STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00388875, IN00390631 and IN00393816. This visit included a State Residential Licensure Survey. Complaint IN00388875 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F689 and F921. Complaint IN00390631 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393816 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 1, 2, 3, 4, 7 and 9, 2022. Facility number: 000471 Provider number: 155572 AIM number: 100290390 Census Bed Type: SNF/NF: 5 SNF: 74 Residential: 8 Total: 87 Census Payor Type: Medicare: 5 Medicaid: 36 Other: 38 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly DeYoung	HFA	12/06/2022

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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	Quality review completed on 11/14/22.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be			

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	free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review and interview, the facility failed to ensure resident dignity was maintained related to an uncovered urinary catheter bag for 1 of 4 residents reviewed for dignity. (Resident 39) Finding includes: On 11/2/22 at 11:55 a.m., Resident 39 was observed lying in bed. A urinary catheter bag was hanging on the side of the bed with visible urine in the bag. There was not a covering over the bag. The bag was visible from the hallway. On 11/3/22 at 10:03 a.m., Resident 39 was observed lying in bed. A urinary catheter bag was hanging on the side of the bed with visible urine in the bag. There was not a covering over the bag. The bag was visible from the hallway. Record review for Resident 39 was completed on 11/4/22 at 1:39 p.m. Diagnoses included, but were not limited to, neurogenic bladder, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 9/8/22, indicated the resident was moderately cognitively impaired. The resident had an indwelling urinary catheter. Interview with CNA 1 on 11/3/22 at 10:05 a.m., indicated they usually cover the catheter bags with a pillow case. The midnight aides must have forgotten to put one over it after they emptied it. 3.1-3(a)	F 0550	**550 Resident Rights** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified** **Catheter dignity bag was provided to Resident #39 and placed on catheter bag.** **2) How the facility identified other residents:**	11/28/2022

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			Rounds were completed on all residents who have a catheter to ensure appropriate dignity was maintained by ensuring proper dignity bag was in place. **3) Measures put into place/ System changes:** **All Nursing staff was re-educated on Resident Rights/Exercise of Rights including but not limited to, maintaining resident dignity.** **Rounds will be completed on all residents who have a catheter bag at varied times and shifts to ensure dignity is maintained for those identified residents. These rounds will be completed at least 3 x per week for 2 weeks and 1 x a week until 100% compliance for 3 consecutive months. Any identified concerns will be promptly addressed with the responsible individual(s).** **The Director of Nursing will be responsible for oversight of these rounds.**	

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			4) How the corrective actions will be monitored: **The DON/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 11/28/22**	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review and interview, the facility failed to ensure residents received reasonable accommodations to meet their needs related to a toilet riser not fitted properly over the toilet and a call light not in reach for 2 of 79 residents observed for accommodation of needs. (Residents 182 and 63) Findings include:	F 0558	**F558 Reasonable Accommodations Needs/Preferences** *This Plan of Correction is the center's credible allegation of compliance.*	11/28/2022

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	1. On 11/1/22 at 10:49 a.m., Resident 182 was observed sitting on his bed in his room. He indicated the toilet riser over the toilet did not fit correctly. The toilet riser hole did not line up correctly over the toilet bowl. When he would sit on the riser to use the restroom his urine would hit the floor in front of him. He had to put towels down on the floor to catch the urine. He indicated he had been in the facility for a few weeks and had spoken to multiple staff about fixing the toilet riser to fit over the toilet correctly but no one had ever attempted to fix it. He indicated the CNAs would offer him use of a urinal. He had told them he preferred to use the toilet and did not like to use a urinal. The toilet riser over the toilet was observed to have a gap from the toilet riser hole and the toilet bowel. The bathroom floor had urine soaked towels on the floor in front of the toilet and a urine soaked roll of toilet paper on the floor. On 11/3/22 at 9:36 a.m., Resident 182 was observed sitting in his wheelchair in his room. He indicated he was discharging home from the facility that day. The same toilet riser was observed over the toilet and their were urine soaked towels on the floor in front of the toilet again. Record review for Resident 182 was completed on 11/3/22 at 9:00 a.m. Diagnoses included, but were not limited to, end stage renal disease and respiratory failure. The resident was admitted to the facility on 10/21/22. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 10/28/22, indicated the resident was cognitively intact.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken for those residents identified:** 1. Maintenance was notified at the time of survey for Resident #182 related to the toilet riser which was secured. Housekeeping was notified and bathroom was cleaned. 2. Resident #63's call light was placed within reach. **2. How the facility identified other residents:** **A**ll residents have the potential to be affected by this cited practice. **3. Measures put into place/ System changes:** Facility staff was re-educated on Reasonable Accommodations Needs/Preferences, including but not limited to, placement of call lights and informing maintenance of equipment that requires repairs.	

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	On 11/3/22 at 9:41 a.m., the MDS Coordinator was observed passing medications outside of the resident's room. She indicated she was unaware his toilet riser did not fit over the toilet. The aides should have let maintenance know. She would inform maintenance and remove the wet towels from the floor.2. On 11/2/22 at 1:07 p.m., Resident 63's call light was observed out of reach of the resident on the floor. Resident 63's record was reviewed on 11/7/22 at 9:13 a.m. Diagnosis included, but were not limited to, dysphagia (swallowing difficulty) following a stroke, dementia, and malnutrition. The Quarterly Minimum Data Set (MDS) assessment, dated 9/27/22, indicated the resident was moderately cognitively impaired for daily decision making. During the environmental tour with the Administrator on 11/4/22 at 2:10 p.m., she indicated she had no further information to provide. 3.1-3(v)(1)		Department Managers/Designees will complete assigned Angel Rounds at least 5 times weekly, at varied times, for 4 weeks to ensure resident call lights are within reach, and to observe resident equipment to ensure any needed repair is communicated to the Maintenance Director. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, Department Managers/Designees will complete Angel Rounds at least 5 times per month at varied times for 2 months to ensure resident call lights are within reach, and to observe resident equipment for needed repairs. Any identified concerns will be promptly addressed with the responsible individual(s). Department Managers/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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			4. Date of compliance: 11/28/2022	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to completing scheduled baths/ showers and providing nail care for 3 of 7 residents reviewed for ADL care. (Residents 34, 63 and 17) Findings include: 1. On 11/1/22 at 1:25 p.m., Resident 34 was observed lying in her bed. She indicated she did not always get her scheduled baths or her hair washed. The resident's record was reviewed on 11/7/22 at 2:05 p.m. The resident was admitted on 8/4/17. Diagnoses included, but were not limited to, fibromyalgia and rheumatoid arthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 9/6/22, indicated the resident was cognitively intact. She required extensive assist of 2 staff for bed mobility and transfers. The bathing tasks indicated the resident preferred bed baths on Monday and Thursday. Since October 1, 2022, she received a bed bath on 10/6, 10/17, 10/20, 10/27, 10/31 and 11/3. Bathing was marked as Not Applicable on 10/3, 10/13, and	F 0677	**F677 ADL Dependent Residents** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. Resident # 34 was immediately given a bed bath per resident's preference at the time of survey, and ongoing. 2. Resident # 63's nails were cleaned; however, resident continues to refuse allow staff to cut nails, care plan updated to reflect resident's	11/28/2022

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	10/24. There was no entry for 10/10. Interview with the Director of Nursing (DON) on 11/7/22 at 3:00 p.m., indicated staff should not be marking bathing as Not Applicable and if she refused, it should be marked as a refusal. 2. On 11/2/22 at 1:07 p.m., and 11/3/22 at 9:11 a.m., Resident 63 was observed in bed. His fingernails were long and had dark debris under them. On 11/7/22 at 9:08 a.m., his fingernails were observed to have been cleaned, but remained uncut. The resident's record was reviewed on 11/7/22 at 9:13 a.m. The resident was admitted on 5/5/22. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis on one side of the body) and dementia. The Quarterly MDS assessment, dated 9/27/22, indicated the resident had moderate cognitive deficits and required extensive assistance for personal hygiene. Interview with CNA 3, on 11/7/22 at 10:10 a.m., indicated nail care should be completed on every bath/ shower day. She did not know why it hadn't been completed, but would take care of today. 3. On 11/1/22 at 2:07 p.m., Resident 17 was observed lying in bed. The resident's hair appeared greasy and her fingernails had dark debris underneath them. The resident indicated she didn't receive bathing regularly and would like her hair washed. On 11/3/22 at 9:27 a.m., Resident 17 was observed lying in bed. The resident's hair appeared greasy still and she had dark debris underneath her fingernails. The resident indicated she still had		wishes and resident educated on the importance of proper hygiene. 3. Resident # 17 no longer resides at the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** Dependent residents who require assistance with ADL completion have the potential to be affected. An audit was conducted to identify those residents. This plan of correction applies to those residents identified. **3) Measures put into place/ System changes:** Nursing staff was re-educated on ADL Care Provided for Dependent Residents, including but not limited to, provision of showers/bed baths, nail care, and providing ADL care for residents unable to carry out activities of daily living and to ensure the residents receive good nutrition, grooming and hygiene. **4) How the corrective actions will be monitored:** The DON/Designee will complete Dignity Rounds at least 5 times	

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	not had any bathing. Record review for Resident 17 was completed on 11/3/22 at 11:55 a.m. Diagnoses included, but were not limited to, neurogenic bladder, multiple sclerosis, wound infection, malnutrition, anxiety, and depression. The Significant Change Minimum Data Set (MDS) assessment, dated 10/10/22, indicated the resident was cognitively intact. The resident required an extensive 2+ person assist for personal hygiene, a total 2+ person assist for bathing. The Preferences section of the assessment indicated it was very important to the resident to choose her bathing. The Bathing Tasks indicated the resident preferred a bed bath on Monday and Thursdays during the 2-10 shift. The Bathing Tasks for 10/1/22 through 11/3/22 was reviewed on 11/7/22. The resident had only received a bed bath with her hair being washed on 10/10/22, 10/27/22, and 11/3/22. There was no documentation marked to indicate the resident had refused any bed baths during that period. Interview with the Director of Nursing on 11/7/22 at 11:25 a.m., indicated the resident should be offered at least 2 bed baths a week. The staff should be documenting on the Bathing Tasks if the resident refused. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(E)		weekly, at varied times, for 4 weeks to ensure residents are provided with nail care and bathing. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, DON/Designee will complete Dignity Rounds at least 5 times per month at varied times for 2 months. Any identified concerns will be promptly addressed with the responsible individual(s). The DON/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/28/2022	
F 0680 SS=D Bldg. 00	483.24(c)(2)(i)(ii)(A)-(D) Qualifications of Activity Professional §483.24(c)(2) The activities program must be			

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	directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State.			
	Based on record review and interview, the facility failed to ensure the Activities Program was directed by a qualified professional. Finding includes: The employee records were reviewed on 11/9/22 at 10:15 a.m. The records lacked documentation related to the Activity Director's qualifications or certifications. Interview with the Human Resources Director on 11/9/22 at 3:39 p.m., indicated the Activity Director was promoted on 1/4/21 to her position, however she had not completed any certifications to be qualified for the position. 3.1-33(e)	F 0680	**F - 680** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken**	11/28/2022

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			for those residents identified: **Licensed Activity Director position was posted on Indeed 11-12-22.** **2. How the facility identified other residents:** **All residents have the potential to be affected by the cited practice.** **3. Measures put into place/ System changes:** **HFA and Human Resource Director (HRD) will review all facility applications for qualified candidates who meet the requirements for an Activity Professional.** **Regional Director of Memory Care and Activity Support will assist with development of monthly Activity calendar and will make weekly visits to the facility to evaluate implementation of the calendar. Additionally, a contracted Activity Consultant will be secured to make regular visits to the facility until a qualified Activities professional is hired.** **HRD/designee will be**	

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			responsible for auditing the Activity Director's employee file monthly to ensure the facility maintains a qualified Activity Director. **4. How the corrective actions will be monitored:** **The HRD/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5. Date of compliance:**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure post fall monitoring was	F 0684	F684	11/28/2022

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	155572	A. BUILDING 00 B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

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	completed timely for another resident for 1 of 5 residents reviewed for accidents. (Resident C) Finding includes: On 11/03/22 at 10:56 a.m., Resident C's record was reviewed. The resident was admitted on 2/15/19. Diagnoses included, but were not limited to, dementia, metabolic encephalopathy and chronic obstructive pulmonary disease. The resident was discharged on 9/6/22. A Significant Change Minimum Data Set assessment, dated 8/30/22, indicated the resident had severe cognitive impairment and required extensive assist of two for bed mobility and used a mechanical lift for transfers. A Reportable Event, dated 8/13/22, indicated the resident had been found on the floor next to her bed. She had been sent to the emergency room for evaluation. The resident was returned to the facility later that day with a C7 (cervical spine) fracture and staples to her head. The post fall charting was started on 8/16/22, there was no post fall documentation on 8/14 or 8/15/22. Interview with the DON on 11/3/22 at 1:51 p.m., indicated there was no post fall documentation for Resident C until 8/16/22 and should have been started the day of the fall. The current policy, "Fall Prevention Program", was provided by the DON on 11/3/22, indicated, "...Accident/ Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident C no longer resides at the facility; therefore, no further corrective action could be taken for this resident. 2) How the facility identified other residents:	

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	interventions...." This Federal tag relates to Complaint IN00388875. 3.1-45(a)		Residents who have sustained falls in the past 30 days have the potential to be affected. Thus, this plan of correction applies to those residents. An audit of documentation of resident falls in the last 30 days has been completed with any necessary corrections/revisions made accordingly. 3) Measures put into place/ System changes: Licensed nursing staff will be re-educated relative to Quality of Care, including but not limited to conducting thorough assessments, and documentation of those assessments, after a resident sustains a fall. Licensed nurses will be educated on proper use/completion of the fall prevention program and completion of appropriate assessments. Director of Nursing (DON), or Designee will review, daily, on scheduled days of work, during clinical meeting, ongoing,	

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			progress notes in an effort to ensure that appropriate, thorough assessments have been conducted and documented. Any identified concerns will promptly be addressed with the responsible individual(s). 4) How the corrective actions will be monitored: The DON/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/28/2022	

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F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure interventions were in place for a resident with a history of falls, which resulted in a fractured clavicle sustained during another fall for 1 of 5 residents reviewed for accidents. (Resident B) Finding includes: Resident B's record was reviewed on 11/3/22 at 9:20 a.m. The resident was admitted on 8/17/22. Diagnoses included, but was not limited to, dementia. A Significant Change Minimum Data Set assessment, dated 9/27/22, indicated the resident had significant cognitive impairment, and required extensive two person assistance for bed mobility. A Fall Care Plan, dated 8/18/22, indicated the resident was at high risk for falls due to generalized weakness and impaired cognition.	F 0689	p="" paraid="315832134" paraeid="{ed047ae6-881e-48c7-a214-751f2a55a88c}{162}">F689 Free of Accident Hazards/Supervision/Devices¿ This Plan of Correction is the center's credible allegation of compliance.¿ ¿ Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿ 1) Immediate actions taken for those residents identified¿ Resident B no longer resides at the facility; therefore, no further corrective	11/28/2022

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	Interventions included anticipate resident need, bed height where feet are flat on the floor, proper foot wear and encourage call light use. A Progress Note, dated 8/27/22, indicated the resident had been found on the floor next to her bed. She was complaining of pain and had decreased range of motion. She was sent to the emergency room (ER) for evaluation and returned to the facility with no major injury noted. Actions indicated an intervention of a floor mat was to be added. An Interdisciplinary Team Note, dated 8/29/22, indicated interventions and care plan were updated. The Fall Care Plan had no updates at that time. A Progress Note, dated 9/20/22, indicated the resident had again been found on the floor next to her bed. The resident was noted to have an injury to the left side of her head, so was sent to the ER for evaluation. The resident returned to the facility later that day with a diagnosis of a left clavicle fracture. Interview with the Director of Nursing (DON) on 11/4/22, indicated the intervention of a floor mat had not been implemented and the care plan had not been updated after the first fall on 8/27/22. The current policy, "Fall Prevention Program", was provided by the DON on 11/3/22, indicated, "...Accident/ Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions...."		action could be taken for this resident.¿ ¿ 2) How the facility identified other residents Residents who have sustained falls in the past 30 days have the potential to be affected. Thus, this plan of correction applies to those residents. An audit of documentation of resident falls in the last 30 days has been completed with any necessary corrections/revisions made accordingly.¿ ¿ 3) Measures put into place/ System changes: ¿ Licensed nursing staff will be re-educated relative to Quality of Care, including but not limited to conducting thorough assessments, and documentation of those assessments, after a resident sustains a fall. Licensed nurses will also be educated on proper use/completion of the fall prevention program, including implementation of appropriate fall prevention interventions post-fall. Director of Nursing (DON), or Designee will review, daily, on scheduled days of work, during clinical meeting, ongoing, progress notes in an effort to ensure that appropriate fall prevention interventions have been implemented with the same documented. Any identified concerns will promptly be addressed with the responsible individual(s). ¿ 4) How the corrective actions will be monitored¿ The DON/Designee	

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	This Federal tag relates to Complaint IN00388875. 3.1-45(a)		will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.¿ ¿ 5) Date of compliance: 11/28/2022¿ ¿	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to ensure residents	F 0692	F692 Nutrition /Hydration	11/28/2022

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	maintained acceptable parameters of nutritional status related to not obtaining a re-weight or having a dietician assessment completed after a significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident 63) Finding includes: The record for Resident 63 was reviewed on 11/7/22 at 9:13 a.m. The resident was admitted on 5/5/22. Diagnoses included, but were not limited to, dementia and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set assessment, dated 9/27/22, indicated the resident had moderate cognitive impairment and had a feeding tube. The resident's weight on 9/16/22 was 157 pounds (lbs), on 10/19/22 he weighed 146 lbs; there was an 11 lb weight loss, or 7% weight loss in one month. There was no re-weight completed. On 10/21/22, a weight change note, weight warning had been triggered in the Progress Notes. The resident was hospitalized from 9/17-9/20/22. There was not a new admission weight upon return to the facility. The current policy, "Weights", was received from the Director of Nursing (DON) on 11/7/22, indicated, "...Re-weight should be obtained if there is a difference of 5# or greater (gain or loss) since previous recorded weight...." and, "...Undesired or unanticipated weight gain/loss of 5% in 30 days...shall be reported to the physician, Dietician and/or Dietary Manager as appropriate...."		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.** Immediate actions taken for those residents identified: Resident # 63 was reweighed at the time of survey showing no significant weight loss. RD completed a nutritional assessment and determined that the residents nutritional needs are being met. **2.** How the facility identified other residents: The facility completed an audit to identify residents with significant weight changes. RD will review the identified and make recommendations, as needed.	

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	Interview with the DON on 11/7/22 at 10:20 a.m., indicated a significant weight change would trigger a warning. There should be a re-weight completed within three days, and the dietician should be notified to assess. She indicated she was not aware the resident had a significant weight loss that had been triggered. 3.1-46		**3.** Measures put into place/ System changes: Nursing staff was re-educated relative to Nutrition/Hydration Status Maintenance, including but not limited to, ensuring that changes in nutritional status are identified timely and assessed with recommended RD interventions implemented. DON, RD, or designee will review weights and the documentation relative to weights at least 5 days a week X 4 weeks, then 3 days a week X 4 weeks to identify those residents who have experienced a change in nutritional status, and to ensure interventions are implemented in timely manner. Any identified concerns will be promptly addressed with the responsible individual(s). **4.** How the corrective actions will be monitored: The DON/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5.** Date of	

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			compliance: 11/28/2022	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, record review and interview, the facility failed to ensure a resident with behaviors had interventions being implemented for 1 of 1 residents reviewed for mood/behavior. (Resident 22) Finding includes: On 11/2/22 at 10:59 a.m., Resident 22 was observed lying in bed. The resident was moaning/groaning and making a repetitive statement of "help me". A CNA was observed walking by the resident's room to retrieve a mechanical lift in the hallway. The CNA did not stop and check on the resident. The resident continued with the groaning/moaning and repetitive statement of "help me" until a CNA came in the room to talk to her at 11:40 a.m. On 11/4/22 at 1:53 p.m., the resident was observed lying in bed moaning/groaning and making repetitive statements of "help me". No staff were observed going into the room to check on the	F 0740	**F740 Behavioral Health Services** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	11/28/2022

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	resident. A continuous observation was completed on 11/7/22 from 1:30 p.m. through 3:13 p.m. The resident was lying in bed moaning/groaning and saying "help me". A housekeeper had gone into the room to clean the room and did not talk with the resident. The Receptionist went in to place papers on the roommate's bedside table and did not talk with the resident. The Social Service Director (SSD) was made aware at 2:16 p.m. and 2:35 p.m., about the resident's moaning/groaning and repetitive statement of "help me". The SSD walked by the resident's room but did not stop in the resident's room to check on the resident. The Assistant Director of Nursing (ADON) was made aware at 3:00 p.m. about the resident's behaviors & verbalizations. She also walked by the resident's room and did not stop in to check on the resident. CNA 2 and the Receptionist again were observed to walk into the room at 3:09 p.m. They both walked to the side of the roommate but did not stop to check on Resident 22 who was moaning and groaning. Record review for Resident 22 was completed on 11/7/22 at 9:54 a.m. Diagnoses included, but were not limited to, dementia and seizure disorder. The Annual Minimum Data Set (MDS) assessment, dated 8/31/22, indicated the resident was cognitively impaired. The resident had mood problems and physical behavior symptoms towards others. The resident's preferences indicated it was very important to her to listen to music, do things in groups of people, attend religious services and to do her favorite activities. A Care Plan, dated 7/25/19 and revised 8/30/19, indicated the resident had a behavior problem.		Resident #22's plan of care has been reviewed and physician/NP has completed a medication regimen review, care plan has been reviewed and revised, as necessary. **2) How the facility identified other residents:** Residents with behaviors have the potential to be affected by the cited practice. An audit was conducted to identify residents who exhibit behaviors, this plan of correction applies to identified residents. **3) Measures put into place/ System changes:** Facility staff was re-educated on Behavioral Health Services, including but not limited to, ensuring residents with behaviors have interventions implemented, reviewed, and revised, as necessary. **4) How the corrective actions will be monitored:** The SSD/Designee will complete visual observation rounds at least 5 times weekly, at varied times, for 4 weeks to identify any	

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	She would frequently yell out loudly, "I am hungry", "Give me something to eat", "help me" was common. Interventions included to encourage group activities and offer snacks. A Social Services Care Plan, dated 7/28/16 and revised 7/21/22, indicated the resident had a history of striking out at objects, staff, grabbing at other residents, yelling out "Help Me!" repeatedly. Interventions included to attempt any or all of the following to assist in redirection: toilet, snack, drink, reposition, move to quiet area, walk, reassurance, validation of feelings, rub back/arm, hold hand, turn music on/off, turn TV on/off, give incontinence care, pain management, lay down for nap, encourage to sit and rest, remove from agitation, dress for appropriate temp, approach by alternate caregiver, call family so resident can talk, give object to hold, give candy/gum, use humor, redirect when necessary, and provide 1 on 1's when necessary. Interview with the SSD on 11/7/22 at 2:16 p.m., indicated she could hear the resident moaning/groaning in her room and would have to look into what interventions were in place for the resident's behavior monitoring. Follow up interview at 2:35 p.m., indicated the resident received 1 on 1 visits. She used to like to read the bible and listen to music, but not so much anymore since the progression of her dementia. Staff should be trying interventions with the resident when she was saying repetitive statements of "help me" and moaning/groaning. Interview with the ADON on 11/7/22 at 3:00 p.m., indicated she could hear the resident moaning/groaning in her room and she would have staff take care of it.		resident(s) that may be exhibiting behaviors and will validate interventions have been attempted to decrease/eliminate the behavior(s). Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, SSD/Designee will complete visual observation rounds at least 5 times per month at varied times for 2 months. Any identified concerns will be promptly addressed with the responsible individual(s). The SSD/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/28/2022	

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	Interview with the Director of Nursing, MDS Coordinator and the ADON on 11/7/22 at 3:14 p.m., indicated staff should not be walking by the resident and ignoring her when she was calling out from her room. They should have attempted an intervention. Interview with the Activity Director on 11/9/22 at 10:54 a.m., indicated the resident received 1 on 1 activities 3 x a week in the morning. Since the resident seemed to be more awake after lunch she would switch her 1 on 1's to then. No one had told her she had been moaning/groaning in bed during the observed times. 3.1-43(a)(1)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food served to resident rooms was received hot for 1 of 2 units observed. This had the potential to affect 21 of 22 residents who resided on that unit. (North Hall) Finding includes:	F 0804	**F - 804** The facility requests desk review for this citation. ***This Plan of Correction is the center's credible allegation of compliance.***	11/28/2022

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(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 11/7/22 at 12:14 p.m., lunch trays were delivered to the North Hall. The carts were open with no doors, and the plates were covered with a plastic dome lid, there was no bottom portion of the plate/ lid combination used to help keep food warm. On 11/07/22 at 12:19 p.m., a test lunch tray was obtained from the serving cart on the North Hall. The Kitchen Employee use a food thermometer and obtained the following food temperatures: - mashed potatoes: 125 degrees. - meatloaf: 108 degrees - mixed vegetables: 117 degrees The meatloaf was sampled and noted to be luke warm to cold. Interview with the Kitchen employee at that time, indicated she had no idea what temperature the food should be when served to residents. Interview with Resident 34, who resided on the North Hall, on 11/7/22 at 1:10 p.m., indicated the food was always served cold. 3.1-21(a)(2)		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified:** **Dietary Staff were in-serviced immediately regarding Food Safety Requirements with return demonstration temping food properly.** **2) How the facility identified other residents:** **All residents have the potential to be affected by the cited practice.** **3) Measures put into place/ system changes:** **Dietary Staff was In-Serviced on 11-20-22 relative to Nutritive Value/Appear, Palatable/Prefer Temp, including but not limited to ensuring food served to resident rooms is hot, ensuring**	

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	155572	A. BUILDING 00 B. WING	11/09/2022

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			that bottom portion of the plate/lid is used to keep food warm, policy regarding food temperatures, and test trays. **An audit will be conducted 3XS weekly, at every meal, by HFA/Food Service Director/Designee for 1 month to ensure food is served at proper temperature. Thereafter, these audits will be conducted randomly at mealtime at least 5X weekly for 2 months. Any identified concerns will be promptly addressed with the responsible individual(s).** **4) How the corrective actions will be monitored:** **HFA/Food Service Director/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 11/28/22**	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to unlabeled, undated and improperly stored food, unpasteurized eggs and staff not cleaning a utensil prior to use in the main kitchen. This had the potential to affect 86 of 87 residents who consumed food prepared in the main kitchen. Findings include: 1. During the initial tour of the kitchen on 11/1/22 at 9:22 a.m., with the Housekeeping Supervisor (HS) the following observations were made in the walk in refrigerator:	F 0812	**F - 812** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	11/28/2022

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	- There were two crates with milk in them sitting directly on the floor. - There was an open bag of blue cheese, undated. - There were 8 fruit cups, uncovered and undated. - Only unpasteurized eggs were available. In the dry storage room: - A bin of oatmeal was uncovered. - A case of bleach was stored directly next to the oatmeal bin. - Three cereal bins on shelf were not labled or dated. 2. During a follow up visit to the kitchen on 11/7/22 at 11:12 a.m., the Kitchen Employee was observed preparing to take food temperatures. She reached into a plastic bin holding utensils and found the thermometer, which was uncapped. Without cleaning the thermometer, she prepared to put it in the meat on the holding cart. The employee was stopped and asked if she should clean the thermometer first. She indicated it should be cleaned first. The current policy, "Labeling and Dating Foods", was received from the HS on 11/1/22, indicated, "...Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date...." The current policy, "Monitoring Food Temperatures for Meal Service", was received from the Administrator on 11/9/22, indicated, "...thermometers are washed, rinsed, sanitized before and after each meal use...." Interview with the HS during the initial tour, indicated the previous dietary manager always stored milk like that and items should be covered and labeled. She indicated she would contact the		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. All items listed were corrected at the time of survey, pasteurized eggs were obtained. 2. The Kitchen Employee was re-educated at the time of survey. Additionally, Dietary staff and Housekeeping Supervisor were in-serviced immediately regarding Food Procurement, storage/preparedness, and sanitation. **2) How the facility identified other residents:** All residents have the potential to be affected by the cited practice. **3) Measures put into place/ System changes:** Dietary staff was in-serviced on 11-20-22 relative to Food Procurement, Store/Prepare/Serve-Sanitary, including but not limited to, ensuring food is stored properly, and cleaning utensils are cleaned	

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	food supplier immediately and get pasteurized eggs. 3.1-21(i)(3)		prior to use. An audit will be performed 3XS weekly, at every meal and randomly throughout the day, by HFA/Food Service Director/Designee times 3 months to ensure food service safety. Any identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** The HFA/Food Service Director/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/28/22**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			

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	Based on observation and interview, the facility failed to keep the resident's environment clean and in good repair related to dirty toilets and dirty towels on the bathroom floor for 2 of 3 halls throughout the facility. (North and West Halls) Findings include: During the Environmental tour on 11/4/22 at 2:10 p.m., the following was observed: 1. North Hall a. Room 3 - The toilet was dirty. Two residents resided in the room and two residents shared the bathroom. b. Room 12-B - A brown colored substance was noted to two areas on the resident's blanket. During an interview with the Administrator during the tour, she indicated the above areas needed to be cleaned. 2. West Hall a. Room 118 - There were wet urine-soaked towels and toilet paper on the floor surrounding the toilet during a random observation on 11/1/22 at 10:49 a.m. During an interview with the MDS Coordinator on 11/3/22 at 9:41 a.m., indicated she was unaware his toilet riser did not fit. This Federal tag relates to Complaint IN00388875. 3.1-19(f)	F 0921	**F – 921 Sanitary Environment** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1. Immediate actions taken for those residents identified:** **1. & 2. All items listed were immediately corrected at time of Survey. Housekeeping staff was re-educated at time of survey regarding maintaining a clean environment for residents.** **2. How the facility identified other residents:** **All residents have the potential to be affected by the cited practice.** **3. Measures put into place/ System changes:**	11/28/2022

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			All staff were in-serviced on 11-20-22 relative to Safe/Functional/Sanitary/Comfortable Environ, including but not limited to, maintaining a clean environment and maintenance notification of resident equipment requiring repairs. **Environmental Supervisor/Designee will be responsible to conduct random visual observation rounds 3XS weekly of resident rooms.** Department Managers/Designees will complete assigned Angel Rounds at least 5 times weekly, at varied times, for 4 weeks to ensure resident rooms are clean, and to observe resident equipment to ensure any needed repair is communicated to the Maintenance Director. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, Department Managers/Designees will complete Angel Rounds at least 5 times per month at varied times for 2 months to ensure resident call lights are within reach, and to observe resident equipment for needed repairs. Any identified concerns will be promptly addressed with the responsible individual(s).	

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			4. How the corrective actions will be monitored: Department Managers/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 11-28-22**	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing in-service education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and	F 9999	**R 120** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	11/28/2022

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	dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure staff completed the required annual in-services for 3 of 10 employee records reviewed. (LPN 1, Dietary Aide 1, and LPN 2) Findings include: The employee records were reviewed on 11/9/22 at 10:15 a.m. 1. LPN 1 was hired on 9/5/18. Her record lacked evidence she had completed annual training in 2021 for abuse, and resident rights. She completed 2 hours for dementia training. 2. Dietary Aide 1 was hired on 11/24/17. His record lacked evidence he had completed annual training in 2021 for resident rights. He completed 1.75 hours for dementia training. 3. LPN 2 was hired on 5/1/18. Her record lacked evidence she had completed annual training in 2021 for abuse, dementia, and resident rights. Interview with the Assistant Director of Nursing (ADON) on 11/9/22 at 11:45 a.m., indicated she had no further information.		*federal and state law.* **1) Immediate actions taken for those residents identified:** **Human Resource Director immediately contacted LPN 1, LPN 2 and Dietary Aide 1 to schedule for competition of required In-Services.** **2) How the facility identified other residents:** **All residents have to potential to be affected by this cited practice.** **3) Measures put into place/ System changes:** **An All-Staff In-Service will be performed on 11-23-22 and 11-25-22 regarding annual in-service requirements and completion of these in-services.** **HR Director/Designee will conduct an audit 1X weekly for 3 months until 100% compliance is achieved, and requirements are met. Any identified concerns will be promptly addressed with responsible individual(s).**	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00388875, IN00390631 and IN00393816. Complaint IN00388875 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F689 and F921. Complaint IN00390631 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393816 - Substantiated. No	R 0000	**4) How the corrective actions will be monitored:** **HR Director/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **11-28-22**	

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	deficiencies related to the allegations are cited. Survey dates: November 1, 2, 3, 4, 7 and 9, 2022. Facility number: 000471 Residential Census: 8 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/14/22.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents			

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	effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff completed the required annual inservices for 3 of 10 employee records reviewed. (LPN 1, Dietary Aide 1, and LPN 2) Findings include: The employee records were reviewed on 11/9/22 at 10:15 a.m. 1. LPN 1 was hired on 9/5/18. Her record lacked evidence she had completed annual training in 2021 for resident rights. She completed 2 hours for dementia training. 2. Dietary Aide 1 was hired on 11/24/17. His record lacked evidence he had completed annual training in 2021 for resident rights. He completed 1.75 hours for dementia training. 3. LPN 2 was hired on 5/1/18. Her record lacked evidence she had completed annual training in 2021 for dementia and resident rights. Interview with the Assistant Director of Nursing (ADON) on 11/9/22 at 11:45 a.m., indicated she had no further information.	R 0120	**R 120** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Human Resource Director immediately contacted LPN 1, LPN 2 and Dietary Aide 1 to schedule for competition of**	11/28/2022

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			required In-Services. **2) How the facility identified other residents:** **All residents have to potential to be affected by this cited practice.** **3) Measures put into place/ System changes:** **An All-Staff In-Service will be performed on 11-23-22 and 11-25-22 regarding annual in-service requirements and completion of these in-services.** **HR Director/Designee will conduct an audit 1X weekly for 3 months until 100% compliance is achieved, and requirements are met. Any identified concerns will be promptly addressed with responsible individual(s).** **4) How the corrective actions will be monitored:** **HR Director/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for**	

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			review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11-28-22**	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to unlabeled, undated and improperly stored food, unpasteurized eggs and staff not cleaning a utensil prior to use in the main kitchen. This had the potential to affect 86 of 87 residents who consumed food prepared in the main kitchen. Findings include: 1. During the initial tour of the kitchen on 11/1/22 at 9:22 a.m., with the Housekeeping Supervisor (HS) the following observations were made in the walk in refrigerator: - There were two crates with milk in them sitting directly on the floor. - There was an open bag of blue cheese, undated. - There were 8 fruit cups, uncovered and undated.	R 0273	**R-273** The facility requests desk review for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	11/28/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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
	- Only unpasteurized eggs were available. In the dry storage room: - A bin of oatmeal was uncovered. - A case of bleach was stored directly next to the oatmeal bin. - Three cereal bins on shelf were not labled or dated. 2. During a follow up visit to the kitchen on 11/7/22 at 11:12 a.m., the Kitchen Employee was observed preparing to take food temperatures. She reached into a plastic bin holding utensils and found the thermometer, which was uncapped. Without cleaning the thermometer, she prepared to put it in the meat on the holding cart. The employee was stopped and asked if she should clean the thermometer first. She indicated it should be cleaned first. The current policy, "Labeling and Dating Foods", was received from the HS on 11/1/22, indicated, "...Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date...." The current policy, "Monitoring Food Temperatures for Meal Service", was received from the Administrator on 11/9/22, indicated, "...thermometers are washed, rinsed, sanitized before and after each meal use...." Interview with the HS during the initial tour, indicated the previous dietary manager always stored milk like that and items should be covered and labeled. She indicated she would contact the food supplier immediately and get pasteurized eggs.		**1) Immediate actions taken for those residents identified:** 1. All items listed were corrected at the time of survey, pasteurized eggs were obtained. 2. The Kitchen Employee was re-educated at the time of survey. Additionally, Dietary staff and Housekeeping Supervisor were in-serviced immediately regarding Food Procurement, storage/preparedness, and sanitation. **2) How the facility identified other residents:** All residents have the potential to be affected by the cited practice. **3) Measures put into place/ System changes:** Dietary staff was in-serviced on 11-20-22 relative to Food Procurement, Store/Prepare/Serve-Sanitary, including but not limited to, ensuring food is stored properly, and cleaning utensils are cleaned prior to use. An audit will be performed 3XS weekly, at every meal and randomly throughout the day, by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	11/09/2022

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			HFA/Food Service Director/Designee times 3 months to ensure food service safety. Any identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** The HFA/Food Service Director/Designee will provide the audit results to the Quality Assurance Committee during monthly meetings for review x6 months, or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/28/22**	