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	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND TERRACE OF DANVILLE	200 S ARBOR LANE DANVILLE, IN 46122

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00433770. Complaint IN00433770 - State deficiencies related to the allegations are cited at R0215. Survey dates: June 11 and 12, 2024. Facility number: 014518 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 21, 2024.	R 0000	This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one			

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

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	(1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure all Certified Nursing Aides (CNA) were licensed while working with residents in the facility. This deficiency had the potential to affect 45 of 45 residents residing in the facility. Findings include: On 6/12/24 at 10:15 a.m., CNA 10's license was found to be expired on 4/8/24. During an interview, on 6/12/24 at 11:42 a.m., the Executive Director (ED) indicated she talked with CNA 10 and learned that CNA 10's expectation was the State would contact her prior to her license expiration date. During an interview, on 6/12/24 at 11:45 a.m., CNA 10 indicated she checked her license status on 4/11/24 and found it was expired. She indicated she had 90 days after the license expired to renew it. She tried to renew her license, but was unable. She was unaware that she needed a license in good standing to work with residents. She indicated she called a government web site to learn how to renew her license once it was expired. She indicated she would provide further information and dates. She left 2 voice messages to an unknown person(s). She did reach someone on an unknown date, they indicated they would sent her a temporary code, this was about 3 weeks ago. She did not receive the temporary code in the mail. CNA 10 indicated the Business Office Manager (BOM) informed her, on or about 4/16/24, that her license was expired.	R 0118	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Staff member 10 was immediately suspended from working until certification was brought to active status. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Please see the measures described directly below. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The Care Team Manager or will be responsible for tracking staff certification expiration dates and communicating any upcoming expirations to the Executive Director on a weekly basis. A certifications binder with monthly tabs has been created to track staff certifications. Staff will be notified 1 month in advance to timely renewal certifications. If certification is not renewed timely, the staff member will be removed from the schedule on their expiration date and not permitted to work until their certification is active. How be monitored to ensure the deficient practice will not recur; i.e.; what quality	07/15/2024

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	During an interview, on 6/12/24 at 11:49 p.m., the ED indicated she was not aware of CNA 10's license being expired prior to this day. She had been completing the healthcare workers schedules since 4/1/24. She would remove CNA 10 from the schedule starting now. During an interview, on 6/12/24 at 11:56 a.m., the ED indicated CNA was a full-time employee getting 40 hours per week. She would be removed from the schedule immediately and will be on leave until her license was renewed. The BOM was part of the leadership team and should have informed her of the expired license. During an interview, on 6/12/24 at 12:02 p.m., the BOM indicated she texted CNA 10 about her license being expired on 4/12/24 and 4/24/24. The BOM indicated she was not aware that CNA 10 could not work without a license. On 6/12/24 at 12:52 p.m., the BOM provided CNA 10's actual working hours from 4/9/24 to 6/12/24. A review of this document indicated CNA 10 worked as a CNA for 41.5 days after her license was expired. A caregiver job description, dated and signed by CNA 10 on 9/16/22, indicated, " ...Executes daily, weekly, and monthly caregiver task assignments including helping residents with activities of daily living such as grooming, assistance with eating, and other care giving services to residents ...Attends and participate in all required trainings, team meetings, town hall meetings, online learning resources, and others as required ...By signing below, I acknowledge that I have reviewed, understand and am able to fulfill the caregiver role and responsibilities and will immediately notify my supervisor if I am ...unable to fulfill the		assurance program will be put into place? The Executive Director will review the certification binder and meet with the Care Team Manager or to review staff certifications with upcoming expiration dates to ensure staff are not schedule to work without first verifying certifications are active.By what date be completed? 7/15/24	

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	responsibilities of my role at any time ...."			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure general and/or specific orientation	R 0119	What corrective action(s) will be accomplished for those residents	07/31/2024

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	was provided to employees upon hire for 1 of 5 employees' records reviewed. These deficiencies had the potential to affect 45 of 45 residents residing in the facility. Findings include: On 6/12/24 at 9:00 a.m., employee files were reviewed. Qualified Medication Aide (QMA) 14 did not have a record of specific orientation upon hire. During an interview on 6/12/24 at 9:38 a.m., the Executive Director (ED) was informed of the missing documentation, and she was asked for additional information. By the exit of the survey on 6/12/24 at 2:08 p.m., no additional information was provided.		found to have been affected by the deficient practice? QMA 14 will complete the Team Member Orientation specific to our company which includes sections on the needs of specialized populations, aged, dementia, policies and procedures, resident rights, employee policies, emergency preparedness, ethical considerations and confidentiality in residential care and records, documentation by 7/19/24. Once completed, a certificate will be documented in QMA 14's employee file. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit of employee files will be done to determine if any other team members need to participate in Team Member Orientation. Team Member Orientation sessions will be held as necessary to bring all employees to compliance. Certificates of completion will be documented in each employee file. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Team Member Orientation will be offered for each new hire group weekly so that no one is missed in the future. Completion will be tracked via a new hire spreadsheet with the Business Office Manager and reviewed with	

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			the Executive Director weekly. How be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place? The new hire spreadsheet will be spot checked against the employee files for accuracy once per month by the Executive Director. By what date be completed? 7/31/24	
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 effectively and to gain understanding of the			

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	current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure employee initial education was completed during the hiring process for 2 of 5 employee records reviewed. This deficiency had the potential to affect 45 of 45 residents residing in the facility. Findings include: On 6/12/24 at 9:00 a.m., employee files were reviewed. On 1/10/24, Qualified Medication Aide (QMA) 15 was hired. After a review of her employee file, the facility had no records of her resident rights and abuse education prior to working with residents. On 1/20/24, Concierge 16 was hired. After a review of her employee file, the facility had no records of her abuse education. During an interview on 6/12/24 at 9:38 a.m., the Executive Director (ED) was informed of the missing documentation, and she was asked for additional information. By the survey exit on 6/12/24 at 2:08 p.m., no additional information was provided.	R 0120	p="" paraid="368318962" paraeid="{ab456abf-8d45-45f6-9eea-c7426d1f8a27}{23}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? QMA 15 will complete the resident rights and abuse education. Documentation will be filed in the employee file. Concierge 16 will complete abuse education and documentation will be filed in the employee file. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit of the employee files will be done to determine if any additional staff members need to complete resident rights education or abuse education. Education will be and documentation will be filed in the employee's file. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?	07/31/2024

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			ul="" role="list" Resident Rights education and Abuse education will be part of the Team Member Orientation and employees will be reeducated annually. How be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place? The business office manager will monitor training due and completion reports of new hires and current employees on a monthly basis and report any follow-up needed to the Executive Director.By what date be completed? 7/31/24	
R 0156 Bldg. 00	410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24. Based on observation and interview, the facility failed to thaw meat per policy, remove spoiled milk from the refrigerator, and date items in the refrigerator once opened for 1 of 1 kitchen observation. Findings include: During a kitchen tour on 6/11/24 at 10:00 a.m., 4 packages of meat inside a clear wrapper were observed in a sink thawing. There was no water observed flowing onto the meat in the sink compartment. Inside the refrigerator were 2 gallons of whole milk. One gallon expired on 6/7/24 and the other expired on 6/8/24.	R 0156	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" The Community disposed of all undated food and staff were educated staff were educated on the Flow of Food/Thawing Food Policy and safe food handling procedures. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" Please see the measures provided	07/31/2024

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	Inside the refrigerator were open jars of food. They lacked dates to indicate when they were opened. The items were ice cream, egg salad, salsa, jelly, mayonnaise, thousand island dressing, cole slaw, barbeque sauce, mustard, and cocktail sauce. During an interview with the Executive Director (ED) on 6/12/24 at 12:42 p.m., she indicated the meat should have had water running over it, the milk should have been removed, and the jars should have been dated. A policy titled, "Flow of Food/Thawing Food," was provided by the ED on 6/12/24 at 1:32 p.m. It indicated, "...Cold running water (70 degrees or below) may be used. Food should be in a clean container with enough water flow to wash away blood and debris. Cook immediately after thawing ...."		below. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Food will be labeled and dated and staff will proper dates for service. Food will be thawed per policy and procedures with cool running water and cooked immediately or refrigerate after thawed. How be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place? The Culinary Service Manager or will monitor staff daily for compliance with safe food handling practices and provide real time documented training as warranted with documentation of training filed in applicable staff personnel files. The Executive Director will spot check monthly for accuracy. By what date be completed? 7/31/24	
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on interview and record review, the facility failed to ensure a resident (Resident B) who had a	R 0215	What corrective action(s) will be accomplished for those residents	07/31/2024

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	history of repeated falls, received appropriate and person-centered assessments, goals and/or interventions to prevent the potential for continued falls for 1 of 3 residents reviewed for accidents. Findings include: During an interview on 6/11/24 at 12:45 p.m., Resident B's wife met with the previous DON and a therapist for a care plan meeting on 3/6/24. During that meeting, she questioned the previous DON and therapist's decision to take his Rollator walker away from him. The DON and Therapist believed that having his walker within reach "enticed him to get up," and she was told by another nurse at the time, "he could not have his walker because it would be considered 'entrapment' as he could and hurt himself with the walker." Resident B's wife argued that he had used the walker for so long, that taking it away from him with his dementia could have a devastating outcome. He had already had multiple falls while he used the walker, but because he had it, she believed he had been able to hold onto it as he went down so that he did not land as hard. As soon as they removed the walker, he fell and fractured his hip so badly the ball of the femur had been dislodged from the socket and required surgical repair. Resident B's wife indicated, not only had they removed the walker out of his reach but kept it in his room within line of sight and put a sign on it which read, "Rollator is to be out of reach from [Resident B] when staff is not present." Resident B's wife indicated that he had dementia, he could not read or understand the sign. "He was not treated appropriately and that the note that was placed on the Rollator due to it being out of reach was so wrong for them to do ..." Resident B's wife indicated, the previous DON		found to have been affected by the deficient practice? Resident B no longer resides in the community.How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Health and Wellness Director, or designee , will document fall interventions in resident service plans as warranted.What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The Health and Wellness Director, or designee, will provide education nursing staff on the Fall Management policy with training documented in the staff personnel files.How be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place? To Support adherence to the Fall Management policy and procedures, for residents with up to three falls in a month, the Health and Wellness Director or designee, will review fall interventions for effectiveness for six (6) months with retraining provided as warranted and training documented in applicable staff personnel files.By what date be completed? 7/31/2024	

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	told her that she needed to find a different facility for him or pay for a one-on-one sitter. This upset her because he was supposed to have adequate supervision and assistance since he was admitted in the secured memory care unit for specialized programming to address his dementia needs. On 6/11/24 at 10:15 a.m., Resident B's medical record was reviewed. He was admitted to the secured memory care unit with diagnoses which included, but were not limited to, vascular dementia (a degenerative brain disease which affects cognitive function and memory) and anxiety. A semi-annual Level of Care (LOC) nursing assessment and evaluation, dated 3/15/23 but was not signed until 6/20/23, indicated Resident B had not sustained any falls in the last three months and was not a fall risk. A review of Resident B's nursing progress notes for the previous three months revealed he had sustained 3 falls on 3/7/23, 3/14/23, and on 3/15/23. a. On 3/7/23 at 7:20 a.m., Resident B was found lying on his back next to his bed. He stated he was ambulating to the bed from the bathroom. He did not complain of any pain and no change in his LOC was noted. The family and physician were notified. b. On 3/13/23 at 1:40 a.m., Resident B called for help, and he was found sitting upright on the floor next to his bed. He indicated he fell from his bed. He had no complaints of pain and no injuries were noted. The family and physician were notified.			

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	c. On 3/15/23 at 12:02 a.m., Resident B used his pendant and was found sitting on the floor. No injuries were noted, and he had no complaints of pain. The family and physician were notified. The Service Plan interventions for the LOC assessment indicated: "Fall interventions are: clutter free; support/assistive devices area available and in good repair, the bed in low position at night; persona items and call device (pendant, pull chord) within reach; non-glare soft lighting at night." A semi-annual LOC nursing assessment and evaluation, dated 8/28/23 but was not signed until 9/15/23, indicated, Resident B had not sustained any falls in the last three months and was not a fall risk. A review of Resident B's nursing progress notes for the previous three months revealed he had sustained 14 falls on the following days; 6/1/23, 6/5/23, 6/22/23, 7/14/23, 8/5/23, 8/6/23, 8/7/23, 8/8/23, 8/11/23, 8/14/23, two falls on 8/21/23, and 8/26/23. a. On 6/1/23 at 10:44 a.m., Resident B went on a walk with other residents and the activity department and sustained a fall. The nurse drove to area and observed resident laying supine on the sidewalk with his Rollator walker next to him. He stated he lost his balance on uneven pavement and fell. A superficial scrape was noted on his back. He was assisted back inside. The family and physician were notified. b. On 6/5/23 at 10:36 a.m., after breakfast, Resident B was found on the floor of his room in front of the bed. No injuries were noted, and he did not complain of pain. The family and physician were			

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		A. BUILDING 00 B. WING	06/12/2024

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WOODLAND TERRACE OF DANVILLE	200 S ARBOR LANE DANVILLE, IN 46122

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	notified. c. On 6/22/23 at 2:57 p.m., Resident B was found sitting in front of his recliner. He stated he slid out from his recliner when he tried to stand up. No injuries were noted, and he did not complain of pain. The family and physician were notified. d. On 6/25/23 at 10:03 a.m., Resident B was found sitting on the floor in front of his bed. Resident B indicated, he went to the bathroom, then coming back he became weak and sat on floor. The family and physician were notified. e. On 7/14/23 at 6:28 a.m., Resident B he was found sitting on the floor of his room and stated that he fell while ambulating to the bathroom. The family and physician were notified. f. On 8/5/23 at 11:55 p.m., Resident B was found sitting on the floor by his bed. He indicated he slid out of bed and eased himself onto the floor. The family and physician were notified. g. On 8/6/23 at 7:43 a.m., Resident B was found sitting on the floor by his bed. He stated his legs gave out and he slid to the floor. The family and physician were notified. h. On 8/7/23 at 5:01 a.m., Resident B pressed his pendant and was found lying on the floor. He indicated he was trying to go to the bathroom. A superficial abrasion was noted to his upper left arm which was treated with first aide, and he was assisted back into bed. The family and physician were notified. i. On 8/8/23 at 10:49 a.m., Resident B pressed his pendant and was found lying on the floor in front of his recliner. He indicated he had got himself up			

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	to go the bathroom. An intervention was documented at the time, that Resident B was educated to ask for assistance before he got up. j. On 8/11/23 at 10:50 a.m., Resident B was found laying on the floor in front of his bed with his walker next to him. Resident ambulated without assistance and landed on the floor due to weakness. A superficial scrape was noted on his right knee. The family and physician were notified. k. On 8/14/23 at 11:13 p.m., Resident B notified the nurse he had fallen earlier but gotten himself up. His left knee was slightly red but also had scabbed over areas from a previous fall. The family and physician were notified. l. On 8/21/23 at 2:44 p.m., Resident B was found sitting on the floor of his doorway. He stated that he transferred himself from recliner to wheelchair and propelled himself to the doorway, then slid out of chair in doorway. He was unable to explain the purpose for leaving the recliner or coming to the doorway. The family and physician were notified. m. On 8/21/23 at 5:30 p.m., Resident B was found lying on the floor of his room. He stated he slipped from his wheelchair. The family and physician were notified. n. On 8/27/23 at 10:36 p.m., Resident B was found lying on the floor by his recliner. He stated he tried to go to the bathroom without his walker. No injuries were noted, and he did not complain of pain. The family and physician were notified. The Service Plan interventions for the LOC assessment were unchanged from his previous assessment despite the increased number of falls			

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	he had experienced. A semi-annual LOC nursing assessment and evaluation dated 3/6/24 (a month late) and was not signed until 3/15/24, indicated, Resident B had not sustained any falls in the last three months and was not a fall risk. A review of Resident B's nursing progress notes for the previous three months revealed he had sustained 2 falls on 1/4/24 and 1/15/24. a. On 1/4/24 at 7:30 p.m., Resident B was found in a kneeling position next to his bed. He stated that his legs had failed him while returning from the bathroom. No injuries were noted, and he did not complain of any pain. The family and physician were notified. b. On 1/15/24 at 2:47 p.m., Resident B was found sitting on the floor and was noted to have been incontinent at the time of his fall. He stated he was trying to use the bathroom, but then stated he was trying to go to bed. No injuries were noted, and he did not complain of any pain. The family and physician were notified. In February 2024, Resident B was put on Physical Therapy (PT) case load. A PT progress note, dated 2/16/24, indicated, " ...patient was on track to meet goals, however over the last few weeks, patient had required more assistance to complete mobility including transfers, bed mobility, and short distance gait. At times, requires two person assist due to physical resistance and inability to assist caregiver. Frequency increased to 2 times a week with focus on caregiver training. Factors limiting functional gains includes, recent decline in function and progression of dementia ...."			

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	A PT progress note, dated 3/4/24, indicated progress was noted, " ...improved initiation compared to last visit. No more than two attempts needed this date ... patient ambulated on level wood surface with rollator walker and required minimal physical assistance ..." A PT progress note, dated 3/4/24, indicated additional progress was noted, " ...patient ambulated on level surface for 40 feet with rollator walker and only required moderate physical assistance and verbal instruction ... Discussed with caregiver patient's functional level and participation in therapy. Felt like patient has reached maximum potential. Caregiver states patient is unpredictable with his participation and sometimes requires assist of 2 which is consistent with therapist's observations ...." The record lacked documentation of nursing staff interventions to address and/or accommodate Resident B's unpredictability of his functional abilities related to the progression of his dementia, increased weakness and confusion, increased frequency of incontinence and toileting needs, and no interventions were documented in place to maintain the level of function he had acquired during his PT. On 3/6/24 at 6:32 p.m., Resident B's wife, the previous DON, and two staff members from the therapy department were present for a comprehensive care plan meeting to address and discuss Resident B's plan of care. The previous DON discussed Resident B's cognitive and physical decline as well as the potential for the need of additional support for ADLs. His wife verbalized understanding but refused third party support at that time. Time was allocated for his wife to ask questions and discuss care/decline			

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	concerns (but no details of her concerns were documented). At the end of the meeting a copy of Resident B's 3/6/24 LOC assessment and Service plan was provided. A nursing progress note, dated 3/8/24 at 5:10 p.m., indicated Resident B was found by his wife lying on the floor in his room. He stated he tried to go to the bathroom. his pants were noted saturated with urine and his wife suggested removing them due to the wetness. A nursing progress note, dated 3/1624 at 10:22 p.m., indicated, Resident B received a new order to start an antibiotic medication due to a UTI. A nursing progress note, dated 3/20/24 at 10:45 p.m., indicated, Resident B was found on the floor sitting on his buttocks. He stated he tried to go to the bathroom and lost his balance and fell. He was educated on the importance of calling for assistance. No injuries were noted, and he did not complain of pain. On 3/22/24 at 9:48 a.m., Resident B was seen by PT and the corresponding PT progress note indicated, " ...Nurse and staff advised to leave rollator out of reach from patient unless staff is present due to most recent fall occurring when patient attempted to ambulate self to bathroom. Patient is at very high risk for falls in standing with gait. Sign written and placed on rollator to promote carryover with recommendations ...." A nursing progress note, dated 3/22/24 at 4:00 p.m., Resident B was found on the floor lying on his right side in front of his recliner and had been incontinent. He indicated he was trying to walk to the bathroom and fell. He was assisted to the toilet and his brief was changed. Resident B			

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	complained of pain in his right groin area. A nursing progress note, dated 3/23/24 at 8:25 a.m., indicated, Resident B was, " ... screaming out in pain ..." and was unable to bare weight on his right leg. The on-call physician ordered a mobile x-ray which was obtained that same day. However, Resident B's pain was uncontrolled, so he was sent to the Emergency Department (ED). On 3/23/24 at 12:58 p.m., Resident B's x-ray results were faxed and received by the facility which indicated he had sustained a displaced fracture of the subcapital right femoral neck. During an interview with the Executive Director (ED) on 6/12/24 at 12:35 p.m., she indicated, she had been out of town at the time of Resident B's fall, and that the previous Director of Nursing (DON) had not contacted her about the fall or informed her of the x-ray results. The ED indicated, resident's in memory care required additional monitoring and supervision because of the disease, and the secured memory care unit specialized in providing dementia care services for all residents. The previous DON however, had not been proactive about Resident B's decline and had not made the ED aware of as many falls as he had. The ED indicated, residents had a right to be protected from falls, and that additional interventions should have been discussed and attempted. On 6/12/24 at 1:30 p.m., the ED provided a copy of current facility policy titled, "Falls Management," revised 5/22/23. The policy indicated, " ...Residents will be evaluated by a licensed nurse for the risk of falls with assessments upon move-in and change of condition. The purpose of the fall evaluation is to assess for appropriate fall			

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	mitigation interventions ... As part of the fall Evaluation the nurse will: a. evaluate potential interventions to reduce or, when possible, eliminate the risk for fall; b. Educate the resident and/or the legal representative regarding potential environmental hazards; c. make recommendations to mitigate falls and injuries subsequent to falls such as requesting an order for therapy to conduct an evaluation to determine needed or beneficial treatment therapy services ... The community nurse will document interventions to reduce the risk of falls in the resident's service plan and will communicate these interventions to team members providing services to the resident ...." On 6/11/24 at 9:30 a.m., during the Entrance Conference, a copy of the admission agreement was requested and provided by the ED. The Admission Agreement was dated 10/15/2020 and indicated, " ...Falls: ... if a resident sustains a fall in our community, our policy is to work with both the resident and/or their designated representative, and the resident's physician, to collectively discuss appropriate interventions in an effort to reduce the risk of future falls .... Dementia Disclosure: Our community is a place that feels like home, were specialized care is provided for individuals with memory impairment ... we strive to meet the increasing needs of our residents as they progress through their unique disease and allow them to live out the balance of their lives in the comfort of their community home ...." This State Residential Finding related to complaint IN00433770.			
R 0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency			

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Bldg. 00	(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 and interview, the facility failed to wear hairnets in the kitchen for 1 of 1 observation of the kitchen. Findings include: On the kitchen tour on 6/11/24 at 10:00 a.m., kitchen staff (Cooks 3, 4 and 5) were observed without hairnets upon entrance to the kitchen. The staff placed hairnets on once the tour started. During the tour, a server entered the kitchen, left the kitchen, and then reentered the kitchen without a hairnet. She asked where the hairnets were kept and placed a hairnet on at that time. On 6/12/24 at 12:42 p.m., the Executive Director (ED) indicated they should have been wearing hairnets in the kitchen. A policy titled, "Use of Gloves and Hair Restraints," was provided by the ED on 6/12/24 at 1:30 p.m. It indicated, " ...When working in a food production area, team members will wear a clean hat or other hair restraint that can keep hair from falling into food and onto food-contact surfaces ...".	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? When working in the food production area of the kitchen, staff will wear a hat or hairnet.How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Please see the measures described below. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Staff will be reeducated on the requirement of wearing hairnets or hats in the kitchen, with review of the requirements provided and documented in staff personnel files on a quarterly basis. How be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place? The Culinary Service Manager will provide the training on the requirement to wear a hairnet or hat in the kitchen and document on the training. The Executive Director or designee will verify training is filed in staff personnel files. By what date be completed? 7/31/24	07/31/2024

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R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and record review, the facility failed to date medications when opened and failed to remove expired medications from use for 1 of 3 medication rooms reviewed. Findings include: On 6/11/24 at 11:32 a.m., the memory care refrigerator located inside the medication room was observed. It had a bottle of lorazepam with no date opened belonging to a resident who discharged from the facility. Resident 3 had a bottle of lorazepam 2 milligram (mg)/milliliter (ml) that was opened on 11/23/23. It was expired. A policy titled, "Medication Management/Medication Storage," was provided by the Wellness Director on 6/12/24 at 12:20 p.m. It indicated, " ...Medication will be stored in the original pharmacy labeled container and stored in accordance with label instructions ....".	R 0300	p="" paraid="682284380" paraeid="{1fcecca1-9ca7-420a-a94a-d4f67d841576}{232}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Expired Medication will be disposed of in accordance with Community medication disposition policies and procedures. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All medication storage areas will be audited for expired medications and medications of discharged residents. If expired medications or medications for discharged residents are identified, the medications will be disposed of in accordance with Community medication disposition policies and procedures.What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The Health and Wellness Director, or designee , will conduct med cart and medication storage room audits twice monthly for	07/31/2024

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			expired medications and medications of discharged residents. How be monitored to ensure the deficient practice will not recur; i.e.; what quality assurance program will be put into place? ul="" role="list" The Health and Wellness Director, or , will audit completion and accuracy of medication storage audits one (1) time monthly for six (6) months and quarterly on an ongoing basis. By what date be completed? 7/31/2024	