STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
JOURNEY SENIOR LIVING OF VALPARAISO	74 E JOURNEY WAY VALPARAISO, IN 46383

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey date: March 16, 2020 Facility number: 014081 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/19/20.	R 0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility is also requesting a desk review for compliance in these areas.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident with known behaviors of exit seeking who resided on the locked memory care unit did not elope from the facility for 1 of 8 residents reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 3/16/2020 at 11:02 a.m. Diagnoses included, but were not limited to, dementia with behaviors and anxiety. The resident resided on the locked memory care unit in the facility.	R 0052	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** All staff inserviced on proper communication and tasks regarding those residents at risk of exit-seeking. Visitor signage remains in place at memory care doors. **How will you identify other residents having potential to be affected by the same deficient**	06/01/2020

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

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	A Memory Care Assessment, dated 10/6/19, indicated the resident was moderately cognitively impaired. The resident would wander frequently. There were no wander guards at the facility but the resident required frequent checks and constant monitoring due to constant exit seeking. A reportable elopement incident occurred on 1/5/2020 at 1:18 p.m.. The resident was noted by staff to be in the parking lot and was escorted back into the facility. The resident was placed on 15 minute checks, and visitor signs were created and placed on all secure unit doors. The staff was educated on additional re-directional ideas for the resident. The Elopement Evaluation, dated 1/5/2020, indicated the resident was disoriented daily. The resident had attempted to leave or had left the building in the past and had 3+ events of exit seeking behavior in the past 30 days. The resident was placed on 15 minute checks x 72 hours. A Nursing Note, dated 1/5/2020 at 1:40 p.m., indicated the resident noted to be exit seeking earlier in the shift. The nurse was assisting other "guests" and then lost sight of "guest". The nurse immediately followed up with other staff who indicated they did not have eyes on the resident. The staff looked in all the rooms and main living areas. The resident was located several minutes later at 1:18 p.m. in the parking lot. The resident was difficult to redirect, was visibly cold and confused. The nurse and other staff escorted the resident back into the facility. The resident was assessed and placed on 15 minute checks.		**practice?** Any resident who resides on the secure Memory Care unit has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?** On 1/6, ED implemented new protocol for front desk breaks to ensure there is constant coverage at the front desk. Nursing staff inserviced on proper documentation for exit-seeking behaviors, noting all interventions attempted. All staff inserviced on proper communication when exit-seeking behaviors occur. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** An Elopement assessment will be done weekly on Resident 7. Director of Wellness and/or designee will audit the memory care charts of all residents who actively exit-seek to ensure documentation is being done. Resident 7's chart will additionally be audited weekly for the completion of the Elopement assessment. The Director of Wellness and/or designee will bring the results of audits to the quarterly QA meeting for review and recommendations. Any	

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	Interview with the Administrator on 3/16/2020 at 1:08 p.m., indicated she was unsure if all the staff was aware that day of the resident's exit seeking behavior. When the nurse had to attend to other residents, the staff should have been with the resident to keep her pre-occupied. There were family of another resident in the locked memory care unit that day. They believe the resident had followed the family out the locked memory care doors and then out of the facility doors. Interview with the Director of Wellness on 3/16/2020 at 1:50 p.m., indicated the resident had behaviors of exit seeking. The nurses should have been documenting the behaviors and what interventions they had attempted. On the day of the elopement, all staff should have been aware of the resident's behavior of exit seeking and been attempting interventions with her. Interview with CNA 1 on 3/16/2020 at 2:53 p.m., indicated the resident had exit seeking behavior on many days. They would do interventions with her. Sometimes the interventions would work and sometimes she would just get angry. They would tell the nurse of the resident's behavior and what interventions they tried on her. A follow up interview with the Administrator on 3/16/2020 at 3:00 p.m., indicated the nurse who was working on the day of the elopement no longer worked at the facility. The staff were aware that day of the resident's behaviors of exit seeking. They did not do 1 on 1 interventions with the resident but should have. The staff member who was stationed at the front entrance lobby of the facility had gone on break during the time of the elopement. That staff member did not tell any other staff members they were going on break.		recommendations made by the committee will be followed up by the Director of Wellness and results brought to next meeting. This will continue for 6 months. Monitoring ongoing.	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure the Service Plan was updated and signed by the resident and/or their responsible party for 2 of 8 records reviewed. (Residents 3 and 8) Findings include:	R 0217	R217 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Director of Wellness had Resident 3 sign own service plan on	06/26/2020

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	1. The record for Resident 3 was reviewed on 3/16/20 at 10:22 a.m. Diagnoses included, but were not limited to, depression and hypertension. The resident was admitted to the facility on 1/4/20. An Admission Senior Living Assessment was completed on 1/10/20. There was no signature noted of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted. Interview with the Director of Wellness (DHS) on 3/17/20 at 1:50 p.m., indicated the resident was alert and oriented and could sign her own Service Plan. It had been overlooked and had not been signed by the resident.2. Resident 8's record was reviewed on 3/16/2020 at 10:38 a.m. Diagnoses included, but were not limited to, dementia, heart failure, kidney disease and high blood pressure. His admission date was 12/16/2019. A Physician's Order, dated 1/27/2020, indicated the resident was to have Physical Therapy to improve his strength. A Nurse's Note, dated 1/29/2020 at 1:16 p.m., indicated Physical Therapy was there and worked with the resident. The Admission Service Plan, dated 12/19/2019, lacked a signature from the resident or the resident's representative. The record lacked an updated Service Plan after therapy services began. Interview with the Director of Wellness on 3/16/2020 at 1:29 p.m., indicated the resident did receive therapy services, the Service Plan was not updated and the resident's representative did not		3/18/20. Resident 8 had expired while out of the community on 3/15/20. Director of Wellness and/or designee audited all charts to ensure all service plans have the signature of the resident and/or responsible party. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?** Director of Wellness re-educated on ensuring every resident and/or responsible party given a chance to review service plan, agree to service plan and to obtain a signature. Director of Wellness also re-educated that if there are any changes to resident care, a new service plan is to be done and new signatures are to be obtained. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Wellness and/or designee will audit all residents chart weekly to ensure that all service plans have been signed by	

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	sign the Admission Service Plan. A policy titled, "Individualized Service Plan," was provided by the Director of Wellness on 3/16/2020 at 2:25 p.m. This current policy indicated, "...It shall evaluate the physical, emotional and social needs of the resident and how the community can meet those needs...The Individualized service Plan should be signed by the resident or responsible party through signature...."		the resident and/or responsible party. The Director of Wellness and/or designee will bring the results of audits to the quarterly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Wellness and results brought to next meeting. This will continue for 6 months. Monitoring is ongoing.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurate related to documenting an admission weight for a new resident and obtaining Physician Orders for a resident self administering medications for 2 of 8 records reviewed. (Residents 5 and 3) Findings include: 1. The record for Resident 5 was reviewed on 3/16/20 at 3:55 p.m. The resident was admitted to the facility on 2/4/20.	R 0349	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Director of Wellness requested physician order for self-administration of meds for resident 3 on 3/18/20. Director of Wellness and/or designee audited all charts to ensure admission orders are in place and items needed upon admission, such as weight, have been done.	06/01/2020

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	The record lacked an admission weight. Interview with the Wellness Director on 3/16/20 at 5:20 p.m., indicated the resident been admitted on 2/4 and sent to the hospital on 2/8/20 and somehow the admission weight had been overlooked. 2. On 3/16/20 at 4:25 p.m. Resident 3 was observed seated in her recliner chair in her room. She was alert and oriented and indicated she self-administered her medications. The record for Resident 3 was reviewed on 3/16/20 at 10:22 a.m. Diagnoses included, but were not limited to, depression and hypertension. The resident was admitted to the facility on 1/4/20. An Admission Senior Living Assessment was completed on 1/10/20 and indicated the resident self-administered her medications, passed the medication knowledge assessment, and did not have an order to self-administer medications on record. The record lacked any Physician's Order for the resident's self administration of medications. Interview with the Director of Wellness (DHS) on 3/17/20 at 1:50 p.m., indicated the resident was alert and oriented and self-administered all her medications except the narcotics. She was unable to find a Physician's Order for the self administration of the medications.		**How will you identify other residents having potential to be affected by the same deficient practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?** Corrective action given to the staff who were responsible for both resident 5 and resident 3's admission. Nursing staff inserviced on move in processes, including the Move-in assessment that was new to staff at the time of resident 5 and 3's move in. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Wellness and/or designee will audit all resident charts weekly to ensure that admission orders are in place, weights and all the necessary processes for an admission are documented. The Director of Wellness and/or designee will bring the results of audits to the quarterly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up	

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			by the Director of Wellness and results brought to next meeting. This will continue for 6 months. Monitoring is ongoing.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure a current emergency file was complete for 4 of 5 residents reviewed. (Residents 2, 3, 4, and 5) Findings include: The facility's Memory Care and Assisted Living Emergency File Binders were reviewed on 3/16/20 at 10:30 a.m. The following files were not complete: 1. Resident 2's file lacked a hospital preference	R 0356	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 2's hospital and physician preference information updated in binder as of 3/17/20. Resident 3's hospital preference, family contact information and physician preference information updated in binder as of 3/17/20. Resident 4's family contact	06/01/2020

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	and a Physician preference. 2. Resident 3's file lacked a hospital preference, family or responsible party contact information, and Physician preference. 3. Resident 4's file lacked family or responsible party contact information. 4. Resident 5 did not have a file in the binder. Interview with the Director of Wellness on 3/16/20 at 1:56 p.m., indicated the files were not complete.		information updated in binder as of 3/17/20. Resident 5's information completed and placed in binder on 3/17/20. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?** Director of Wellness and Front Operations coordinator inserviced on what needs to be placed in emergency binder for each resident within the community. Copy of list of items required placed in front of exit binder for future reference. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Wellness and/or designee will audit the exit binders weekly to ensure that all required emergency information is completed and in the binder. The Director of Wellness and/or designee will bring the results of audits to the quarterly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by	

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			the Director of Wellness and results brought to next meeting. This will continue for 6 months. Monitoring is ongoing.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident had a documented two step Mantoux (test for tuberculosis) completed upon admission in to the facility for 1 of 2 closed records reviewed. (Resident 8) Finding includes: Resident 8's record was reviewed on 3/16/2020 at 10:38 a.m. Diagnoses included, but were not limited to, dementia, heart failure, kidney disease	R 0410	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 8 never returned to the community due to expiring on 3/15/20. **How will you identify other residents having potential to be affected by the same deficient**	06/01/2020

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	and high blood pressure. His admission date was 2/16/2019. The first Mantoux test was completed on 12/21/2019 and was negative. The record lacked a completed second Mantoux test. Interview with the Director of Wellness on 3/16/2020 at 1:29 p.m., indicated the second Mantoux test was missed. A policy titled, "TB (Tuberculosis) Tracking: Residents," was provided by the Director of Wellness on 3/16/2020 at 2:25 p.m. The current policy indicated, "...The second step must be administered no less than 7 days after the initial step is read...."		**practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?** Corrective action given to Director of Wellness and TB certified nurse regarding the assurance of administering TB testing accurately and timely. Nursing staff educated on the updated TB administration process. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Wellness and/or designee will audit resident charts weekly to ensure that all residents TB's are done timely and completed correctly. The Director of Wellness and/or designee will bring the results of audits to the quarterly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Wellness and results brought to next meeting. This will continue for 6 months. Monitoring is ongoing.	