| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00411782, IN00412422, and IN00412687.<br><br>Complaint IN00411782 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00412422 - State deficiencies related to the allegations are cited at R0036, R0052, R0054, R0116, R0119, and R0120.<br><br>Complaint IN00412687 - State deficiencies related to the allegations are cited at R0036, R0052, R0116, R0119, R0120, and R0240.<br><br>Survey dates: July 18 & 19, 2023<br><br>Facility number: 013825<br><br>Residential Census: 95<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 7/24/23. | R 0000 | | |
| R 0036<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(k)(1-2)<br>Residents' Rights- Deficiency<br>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:<br>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or<br>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Kristin Landahl | Executive Director | 10/18/2023 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | Based on record review and interview, the facility failed to notify residents' families about a resident to resident altercation, for 2 of 3 residents reviewed for family notification. (Residents C and E)<br><br>Finding includes:<br><br>A. Resident C's record was reviewed on 7/18/23 at 3 p.m. The diagnoses included, but were not limited to, dementia.<br><br>An Incident Form, received from the Administrator and dated 7/2/23 at 1:30 a.m., indicated Resident C had fallen and was transferred to the hospital Emergency Room.<br><br>A Nurse's Progress Note, dated 7/2/23 at 3:53 a.m., indicated it was reported from Resident E that Resident C had attacked her while she was sitting in her wheelchair in front of her room. Resident E indicated Resident C had pulled her hair, scratched her arms, and kicked at her legs. The Nurse and other staff brought Resident C to the Nurses' Station and away from Resident E.<br><br>During an interview on 7/19/23 at 10:36 a.m., LPN 1 indicated the altercation had occurred on 7/1/23 around 8:30 or 9 p.m. and he had made a late entry in the record.<br><br>An Incident Form, dated 7/1/23 at 10:15 p.m. and received from the Administrator, indicated, "last night", Resident E claimed Resident C had opened her apartment door and came into her room and started attacking her. Resident E indicated Resident C had kicked her, scratched her arms and pulled her hair. There had been no apparent skin or wound injuries. | R 0036 | In-service completed on resident rights and abuse, which included<br>1. Sexual abuse<br>2. Physical abuse<br>3. Mental abuse<br>4. Neglect and involuntary seclusion. | 07/22/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | B. Resident E's record was reviewed on 7/19/23 at 11:40 a.m. The diagnoses included, but were not limited to, dementia.<br><br>A Nurse's Incident Note, dated 7/2/23 at 9:03 a.m., indicated on 7/1/23 evening, Resident E indicated she had been attacked by Resident C. Resident C had kicked her, scratched her arms, and pulled her hair.<br><br>There was no documentation in either record to indicate Resident E's and Resident C's families had been made aware of the resident to resident altercation.<br><br>During an interview on 7/19/23 at 10:01 a.m., the Director of Nursing was unable to determine if the Resident C and E's family had been notified of the altercation.<br><br>This state residential finding relates to Complaints IN00412422 and IN00412687. | | | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse;<br>(4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br><br>Based on record review and interview, the facility failed to ensure residents were free from abuse, related to neglecting to protect Memory Care Residents from other Memory Care residents who continually exhibited physical and verbal aggression, which resulted in a resident (Resident | R 0052 | See also R 0036. Resident rights and abuse in-service completed 7/22/2023 | 07/22/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | E) being harmed and transferred to the Emergency Room for an evaluation and treatment. The facility also failed to report allegations of abuse to the Administrator and/or Director of Nursing so the abuse allegation could be investigated and interventions could be initiated to prevent further abuse. (Residents B and C)<br><br>Findings include:<br><br>1. Resident B's record was reviewed on 7/18/23 at 12:17 p.m. The diagnoses included, but were not limited to, dementia.<br><br>A Health Assessment, dated 7/7/23, indicated a severely impaired cognitive impairment, resisted care, and required supervision.<br><br>A Service Plan, dated 3/8/23, indicated behaviors of wandering into others apartments, removing or rearranging objects that belong to others, defecating on the floors, and use of offensive language. The staff were to provide redirection and encouragement to maintain in a common areas and own apartment. The staff were to place the objects back as needed and was to provide redirection for appropriate language.<br><br>The Nurses' Progress Notes indicated the following behaviors:<br><br>On 3/19/23 at 7:34 p.m., she approached another resident and their spouse and became verbally aggressive with expletives and insults.<br><br>On 3/21/23 at 10:46 a.m., she was cussing at another resident's family member.<br><br>On 4/9/23 at 5:34 a.m., she was found lying in another resident's bed and became aggressive | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | when staff attempted to direct her to her room. She began to yell at the resident in the room and was extremely hard to redirect.<br><br>On 4/14/23 at 6:20 p.m., she wandered into another resident's room and became angry when being verbally redirected.<br><br>On 4/17/23 at 12:42 p.m., she was wandering into several other resident rooms and touching/moving items in those rooms. She became very angry and started yelling and cursing when attempts were made by staff to redirect her. She was not easily redirected.<br><br>On 5/16/23 at 5:43 p.m., she was arguing with another resident, became angry and hit a staff member in the head.<br><br>On 6/6/23 at 1:53 p.m., she was found in another resident's room, lying in bed and naked. She physically fought staff when they escorted her out of the room. She physically fought staff when care was provided. She was not easily redirected.<br><br>On 6/24/23 at 5:38 a.m., she continued to exhibit aggressive behavior towards staff and visitors. Staff informed the Nurse, the resident had taken her clothes off and defecated in another resident's room while visitors were in the room.<br><br>On 7/2/23 at 11:29 a.m., she was observed picking up several objects on the staff's work carts and moving them around. When she was asked to return the items, she became loud and threw items at the staff. She then stood over a male resident and was yelling at him very close to his face. The male resident yelled at her to get away from him. She continued to yell at the resident. She was not easily separated from the male resident. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | On 7/6/23 at 3:45 p.m., the Director of Nursing (DON) documented she had received a telephone call from the staff and was informed a witness had observed Resident B pushing Resident E with, "extreme force". She was using profanity and aggression toward Resident E while she was in Resident E's apartment. Upon exiting Resident E's apartment, she shoved Resident E causing a fall and injuring Resident E's right upper arm/shoulder and right hip. Resident B was witnessed swearing, throwing the other resident's clothing and person belongings, and screaming she would kill her. She threatened to pour gas on Resident E and set her on fire. Resident E was in excruciating pain and complained of severe back, neck and right sided pain. The Ambulance was notified for a transfer to the hospital. The Power of Attorney was made aware.<br><br>A typed and signed statement from LPN 2, dated 7/19/23, indicated she had responded to a resident to resident altercation in the Memory Care Unit. Resident E was observed on the floor outside of her apartment. The resident indicated Resident B came into her apartment and she wanted her to get out. She asked her to leave and Resident B refused. She started "shooing" the resident out and when they reached the doorway, Resident B grabbed her by the shoulder and forcefully shoved her to the floor. Resident B complained of her whole right side hurting and the ambulance was called for transport to the hospital.<br><br>A signed statement from a Personal Care Giver/ Visitor for another resident, dated 7/6/23, indicated she heard someone yelling for help from the hallway. She observed and heard Resident E yelling "help! get out!" Then she saw Resident E "fly" into the hallway. "...it appeared she was very | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | forcefully and violently pushed extremely hard..." Resident E fell on her right side. She then heard the door to Resident E's apartment slam. She yelled for help. CNA 1 responded and opened the door to the apartment and Resident B was in the Resident E's apartment. As Resident B walked past the witness, she put her face very close to the Witness's face and walked away.<br><br>A signed statement from CNA 1, dated 7/6/23 at 3:18 p.m., indicated she had been called to the hallway by a Personal Care Giver/Visitor of another resident. Resident E was on the floor in the hallway and had stated she had been pushed out of her apartment by Resident B. Resident B remained in Resident E's apartment and was aggressively rummaging through her items. She was directed to leave the apartment and she walked out of the apartment, was angry, speaking in Spanish and walked toward Resident E.<br><br>LPN 2 was interviewed on 7/19/23 at 2:33 p.m. and indicated Resident E was on the floor outside her apartment when she arrived at the Memory Care Unit and Resident B was in Resident E's apartment. Resident E informed LPN 2 she had been attempting to get Resident B out of her apartment when she pushed her to the floor. The actual push had not been witnessed. The Witness had just walked out of another apartment due to the resident yelling help and saw Resident E start to fall to the floor with force. Resident E was very upset and was hurting. She could barely get up. The Police came to the facility, she was unsure who had notified the Police and he assisted in calming Resident E.<br><br>CNA 1 was interviewed 7/19/23 at 2:45 p.m., and indicated she had not witnessed the incident. She was in the TV room and had not heard the yelling. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | The Witness had heard the yelling, responded and yelled for her to come to the area. This had not been the first physical altercation Resident B had with other residents. All altercations had been reported to the Nurses or the QMAs.<br><br>The DON was interviewed on 7/19/23 at 3:16 p.m., and indicated she had not been made aware of the other altercations and would need to complete an investigation. She indicated Resident B's Service Plan had not been updated from 3/8/23 to 7/7/23 with new interventions for behaviors.<br><br>2. Resident C's record was reviewed on 7/18/23 at 3 p.m. The diagnoses included, but were not limited to, dementia.<br><br>A Health Assessment, dated 6/28/23, indicated a moderately impaired cognitive status, a history of wandering, resistive to care at times, and ambulated independently.<br><br>The Service Plan, dated 6/28/23, indicated, observe for disturbances in behavior.<br><br>A Nurse's Progress Note, dated 6/30/2023 at 6:38 p.m., indicated there had been aggressiveness towards the staff and other residents.<br><br>A Nurse's Progress Note, dated 6/30/2023 at 11:15 p.m., indicated extremely aggressive behavior was present and she refused to be redirected when she was removing her clothing in the common area. She was screaming and hitting staff. She approached other residents in a "hysterical manner".<br><br>A Nurse's Progress Note, date 7/1/2023 at 12:52 a.m., indicated aggressive behavior continued toward the staff. She was yelling and hitting staff. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | She was disrobing and was not easily redirected.<br><br>A Nurse's Progress Note, dated 7/2/23 at 3:53 a.m., indicated it was reported from Resident E that Resident C had attacked her while she was sitting in her wheelchair in front of her room. Resident E indicated Resident C had pulled her hair, scratched her arms, and kicked at her legs. The Nurse and other staff brought Resident C to the Nurses' Station and away from Resident E.<br><br>During an interview on 7/19/23 at 10:36 a.m., LPN 1 indicated the altercation had occurred on 7/1/23 around 8:30 or 9 p.m. and he had made a late entry in the record.<br><br>An Incident Form, dated 7/1/23 at 10:15 p.m., and received from the Administrator, indicated, "last night", Resident E claimed Resident C had opened her apartment door and came into her room and started attacking her. Resident E indicated Resident C had kicked her, scratched her arms and pulled her hair. There had been no apparent skin or wound injuries.<br><br>3. Resident E's record was reviewed on 7/19/23 at 11:40 a.m. The diagnoses included, but were not limited to, Dementia.<br><br>A Healthcare Assessment, dated 6/7/23, indicated a mildly impaired cognitive status.<br><br>A Service Plan, dated 7/3/23, indicated there were no current behaviors.<br><br>A Nurse's Incident Note, dated 7/2/23 at 9:03 a.m., indicated on 7/1/23 evening, Resident E indicated she had been attacked by Resident C. Resident C had kicked her, scratched her arms, and pulled her hair. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 signed statement from LPN 1, and received from the DON on 7/19/23, indicated on 7/1/23 around 10:15 p.m., he had been informed by another staff member Resident E had been "attacked" by Resident C in Resident E's apartment. When he arrived at the apartment, Resident C remained in the apartment and was removed.<br><br>A Nurse's Incident Note, dated 7/6/23 at 6:47 p.m., indicated she was observed on the floor and stated she had been attacked by another resident as she was attempted to get the other resident to leave her apartment. The other resident grabbed her shoulder's and forcefully threw her to the floor. She complained of her right side hurting. She was able to repeat the same story to other staff, family, Medics, and the Police. She was transferred to the Hospital for evaluation of her injuries. Her family was notified.<br><br>The Hospital Emergency Room Notes, dated 7/6/23 at 3:39 p.m., indicated right hip and shoulder pain, tenderness of the right upper extremity and posteriorly over the joint line with no deformity or bruising. Range of motion was present. The exam was suggestive most likely of a soft tissue injury. There were no fractures.<br><br>During an interview on 7/19/23 at 10:01 a.m., the DON and the Administrator indicated the resident to resident altercation on 7/1/23 had not been reported to them and an investigation had not been completed.<br><br>The facility abuse policy, dated 7/2022, and received from the Administrator as current, indicated all residents would be free from abuse and neglect. All allegations or incident of abuse and neglect would be thoroughly investigated. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | The residents' legal representative were to be notified within 24 hours of all alleged occurrences. The allegations or incidents were to be reported immediately to the DON and the Administrator.<br><br>This state residential finding relates to Complaints IN00412422 and IN00412687. | | | |
| R 0054<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(x)<br>Residents' Rights - Deficiency<br>(x) Residents have the right to confidentiality of all personal and clinical records. Information from these sources shall not be released without the resident ' s consent, except when the resident is transferred to another health facility, when required by law, or under a third party payment contract. The resident ' s records shall be made immediately available to the resident for inspection, and the resident may receive a copy within five (5) working days, at the resident ' s expense.<br>Based on record review and interview, the facility failed to ensure a Power of Attorney (POA) for a resident received copies of the resident's medical record within five working days, for 1 of 1 POA who requested copies of a medical record. (Resident B)<br><br>Finding includes:<br><br>The Administrator indicated on 7/18/23 at 12:08 p.m., there had been one request for copies of a medical record at the end of April by the POA for Resident B. The medical record was copied and sent on 6/27/23. The POA never received the medical record. The Company the records were sent through was unable to find the package and it had not been delivered. The records were sent by email to the POA on 7/9/23 and the POA | R 0054 | All paperwork was submitted prior to this date, however, only one page of chart notes printed. I resent via USPS and the paperwork was received 7/29/2023. | 07/29/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | indicated she was unable to open the email. The records would be sent by email again on 7/18/23. She indicated the facility had just hired a new Director of Nursing and they were not sent out due to the transition.<br><br>The Assisted Living/Memory Care Residency Agreement, dated 2019 and received from the Administrator as current, indicated after the medical record were requested by the resident (POA), the records would be received within five days.<br><br>This state residential finding relates to Complaint IN00412422. | | | |
| R 0116<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(a)<br>Personnel - Noncompliance<br>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.<br>Based on record review and interview, the facility failed to screen employees hired in the past four months, related to criminal background checks and references, for 6 of 6 employee records reviewed. (LPN 1, Dietary Server 1, Home Health Aide (HHA) 1, HHA 2, LPN 3, and HHA 3)<br><br>Findings include:<br><br>Employee files were reviewed on 7/19/23 at 9 a.m. The following employees lacked a criminal background check and/or references completed prior to hire: | R 0116 | Education completed with business office manager. Policy reviewed and employee has access to complete these screenings. | 07/31/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | LPN 1 was hired on 3/7/23, there was no criminal background check.<br><br>Dietary Server 1 was hired on 6/8/23, there was no criminal background check.<br><br>HHA 1 was hired on 7/4/23, there were no references obtained.<br><br>HHA 2 was hired on 6/7/23, there was no criminal background check.<br><br>LPN 3 was hired on 5/15/23, there was no criminal background check.<br><br>HHA 3 was hired on 5/29/23, there was no criminal background check.<br><br>During an interview on 7/19/23 at 9:45 a.m., the Business Office Manager indicated she was in the process of running criminal background checks and she had not completed several yet. She indicated an audit had just been completed by the Corporate Office and discovered the criminal background checks had not been completed.<br><br>A policy for new hires, dated 8/2021 and received from the Administrator as current, indicated offers of employment were subject to reference checks and other state required pre-employment practices. Any pre-employment documentation that was incomplete or missing would delay the employee's start date.<br><br>This state residential finding relates to Complaints IN00412422 and IN00412687. | | | |
| R 0119<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-<br>Personnel - Noncompliance<br>(d) Prior to working independently, each | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:<br>(1) Instructions on the needs of the specialized populations:<br>(A) aged;<br>(B) developmentally disabled;<br>(C) mentally ill;<br>(D) dementia; or<br>(E) children;<br>served in the facility.<br>(2) A review of the facility's policy manual and applicable procedures, including:<br>(A) organization chart;<br>(B) personnel policies;<br>(C) appearance and grooming policies for employees; and<br>(D) residents' rights.<br>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.<br>(4) Review of ethical considerations and confidentiality in resident care and records.<br>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.<br>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. | | | |
| | Based on record review and interview, the facility failed to orient employees to the facility's abuse policy, for 6 of 6 employees hired in the past 4 months. (LPN 1, Dietary Server 1, Home Health Aide (HHA) 1, HHA 2, LPN 3, and HHA3)<br><br>Finding Includes: | R 0119 | Abuse policy in-service with staff included in the in-service of resident rights under R0036 and R0052. In addition, Abuse classes have been assigned for all current staff and added to the new employee onboarding package via | 07/31/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | Employee files were reviewed on 7/19/23 at 9 a.m. LPN 1, Dietary Server 1, HHA 1, HHA 2, LPN 3, and HHA 3 all started employment in the past 4 months and had not been oriented to the facility's abuse policy at the time of employment.<br><br>During an interview on 7/19/23 at 12:28 p.m., the Business Office Manager indicated the employees had not be educated on the facility abuse policy at the time of their employment.<br><br>A facility policy for employee orientation, dated 8/2015 and received from the Administrator as current, indicated new employee orientation included Resident Rights and Abuse education.<br><br>This state residential finding relates to Complaints IN00412422 and IN00412687 | | our Relias online education system. | |
| R 0120<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(e)(1-3)<br>Personnel - Noncompliance<br>(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:<br>(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. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | (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 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.<br>(3) Inservice records shall be maintained and shall indicate the following:<br>(A) The time, date, and location.<br>(B) The name of the instructor.<br>(C) The title of the instructor.<br>(D) The names of the participants.<br>(E) The program content of inservice.<br>The employee will acknowledge attendance by written signature.<br>Based on record review and interview, the facility failed to ensure inservice education was completed yearly for all employees who had worked at the facility longer than four months, related to abuse and resident rights education for 2 of 5 employees reviewed for inservice education. (Housekeeper 1 and CNA 2)<br><br>Finding includes:<br><br>Employee files were reviewed on 7/19/23 at 9 a.m. Housekeeper 1 was employed at the facility on 10/20/21 and had not received abuse education in 2022. CNA 2 was employed at the facility on 8/18/22 and had not received education on abuse or resident rights.<br><br>During an interview on 7/19/23 at 12:28 p.m., the Business Office Manager indicated the employees had not been educated yearly on the the abuse and resident rights policies. | R 0120 | Same as R0036, R0052 and R0119 | 07/31/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 facility policy for employee orientation, dated 8/2015 and received from the Administrator as current, indicated employees would receive ongoing in-service education, which would include resident rights and abuse.<br><br>This state residential finding relates to Complaints IN00412422 and IN00412687 | | | |
| R 0240<br><br>Bldg. 00 | 410 IAC 16.2-5-4(d)<br>Health Services - Deficiency<br>(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.<br>Based on record review and interview, the facility failed to ensure a resident received necessary care and services, related to a thorough assessment not completed after a fall to determine if the resident had signs and symptoms of a fractured hip prior to moving the resident off the floor into a sitting position, for 1 of 3 residents reviewed for necessary care and services. (Resident C)<br><br>Finding includes:<br><br>Resident C's record was reviewed on 7/18/23 at 3 p.m. The diagnoses included, but were not limited to, dementia.<br><br>A Healthcare Assessment, dated 6/28/23, indicated a moderately impaired cognitive status, was independent with mobility, with a normal gait and balance. There was a moderate potential for falls.<br><br>A Nurse's Progress Note, dated 7/2/23 at 2:32 a.m., indicated the resident was found on the bedroom floor. The nurse and a staff member lifted her off the floor and placed her in the wheelchair. She | R 0240 | In-service for Licensed and unlicensed staff on LCS policy and procedure regarding personal care, assistance with ADLS and safety.<br><br>In-service for licensed and unlicensed staff with Synchrony Rehab on falls and safety<br><br>In-service for licensed staff on documenting and assessing residents with fall. | 08/21/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CLARENDALE OF SCHERERVILLE | 7770 BURR STREET<br>SCHERERVILLE, IN 46375 |

| (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 |
|---|---|---|---|---|
| | displayed a grimace when she sat in the chair and complained of pain in her right hip.<br><br>An Incident Form, received from the Administrator and dated 7/2/23 at 1:30 a.m., indicated a pulse, blood pressure and temperature was checked at the time of the fall. The written note on the report indicated the nurse had assessed the resident.<br><br>There was no documentation on the Incident Form or the Progress Notes the resident had been assessed for shortening/outward rotation/range of motion of the bilateral lower extremities or for pain prior to her being assisted off the floor.<br><br>During an interview on 7/19/23 at 10:29 a.m., LPN 1 indicated he had checked the resident's vital signs and then, when they lifted her up and placed her in the chair, he noticed she had signs and symptoms of pain. He had not assessed her for signs and symptoms of a fracture prior to her being lifted off the floor.<br><br>A facility policy for post incident/accident care, dated 11/2017 and received from the Administrator as current, indicated after an incident/accident, the resident was not to be moved until they had been examined for possible injuries by a Licensed Nurse and 911 was to be notified if uncertain there was an injury or if there was no Licensed Nurse available. The Licensed Nurse was to inspect the body for obvious signs/symptoms due to trauma and ask/determine as best as possible the level of pain.<br><br>This state residential finding relates to Complaint IN00412687. | | | |