family. An interview was conducted with Family Member 3 on 1/15/25 at 11:42 a.m. She indicated when Resident D was admitted to the facility, the family verbally informed staff how they wanted Resident D to be cared for, but nothing written was ever given to them. An interview was conducted with the ED on 1/15/25 at 1:10 p.m. She indicated she did not think Resident D's family was involved with her, 8/29/24 and 9/29/24, service plan reviews. The previous Director of Nursing probably did the reviews on her own. 3. Resident F's clinical record was reviewed on 1/14/25 at 12:00 p.m. The diagnoses included, but were not limited to, anxiety, dementia, fatigue, and re-current UTI (urinary tract infection). The service plan for Resident F was provided by the ED on 1/16/25 at 10:15 a.m. It indicated Resident F had an initial assessment on 2/22/24. No resident or family representative signatures were present on the document. 4. The clinical record for Resident C was reviewed on 1/15/2025 at 2:10 p.m. The medical diagnoses included poor memory. A cognitive assessment, entitled "Mini-Mental State Exam", was completed on 5/20/2024, and indicated Resident C was mildly cognitively impaired. An assessment, entitled "Custom Level of Care Tool", last revised on 10/8/2024, indicated a blank for the Resident/Resident Representative		assessments/ service plans and signatures is tracked by the electronic health record. The Executive Director and Health and Wellness Director will be educated on the policy and process in the EHR. ***- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to accuracy of service plans and family involvement in service plan reviews. If monitoring is for six months or less, please explain the criteria will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.*** Compliance with the assessments/ service plans and signatures is tracked by the electronic health record. The Health and Wellness Director or designee will be responsible for overseeing compliance. The Executive Director and Health and Wellness Director will be educated on the policy and process in the EHR. Compliance will be tracked in the monthly Quality Committee. ***- By what date the systemic changes will be completed?*** 3/15/2025 ="" p="">	

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Signature for the 5/20/2024 revision.

5. The clinical record for Resident J was reviewed on 1/15/2025 at 1:45 p.m. The medical diagnoses included multiple falls and unsteady gait.

A cognitive assessment, entitled "Mini-Mental State Exam", was completed on 9/2/2024, and indicated Resident J was cognitively intact.

An assessment, entitled "Custom Level of Care Tool", was last revised on 10/4/2024. The form indicated blanks for the Resident/Resident Representative Signatures for revisions on 9/4/2024 and 10/1/2024.

6. The clinical record for Resident K was reviewed on 1/15/2025 at 2:00 p.m. The medical diagnoses included dementia.

A cognitive assessment, entitled "Mini-Mental State Exam", was completed, on 5/29/2024, and indicated Resident K had mild cognitive impairment.

An assessment, entitled "Custom Level of Care Tool", was last revised on 10/12/2024. The form indicated blanks for the Resident/Resident Representative Signatures for revisions on 4/19/2024 and 10/12/2024.

An interview with the ED, on 1/15/2025 at 3:15 p.m., indicated the facility had not completed family meetings with Resident C, Resident J, or Resident K.

A policy entitled, "Resident Assessment", was provided by the Executive Director on 1/15/2025 at 11:30 a.m. The policy indicated to share the results of the screening process with residents/resident

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	representatives and to update the level of care as needed, but not less than yearly. This Residential tag relates to Complaints IN00448530, IN00448733, and IN00450630.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to provide bathing as service planned and medications as ordered for 4 of 8 residents reviewed for bathing and medication review. (Resident D, F, J, and K) Findings include: 1. Resident F's clinical record was reviewed on 1/14/25 at 12:00 p.m. The diagnoses included, but were not limited to, anxiety, dementia, and depression. An electronically transmitted prescription for Resident F was written, on 10/18/24 at 5:09 p.m., for nitrofurantoin macrocrystal (antibiotic) 100 mg (milligrams) orally twice daily. Licensed Practical Nurse (LPN) 10 noted the order on the prescription on 10/19/24. The Medication Administration Record (MAR) for October 2024 was reviewed on 1/16/25 at 10:30 a.m. It indicated Resident F began nitrofurantoin on 10/20/24 at 9:00 a.m. The MAR indicated Resident F did not receive the 5:00 p.m. dose on 10/21/24. Resident F's MAR for November 2024 was reviewed on 1/15/25 at 11:45 a.m. The MAR indicated Resident F was to take Premarin	R 0240	**R 240 Health Services** - ***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to providing bathing per the service plan and medications as ordered.*** Residents were bathed per the schedule or if several days out, bathing occurred that day.Bathing schedule created and reviewed with care team at All Staff Meeting. Medication Administration Records reviewed and policy on med administration including documentation expectations discussed with associates who complete med administration. Policy reviewed for proper documentation of med administration. ***- How other residents having the potential to be affected by the***	03/31/2025

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RANDALL RESIDENCE AT GATEWAY PARK	6338 WEST QUIET ROAD GREENFIELD, IN 46140

(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
	(conjugated estrogen) cream vaginally three times a week at bedtime. Doses were not documented as given on 11/16/24 and 11/25/24. An order for mirtazapine (antidepressant) 30 mg tablet; one tablet orally at bedtime doses were not documented as given on 11/23/24, 11/25/24, and 11/26/24. During an interview with the Executive Director (ED) on 1/15/25 at 12:48 p.m., she indicated she did not know why the doses were not documented as given. A Medication Administration Policy provided by the ED, on 1/14/25 at 10:30 a.m., indicated the following, "... staff would remind/administer medications to a resident... Initial the MAR for the current time when the medication is administered to the resident". 2. The clinical record for Resident D was reviewed on 1/13/25 at 12:33 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility, on 8/29/24, and resided on the memory care unit of the facility. An interview was conducted with Family Member 3 on 1/14/25 at 1:50 p.m. She indicated Resident D was not getting her showers, as scheduled. There was not enough staff to ensure Resident D was provided the care she needed, including showers and toileting. The Memory Care Staff Task Sheet, 6:00 a.m. to 6:00 p.m., indicated Resident D's showers were scheduled for Tuesdays and Fridays on day shift. The 8/29/24 service plan, last reviewed 9/29/24, indicated staff would assist Resident D with showers, encouraging her to do as much for herself as possible.		***same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put into place to identify potential residents who could be affected by the same deficient practice related to providing bathing per the service plan and medications as ordered.*** Residents who didn't receive bathing per schedule were prioritized for bathing. Bathing schedule created and reviewed with care team at All Staff Meeting. Residents with medications not documented will have medication error incident reports completed. Physician, resident and/or family/ responsible party will be notified as appropriate. ***- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for providing bathing per the service plan and medications as ordered.*** Bathing schedule created and staff re-educated on Basic Care Policy and Procedure. Will be transferring to Electronic Health Record that details services and staff sign off on tasks i.e. bathing, so electronic	

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	An interview was conducted with Certified Nurse Aide (CNA) 5 on 1/14/25 at 11:40 a.m. She indicated she worked at the facility for a year, on day shift, and always worked on the memory care unit. Resident D required two staff to assist her with showers. There was not always two CNAs available to assist with showers, usually due to a CNA calling off work that day. When that was the case, the nurse or Qualified Medication Aide (QMA) on the unit wasn't available to assist either, because that would leave no staff on the floor. Only having one CNA available on the unit, usually happened "about once a week." When this happened, CNA 5 was not always able to get everything done, including showers that required two staff member assistance. On 1/15/25 at 10:28 a.m., the ED provided the shower sheets from Resident D's 8/29/24 admission through present. The earliest shower sheet was dated 10/8/24. There were no shower sheets from 8/29/24 through 10/7/24, 10/23/24 through 11/2/24, 11/17/24 through 11/21/24, 11/26/24 through 12/3/24, and 12/11/24 through 12/21/24, to verify Resident D received a shower during those time frames. An interview was conducted with the ED on 1/15/25 at 10:28 a.m. She indicated there were no more shower sheets for Resident D. Resident D was mistakenly not added to the shower list after her 8/29/24 admission until 9/18/24, so she missed some showers when she was first admitted. There was no shower sheet for 9/28/24, but she knew Resident D received a shower on that date, because the family texted her about it, so the ED made sure Resident D received one that day. 3. The clinical record for Resident J was reviewed on 1/15/2025 at 1:45 p.m. The medical diagnoses		verification of bathing will be available to Director of Health and Wellness. Care Team re-educated on shower sheets. Director of Health and Wellness or designee will compare shower sheets with shower schedule to verify completion. This will be audited weekly x 2 months and then random audits ongoing. Medication Administration Records will be reviewed daily for compliance and follow up. New consulting management company is implementing new electronic health record that will report on any meds not documented. ***- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to providing bathing per the service plan and medications as ordered. If monitoring is for six months or less, please explain the criteria will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.*** Bathing will be tracked in our electronic health record via CareTracker. The Director of Health and Wellness will monitor for compliance. Audit will be discussed in Quality Committee. Medication	

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	included multiple falls and unsteady gait. An assessment, entitled "Custom Level of Care Tool", was last revised on 10/4/2024. The form indicated Resident J needed physical assistance with bathing. A cognitive assessment, entitled "Mini-Mental State Exam", was completed, on 9/2/2024, and indicated Resident J was cognitively intact. Shower sheets for Resident J indicated in the last fourteen days, Resident J received one shower on 1/11/2025. A confidential interview indicated Resident J had not been receiving showers because Resident J preferred a female caregiver assist with personal bathing tasks and only a male caregiver was assigned to them most days. A confidential interview indicated Resident J had not received showers on second shift because they were unaware Resident J's shower times had changed. An interview with Resident J, on 1/14/2025 at 2:35 p.m., indicated they had not received showers for "almost two weeks" in the last thirty days and they preferred to have morning showers, but since there was only a male caregiver on day shift, they would have to take their showers in the evening if they received one. 4. The clinical record for Resident K was reviewed on 1/15/2024 at 2:00 p.m. The medical diagnoses included dementia. A cognitive assessment, entitled "Mini-Mental State Exam", was completed on 5/29/2024 and		Administration documentation will be tracked in our electronic health record. The Director of Health and Wellness will monitor for compliance. Audit will be discussed in Quality Committee. ***- By what date the systemic changes will be completed*** 3/31/2025 ="" p="">	

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indicated Resident K had mild cognitive impairment.

No shower sheets were provided for Resident K.

A confidential interview indicated Resident K did not receive showers because Resident K did not want a male caregiver to provide her bathing tasks and Resident K was not listed on the shower schedule even though Resident K needed assistance.

A confidential interview indicated Resident K had not received showers on second shift because Resident K was not on the shower schedule, but they believed Resident K would need assistance with bathing for safety.

An interview with Resident K, on 1/14/2025 at 2:45 p.m., indicated they needed assistance with bathing, but often did not get it. The staff had told Resident K they were changing Resident K's showers to evenings, but Resident K preferred mornings and Resident K had not received assistance for bathing since the start of the year. Resident K indicated the ability to "wash up" in the bathroom independently to include sitting on the toilet and providing perineal care, but Resident K voiced the inability to shower independently.

An interview with the Executive Director, on 1/15/2025 at 3:10 p.m., indicated no shower sheet were completed for Resident K because Resident K was listed as independent with bathing, but she could see how Resident K would need assistance.

A policy, entitled "Bathing", was provided on 1/16/2025 at 11:30 a.m. by the Executive Director. The policy indicated, " ...Resident are bathed in

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	their preferred way at their preferred times ..." This Residential tag relates to Complaints IN00448530, IN00448662, IN00448733, and IN00450630.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency			
	Based on interview and record review, the facility failed to ensure nurse authorization for PRN (as needed) medication administration and follow-up on effectiveness of PRN medication for 2 of 7 residents whose medications were reviewed. (Residents C and D) Findings include: 1. The clinical record for Resident D was reviewed on 1/13/25 at 12:33 p.m. Her diagnoses included, but were not limited to, dementia. The physician's orders indicated to administer two tablets of Extra Strength Tylenol 500 milligrams (mg) three times a day as needed. The December 2024 medication administration record (MAR) indicated Resident D was administered the above referenced PRN Tylenol, on 12/2/24 and 12/9/24, by a Qualified Medication Aide (QMA). There was no verification in the clinical record to indicate a nurse authorized the 12/2/24 administration. The MAR did not indicate follow up for effectiveness of the 12/2/24 or 12/9/24 administrations. An interview was conducted with the Executive Director (ED) on 1/16/25 at 1:00 p.m. She indicated she spoke with the QMA who administered the	R 0246	**R 246 PRN – Medication** ***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to nurse authorization for an as needed (PRN) medication administration and follow-up on effectiveness of PRN medication.*** QMA's and nurses were re-educated on the requirements to obtain nurse approval for any prn medication administration and document on effectiveness of prn medications per policy on 2/19/2025. ***- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put into place to identify potential residents who could be affected by the same deficient practice***	03/18/2025

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	12/2/24 PRN Tylenol and was informed she received verbal permission, but it wasn't documented anywhere. There was no verification of follow up for effectiveness of the 12/2/24 or 12/9/24 administrations. 2. The clinical record for Resident C was reviewed on 1/15/2025 at 2:10 p.m. The medical diagnoses included poor memory. An assessment, entitled "Custom Level of Care Tool", last revised on 10/8/2024, indicated Resident B utilized facility staff for medication administration. Review of the medication administration record, dated for the month of December 2024, indicated Resident C received seven doses of as needed medication without documented nurse authorization and no follow-up for efficacy of medication. An interview with QMA 9, on 1/14/2025 at 1:50 p.m., indicated until a week ago, she was not aware she had to document a nurse authorization for as needed medication, and she did not check on medication effectiveness because she was unable to assess residents. She was not aware of a procedure to ensure as needed medications were effective for residents. An interview with the Executive Director, on 1/16/2025 at 12:45 p.m., indicated it was the responsibility of the nursing staff to ensure nurse authorization was documented and it was the responsibility of the nurse to ensure as needed medications were effective. A policy entitled, "Caregiver's Role in Medication", was provided by the Executive Director on 1/15/2025 at 11:30 a.m. The policy		***related to nurse authorization for an as needed (PRN) medication administration and follow-up on effectiveness of PRN medication.*** QMA's and nurses were re-educated Med Administration Policy including the requirements to obtain nurse approval for any prn medication administration and follow up on effectiveness of prn medications per policy at All Staff Meeting on 2/19/2025. ***- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for nurse authorization for an as needed (PRN) medication administration and follow-up on effectiveness of PRN medication.*** QMA's and nurses were re-educated on the requirements to obtain nurse approval for any prn medication administration and follow up on effectiveness of prn medications per policy at All Staff Meeting on 2/19/2025. New QMA's and nurses will also be educated as part of onboarding. The new electronic health record has nurse approval for prn medication administration in place. Will educate and implement once EMAR is live.	

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	indicated to report when a resident requests an as needed medication to your medication agent or supervisor and to observe the effectiveness of as needed medications. This Residential tag relates to Complaints IN00448530, IN00448733, and IN00450630.		***- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to nurse authorization for an as needed (PRN) medication administration and follow-up on effectiveness of PRN medication. If monitoring is for six months or less, please explain the criteria will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.*** The Health and Wellness Director or designee will complete audits weekly for 2 months to verify nurse authorization is completed for PRN med administration per regulatory requirement. Once EHR is implemented, the system won't allow a med tech to administer without nurse approval documented, and PRN effectiveness is reported on if not completed. Will track compliance monthly in Quality Committee Meeting. ***- By what date the systemic changes will be completed*** 2/28/2025 for education/ audit begin date. EHR process, 3/18/2025. ="" p="">	

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R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on interview and record review, the facility failed to utilize a transfer form that included the name of the receiving institution, the resident's personal property, information related to the resident's functional abilities and physical limitations, nursing care, current diet, condition on transfer, and date of chest x-ray and skin test for tuberculosis for 1 of 2 residents whose closed record was reviewed. (Resident F) Findings include: The clinical record for Resident F was reviewed on 1/14/25 at 12:00 p.m. The diagnoses included, but were not limited to, anxiety, dementia, and re-current UTI (urinary tract infection). A progress note written by Qualified Medication Aide (QMA) 8 for Resident F, on 11/9/24, indicated "Res. [resident] was sent out to the hosp. [hospital]. Res. [resident] was feeling sick and was feeling weak". Resident F's clinical record did not indicate a transfer form was sent with the resident upon transferring to an acute care facility. The clinical record also did not reflect the condition of the resident. An interview conducted with QMA 8, on 1/14/25 at 11:46 a.m., indicated she did not remember if she notified the Director of Nursing (DON) or physician and could not remember if anything was sent with Resident F. An interview was conducted with the Executive Director (ED) on 1/16/25 at 12:25 p.m. She indicated the staff on duty were to fill out and	R 0354	**<u>R 354 Transfer forms:</u>** ***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to utilization of a transfer form to include the necessary information.*** Staff educated on the Change in Condition policy and requirement to utilize the Indiana transfer form. Transfer form was printed out and placed in med rooms. Staff educated to place completed form in HWD office for review prior to being filed in resident medical record. ***- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put into place to identify potential residents who could be affected by the same deficient practice related to utilization of a transfer form to include the necessary information.*** Hospitals currently caring for a resident of Randall	02/28/2025

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	make a copy of the state provided transfer form when any resident was going to be transferred to another facility. The transfer form was to be sent with the resident upon transfer and the copy was to be put in the DON's mailbox for review. The ED indicated she did not know if the DON or resident's provider were notified of Resident F's transfer, and she did not know why the transfer form was not filled out. The Resident Relocation and Discharge Policy was provided by the ED on 1/16/25 at 10:15 a.m. The policy indicated the following, "...Coordinate the resident's discharge or transfer to provide continuity of care. Provide necessary information about the resident to the receiving organization..." This Residential tag relates to Complaint IN00447785.		Residences at Gateway were contacted to verify coordination of care and a completed transfer form will be sent. ***- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for utilization of a transfer form to include the necessary information.*** Weekly audits for 2 months will be completed by the Health and Wellness Director or designee to verify transfer forms were completed for residents who transfer to higher level of care. Change of Condition policy was reviewed with staff on 2/19/2025. Transfer form will be uploaded into EHR for electronic compliance auditing once her is in place. ***- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to utilization of a transfer form to include the necessary information. If monitoring is for six months or less, please explain the criteria will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.***	

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			The Director of Health and Wellness or designee will verify compliance by completing weekly audits x 2 months, then monthly and reported through the Quality Committee Meeting. ***- By what date the systemic changes will be completed?*** 2/28/2025. ="" p="">	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on interview and record review the facility failed to have resident pictures in the emergency binder for 7 of 7 residents reviewed for emergency file (Resident H, Resident G, Resident B, Resident C, Resident J, Resident K and Resident D). Findings include: 1. Review of the record of Resident H, on 1/13/25 at 1:40 p.m., indicated the diagnoses included, but were not limited to, hypertension and kidney disease. Resident H did not have a picture in the facility's emergency binder. 2. Resident G's clinical record was reviewed on 1/13/25 at 1:30 p.m. The diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, hypertension, and depression. The Emergency Information Binder was provided by the Executive Director (ED) on 1/14/25. Review of the binder indicated Resident G did not have a picture for identification in the binder.	R 0356	br=""> **R 356 Emergency Binder** ***- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Please describe what immediate corrective actions were put in place related to the residents pertaining to having resident pictures in the emergency binder.*** Emergency Binder was updated to include photos for these residents. ***- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Please describe what actions were put***	02/28/2025

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3. The clinical record for Resident B was reviewed on 1/14/2025 at 2:00 p.m. The medical diagnosed included dementia.

4. The clinical record for Resident C was reviewed on 1/15/2025 at 2:10 p.m. The medical diagnoses included poor memory.

5. The clinical record for Resident J was reviewed on 1/15/2025 at 1:45 p.m. The medical diagnoses included multiple falls and unsteady gait.

6. The clinical record for Resident K was reviewed on 1/15/2025 at 2:00 p.m. The medical diagnoses included dementia.

An interview conducted with Licensed Practical Nurse (LPN) 4, on 1/14/2025 at 1:35 p.m., indicated they did not know of any emergency binder with identifying information for the residents. In the case of a fire, they would grab their nursing report sheet, but it only entailed the resident's name and room number.

An interview with Certified Nurse Aide (CNA) 7, on 1/15/2025 at 12:45 p.m., indicated they had never heard of an emergency binder since they had been there, and they were certain they did not have one. In the event of a fire or other need to evacuate, they would take the residents down the stairwell and wait outside. They were not sure how they would take count or have important information on the residents.

7. The resident emergency information binder was provided by the ED on 1/14/25 at 10:35 a.m. A picture of Resident D was not included with her other emergency information.

An interview was conducted with the ED on 1/14/25 at 10:55 a.m. She indicated there should be

into place to identify potential residents who could be affected by the same deficient practice related to having resident pictures in the emergency binder.

The emergency binder is being completely redone by new Consultant Management Company to include the state required information including photos. New Resident Information Sheets are being completed by resident/ responsible parties to verify accurate information.

- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Please describe how all staff were educated on the procedure for having resident pictures in the emergency binder.

The emergency binder will be updated with new resident information as admissions occur. This is included on the Move In Manifest as a task and is monitored by the Executive Director.

- How the corrective actions will be monitored to ensure the deficient practice will not recure? Who is responsible to monitor the systemic changes related to having resident pictures in the emergency

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	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDALL RESIDENCE AT GATEWAY PARK	6338 WEST QUIET ROAD GREENFIELD, IN 46140

(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
	a picture of each resident in the resident emergency information binder. She never looked in the binder until yesterday, when the binder was requested, so she was unaware it did not include residents' pictures. An interview was conducted with the ED on 1/14/25 at 10:55 a.m. She indicated there was no facility policy regarding the resident emergency binder. This Residential tag relates to Complaints IN00450630 and IN00448733.		***binder. If monitoring is for six months or less, please explain the criteria will be used to determine whether further monitoring is necessary or if the monitoring can be stopped.*** This is included on the Move In Manifest as a task and is monitored by the Executive Director. The completion of the Move In Manifest and weekly audit of Emergency Binder will be reviewed at Monthly Quality Meeting. Weekly audit of Emergency Binder will continue for 2 months, then monthly. ***- By what date the systemic changes will be completed?*** ="" p=""> 2/28/2025	