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	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

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R 0000 Bldg. 00	This visit was for the State Residential Licensure Survey and the Investigation of Complaint IN00419038. This visit was done in conjunction with the Post Survey Revisit (PSR) to Investigation of Complaint IN00398471 completed on 6/1/23. This visit was done in conjunction with PSR to the Investigation of Complaints IN00412422 and IN00412687 completed on 7/19/23. Complaint IN00419038 - No deficiencies related to the allegations are cited. Complaint IN00398471 - Corrected Complaint IN00412422 - Not Corrected Complaint IN00412687 - Not Corrected Survey dates: October 23 and 24, 2023 Facility number: 013825 Residential Census: 96 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/30/23.	R 0000	The submission of the Plan of Correction does not indicate an admission by Storypoint of Schereville that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of Story Point of Schereville. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the Credible Allegation of Compliance with all State requirements governing the operations of this Community.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Yarnell Rumple	Administrator	12/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's Responsible Party and/or Physician were notified timely after a fall, obtaining a skin tear, bruising, and areas of excoriation for 3 of 11 records reviewed. (Residents D, K, and F) Findings include: 1. The record for Resident D was reviewed on 10/23/23 at 1:00 p.m. Diagnoses included, but were not limited to, dementia and constipation. Nurses' Notes, dated 9/13/23 at 7:09 a.m., indicated the resident was observed sitting on her bottom on the floor of the Oaks hallway. The resident was assessed and was asked why she was without her rollator. The resident indicated, "because I think I normally walk without it or the people will carry me." The resident denied hitting her head, any pain, and her current condition was consistent with her condition prior to the fall. The Director of Nursing (DON) and the Physician were made aware, family notification was pending at that time. There was no further documentation indicating the resident's family was notified of the fall. Nurses' Notes, dated 9/17/23 at 12:01 a.m., indicated the resident was found sitting on the floor in the Oaks common area without her walker. The resident indicated she did not know how she fell. She complained of mild pain which she later	R 0036	1 Residents D, K and F will have their respective service plans updated to reflect the events. Wellness Staff will be educated regarding the need to contact the physician and the resident's legal representative upon significant change/post event. 2 All residents have the potential to be affected. 3 The Wellness Director/designee will review the 24-hour report for physician and legal representative notification upon change of condition. If concerns are noted, The Wellness Director/Executive Director will be notified immediately for corrective action. 4 To ensure on-going compliance with this corrective action, the Wellness Director/designee will be responsible for the completion of the "Physician and Legal representative Audit tool" daily for two weeks and then weekly for two weeks. Weekly audits will continue until 100% compliance is achieved. One 100% compliance is achieved in the weekly audits, monthly audits will be reviewed for quality assurance purposes for a	12/08/2023

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	denied during the assessment. A light red bruise was noted to her right knee and slight edema was noted to her right heel. The Assistant Director of Health Services was made aware. The resident's physician and emergency contact were to be notified. Will continue to monitor. There was no documentation indicating the resident's physician and emergency contact were notified. Nurses' Notes, dated 10/10/23 at 8:54 p.m., indicated the resident was observed with a new skin tear to the right forearm. The area was cleansed with normal saline and a dry dressing was applied. The Executive Director and the Physician were sent notification. POA (Power of Attorney) notification was pending. There was no further documentation indicating the resident's POA was notified. Nurses' Notes, dated 10/19/23 at 6:56 a.m., indicated staff were called to the resident's room due to her sitting on the edge of the bed and she slid off. The resident denied hitting her head. A reddened area was observed on the right upper region of her back. The Executive Director was notified and communication was sent to the physician. POA notification was pending at that time. There was no further documentation indicating the resident's POA was notified. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no further documentation related to the family being notified of the above incidents. 2. The record for Resident K was reviewed on 10/23/23 at 2:44 p.m. Diagnoses included, but were not limited to, dementia, atherosclerotic heart disease, and hypertension.		period of three additional months.	

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	Nurses' Notes, dated 10/9/23 at 1:45 a.m., indicated the resident was found on the floor on her buttocks. She was unable to explain how she ended up on the floor. The resident was assisted back to bed by staff. The Executive Director and the Physician were notified. Power of Attorney (POA) notification was pending at that time. There was no further documentation regarding POA notification. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no further documentation related to the family being notified of the resident's fall. 3. The record for Resident F was reviewed on 10/23/23 at 1:45 p.m. Diagnoses included, but were not limited to, syncope, mild protein-calorie malnutrition, orthostatic hypotension, history of falling, hypertension, Depression, acute cystitis without hematuria and atrial fibrillation. The resident was admitted on 7/21/22. Nurses' Notes, dated 9/9/23 at 2:33 a.m., indicated the resident was observed with a purple-bluish bruise to the abdomen above the left hip and left knee that may have developed from the last fall on 9/3/23. A communication document was faxed to the physician. Nurses' Notes, dated 9/12/23 at 3:08 p.m., indicated the NP (Nurse Practitioner) responded to communication sent regarding the discoloration to the left abdomen, hip, and knee. The NP will see the resident next time they were at the facility. There was no documentation the resident's family was notified of the bruising. Nurses Notes, dated 10/1/23 at 11:54 p.m., indicated the resident was observed with redness			

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	and excoriation to the buttocks. A communication document was faxed to the physician requesting an as needed order for barrier cream. A Nurses' Note, dated 10/4/23 (3 days later) at 1:02 p.m., indicated new orders were obtained to start Calazime cream every 6 hours for excoriation. There was no other documentation indicating the physician was notified again on 10/2 and 10/3/23 for an order for the excoriation Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no documentation the resident's family was notified of the bruised areas, nor was there continued attempts to reach the physician timely regarding the excoriation.			
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 observation and interview, the facility failed to ensure residents were free from involuntary seclusion related to automatic door locks which locked the resident's room door once inside for 15 resident rooms on all three memory care units. (Crabtree, Magnolia, and Oaks units). This had the potential to affect all 51 residents who resided on the three memory care units. Findings include: 1. On 10/24/23 at 11:30 a.m., on the Oaks memory care unit, all the resident rooms were observed	R 0052	1.Residents who were part of the 15 apartments identified during the survey were affected by the deficient practice. 1.All residents have the potential to effected by this deficit practice. 2.Residents on all 3 memory care neighborhoods are having their locks removed and replaced with free entry doorknobs by 11-22-23. 3.Maintenance Director will replace locks and perform monthly	12/08/2023

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	with a silver key pad lock on the outside of the doors. The handle was turned on one of the doors, however, it was locked. QMA 1 indicated all the doors were locked and the combination to get inside was either the resident's room number or 1234. The QMA indicated only a few residents had the key pad locks before, but just recently the facility had put the key pad locks on all the doors. Upon entering room 1041 using the room number as the pass code and by pressing the unlock icon on the key pad, the door was unlocked and opened easily. After entering the room, the door automatically shut and locked on its own. The locked changed from a vertical position (unlocked) to a horizontal positron (locked). The room was empty as the resident was in the lounge. The door lock had to be manually turned to a vertical position to open and leave the room. 2. On 10/24/23 at 11:33 a.m., room 1042 was observed. The resident's room number was used as the code to enter the room. After walking inside the room, the room door automatically closed and the door lock automatically turned to a horizontal position and was locked. The resident was not in the room at the time. The door lock had to be manually turned to a vertical position to open and leave the room. Interview with the Executive Director ED) on 10/24/23 at 11:42 a.m. indicated the key pad locks were not intended to auto lock once inside. If the doors were automatically being locked once inside, the nursing staff should have informed maintenance the doors were auto locking. Interview with the Maintenance Supervisor on 10/24/23 at 11:50 a.m., indicated the doors were not supposed to be set to auto lock and he does		rounds to ensure compliance. 4.Date of compliance 12-8-23.	

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	not routinely check the doors to see if they were set to auto lock. On 10/24/23 at 12:05 p.m., the Maintenance Supervisor came back after checking all 3 units and the key pad locks and indicated 15 rooms had the auto door lock turned on. He had no idea why they were turned on, or maybe the families wanted it that way so no other residents would enter the rooms. Interview with the ED on 10/24/23 at 1:15 p.m., indicated the keypad entry system were placed on all the resident doors in early 2023, however, she could not remember the exact date. She indicated most families wanted the rooms locked due to other residents wandering and going in and out of other resident rooms. All rooms had the keypad entry doors system on all 3 locked memory care units. Crabtree was a high functioning unit, Magnolia was a moderate functioning unit and the residents on the Oaks unit were low functioning and required the most assistance. The residents on all 3 memory care units had some level of cognition impairment.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be			

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	conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were completed quarterly on each shift and that an attempt was made to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. This had the potential to affect 96 residents who resided in the facility. Finding includes: On 10/24/23 at 9:47 a.m., the Maintenance Supervisor provided fire safety training sheets for the following dates: 10/24, 11/22, 12/16/22, 1/19, 2/27, 3/17, 4/25, 5/5, 6/18, 7/14, 8/27, and 9/10/23. There was no time documented on the sheets and there was no documentation on the sheets indicating a fire drill was held. Interview with the Maintenance Supervisor on 10/24/23 at 10:02 a.m., indicated he was not instructed to write down the time and location of where the fire drill was held. He also indicated he was told to use the inservice sheet and have everyone sign that sheet when the drill was conducted. He had not conducted a fire drill on the midnight shift and he was not aware of the	R 0092	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that other residents, staff, and families/visitors could have the potential to be affected by the alleged deficient practice. 3. The Executive Director reviewed with the Maintenance Director the Fire Drill Procedure that clearly delineates the required frequency of drills and the Responsibility to conduct the drills. In addition, a schedule was developed for the remainder of 2023 and 2024 that ensures quarterly drills reflective on each shift. The local fire department has been requested to assist us in a fire and disaster drill every six months. Please see attachments of the schedule. We are awaiting their response. 4. The monthly Safety Committee will review all drills to ensure the schedule is being maintained and make any necessary	12/08/2023

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	local fire department being invited to participate in the past 6 months.		recommendations/adjustments. In addition, the monthly fire drills will be monitored from our Home Office monthly. Communities are required to input the drills into a safety smart sheet monthly in order to ensure compliance with the regulatory requirement.	
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 (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 record review and interview, the facility failed to ensure any unlicensed employee providing more than limited assistance with activities of daily living must either be a CNA (Certified Nursing Assistant), HHA (Home Health Aide), or a licensed nurse related to the hire of unqualified staff who provided more than limited assist for residents for 4 of 37 employees reviewed for certificates and/or licenses. (HHA 3, HHA 4, CNA 1, and the DON) Findings include: The Employee licenses and certificates were reviewed on 10/24/23 at 2:30 p.m. The following employees were hired without proper licensing or certification:	R 0118	1 Residents under the care of HHA 3, HHA 4, CNA 1, DON for the period that they were employed were affected by this deficit practice. 2 The Community realizes that all residents had the potential to be affected by the deficient practice. 3 The identified staff were removed from those positions from the schedule. All staff members who have licenses are being reviewed. The Wellness Director was replaced by a qualified Indiana licensed Registered Nurse	12/08/2023

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	a. HHA 3 was hired on 7/2/23 and had no certificate to be a HHA. She was enrolled in a CNA class as of 10/3/23, but had not completed the class. b. HHA 4 was hired on 6/4/23 and had no certificate to be a HHA. She was enrolled in a CNA class as of 10/3/23, but had not completed the class. c. CNA 1 was hired on 10/10/23 and had no certificate to be a CNA. She was enrolled in a CNA class starting on 10/30/23. d. The DON was hired on 5/15/23 and had an expired LPN license from another state. She continued to work as the DON until she was terminated on 10/3/23. Interview with the Executive Director on 10/24/23 at 3:50 p.m., indicated all of the above employees were hired with no certificate or license to work with the residents in their hired capacities. The employees have been removed from the schedule.		to act as the interim Wellness Director. She has been appointed to LTC Provider Services on November 1, 2023. The systemic change will be that the Resident Services Coordinator will check the Indiana Professional Licensed Agency database prior to hire to ensure that the license is current and in good standing. All licensed personnel will have their respective licenses placed in a binder denoting the month of expiration. 4 The ED will conduct monthly audits on licenses to ensure licenses are not expired and remain in good standing. Any negative findings will be forwarded to the Wellness Committee (QAPI) monthly for review. Anyone found to be without a license in good standing or an expired license will be removed from the schedule until compliance can be met.	
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			

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	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 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 the required personnel annual inservices, which include Dementia, were completed for 2 of 5 staff members reviewed. (HHA 1 and Concierge) Findings include: Review of the employee records was completed on 10/24/23 at 9:12 a.m.	R 0120	R 120 1.The residents under the care/services of identified HHA1 and concierge were affected by this deficit practice. 2.The Community realizes that all residents have the potential to be affected by the deficient practice.	12/08/2023

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	1. The Concierge was hired on 7/7/21. The Concierge only completed 1.5 hours of the required yearly 3 hours of Dementia training for the 2022 calendar year. 2. HHA (Home Health Aide) 1 was hired on 12/10/21. HHA 1 only completed 1.75 hours of the required yearly 3 hours of Dementia training for the 2022 calendar year. Interview with Executive Director on 10/24/23 at 2:48 p.m., indicated the employees should have completed 3 hours of annual Dementia training.		3.The concierge and HHA 1 will have her dementia training completed by 11-20-23. All staff members have had their Relias training audited to ensure three hours of dementia training has been completed. Any staff members found to be deficient in their training will participate in dementia training through Relias by 12-8-23. 4 Memory Care Director and ED will ensure that training is completed by that date. Anyone not in compliance will be removed from the schedule until such time that they become compliant with the training.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure kitchen areas were maintained in good repair related to stained walls and rusted ceiling tile trim for 1 of 1 kitchen areas. The facility also failed to ensure residents refrained from smoking inside their rooms for 1 of 1 residents reviewed for smoking. This had the potential to affect 96 residents who resided in the facility. (The Main Kitchen and Resident 8)	R 0154	1.No residents were affected by the deficient practice. 2.The Community realizes that all residents have the potential to be affected by the deficient practice. 3.The walls in the dishwashing area has been cleaned. The ceiling has been cleaned. The systemic change is that new	12/08/2023

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	Findings include: 1. During the kitchen sanitation tour on 10/23/23 at 9:10 a.m., the following was observed: a. The walls in the dishwashing area were stained with a black substance. b. The ceiling tile trim located in the dishwashing area had an accumulation of rust. Interview with the Dietary Food Manager (DFM) on 10/24/23 at 1:00 p.m., indicated the black substance on the wall was mold and the ceiling tile trim needed to be cleaned. 2. The record for Resident 8 was reviewed on 10/23/23 at 2:20 p.m. Diagnoses included, but were not limited to, high blood pressure, atrial fibrillation, glaucoma, degeneration of the nervous system due to alcohol consumption. A Service Plan, dated 6/8/23, indicated the resident was a smoker who can independently smoke outside of the community. The staff will keep the cigarettes in the cart and dispense as requested. A Nurses' Note, dated 9/13/23 at 3:11 a.m., indicated the resident was completely inebriated and was smoking in his room. The resident has been told 3 times about not going to designated areas to smoke, however, the resident was unable to respond due to inebriation. The Director of Nursing was made aware. A Nurses' Note, dated 10/18/23 at 3:08 a.m., indicated the resident was extremely inebriated, and was smoking in his room. Staff explained to the resident that he had been made aware multiple times that he can not smoke in the community.		cleaning schedules have been implemented. Culinary staff were educated on the cleaning schedules and the expectations. Resident #8 has signed an acknowledgement of the no smoking in the Community policy after a discussion with the ED on no smoking in his apartment. Resident was informed of future consequences if non-compliant with the lease agreement. Should resident # 8 be found smoking in his apartment in the future, a 30-day discharge and transfer notice will be issued immediately. 4 Cleaning of the kitchen will be audited weekly by the Executive Chef/Executive Director weekly for the next three months or until 100% compliance is met. Resident # 8 will have his apartment inspected weekly and will remain on-going. Housekeeping staff will report any negative findings to the Executive Director immediately.	

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	Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no smoking assessment for the resident, however, it was in his contract the facility was a non-smoking campus. The residents were not allowed to smoke in their rooms.			
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.			

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	Based on record review and interview, the facility failed to ensure the service plans were signed by the residents and they were revised and updated according to the residents' change in condition for 8 of 11 residents reviewed for service plans. (Residents D, K, 6, F, 8, 2, 1, and 7) Findings include: 1. The record for Resident D was reviewed on 10/23/23 at 1:00 p.m. Diagnoses included, but were not limited to, dementia and constipation. The Health and Service Evaluation was completed on 8/15/23. The evaluation had not been signed by the resident and/or her family. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the service plan should have been signed by the resident's family. 2. The record for Resident K was reviewed on 10/23/23 at 2:44 p.m. Diagnoses included, but were not limited to, dementia, atherosclerotic heart disease, and hypertension. The Health and Service Evaluation was completed on 6/13/23. The evaluation had not been signed by the resident and/or her family. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the service plan should have been signed by the resident's family. 3. The record for Resident 6 was reviewed on 10/23/23 at 1:58 p.m. Diagnoses included, but were not limited to, non-Hodgkin's lymphoma, oxygen dependent, and respiratory failure. The Health and Service Evaluation was completed	R 0217	R 217 1.Residents D,K,G.F, 8, 2, J and 7 were all affected by this deficit practice. 2.All facility residents had the potential to be affected by this deficit practice. 3.Service plans for identified residents will be corrected by 12-08-2023. All resident service plans will be audited by 12-08-2023 1.Service plans will be audited 2xs per month to ensure compliance by the ED. This practice will remain on-going until 100% compliance is maintained for three consecutive months.	12/08/2023

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	on 8/28/23. The evaluation had not been signed by the resident and/or her family. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the service plan should have been signed by the resident's family. 4. The record for Resident F was reviewed on 10/23/23 at 1:45 p.m. Diagnoses included, but were not limited to, syncope, mild protein-calorie malnutrition, orthostatic hypotension, history of falling, hypertension, Depression, acute cystitis without hematuria and atrial fibrillation. The resident was admitted on 7/21/22. An updated 7/25/23 Service Plan was completed, however, it was not signed by the resident and/or the resident's responsible party. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the completed Service Plan was not signed by the resident's responsible party. 5. The record for Resident 8 was reviewed on 10/23/23 at 2:20 p.m. Diagnoses included, but were not limited to, high blood pressure, atrial fibrillation, glaucoma, degeneration of the nervous system due to alcohol consumption. The Service Plan, dated 6/8/23, was completed, however, it was not signed by the resident. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the completed Service Plan was not signed by the resident. 6. The record for Resident 2 was reviewed on 10/23/23 at 1:00 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood			

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	disturbance, and anxiety, high blood pressure, and hypothyroidism. An updated Service Plan, dated 5/30/23 was completed, however it was not signed by the resident and/or the resident's responsible party. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the completed Service Plan was not signed by the resident's responsible party. 7. Resident 1's record was reviewed on 10/23/23 at 10:30 a.m. Diagnoses included, but were not limited to, anxiety, arthritis, depression, and hypertension (high blood pressure). The Service Plan was not signed by the resident and/or responsible party. Interview with the Executive Director on 10/24/23 at 2:48 p.m. indicated there was no signed service plan. 8. Resident 7's record was reviewed on 10/23/23 at 11:44 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), hyperlipidemia (high cholesterol), and urinary retention. The Service Plan was not signed by the resident and/or responsible party. Interview with the Executive Director on 10/24/23 at 2:48 p.m. indicated there was no signed service plan.			
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			

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	local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was prepared and stored under sanitary conditions related to staff not wearing hair restraints, scoops stored in bulk food bins, dust on light covers and fan grates, dried food spillage on food preparation equipment, and handling food with the same pair of gloves for 1 of 1 kitchen areas and for 1 of 1 meals observed. (The Main Kitchen and the Memory Care Unit) Findings include: 1. During the kitchen sanitation tour on 10/23/23 at 9:10 a.m., the following was observed: a. Three wait staff members were observed going in and out of the kitchen. They were not wearing hair restraints. One of the wait staff members indicated there were no "hair nets" available. b. Scoops were observed inside of the sugar, rice, and flour bins. The lid to the bins were also sticky and had an accumulation of dried food spillage. c. There was an accumulation of dust on the fan grates located inside of the walk in refrigerator. d. There was an accumulation of dust on the plastic light covers located above the meat slicer, which was uncovered. There was also an accumulation of dust on the plastic light covers located above the food preparation area. e. The microwave located outside of the dry storage room had an accumulation of dried food spillage on the door. f. The bottom shelf of the reach in freezer had an	R 0273	1.No residents were affected by the deficient practice. 2.The Community realizes that all facility residents have the potential of being affected by this deficit practice. 3.Education on infection control including the use of hair nets and glove usage will be Completed by 12-08-23. Scoop containers were purchased on 11-7-23. Identified Issues with food spillage including microwave, freezer, convection oven, and stove. Grates were addressed and corrected on 11-9-23. Signage regarding the mandatory use of utilizing hairnets in the kitchen have been posted. Any employee found to be non-compliant with this mandate will have corrective actions administered. 1.The Executive Chef/Executive Director will complete kitchen sanitation sheets 1x per week to ensure compliance until 100% compliance is achieved for three consecutive months.	12/08/2023

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	accumulation of food debris. g. The top and sides of the convection oven had an accumulation of dust and food spillage. h. The stove grates had an accumulation of dried food spillage. Interview with the Executive Director on 10/24/23 at 10:45 a.m., indicated all of the above was in need of cleaning. 2. On 10/24/23 at 11:30 a.m., Home Health Aide (HHA) 2 was observed preparing the residents' lunch meal in a room behind the Memory Care nurses' station. She was not wearing a hair restraint and was observed with blue latex gloves to both hands. She was observed picking up the cooked chicken tenders and onion rings with her gloved hands and placing them on the residents' plates. She was also observed wearing the same pair of gloves and touching the plates, other utensils, and the steam table with the same gloved hands. She used the same gloved hands to remove french rolls from a plastic bag and put the cooked chicken mixture inside. She continued to serve 5 residents' plates touching the food with the same gloved hands. She left the kitchen with the plates and served them to the residents. She then removed her gloves and donned another pair of clean gloves and did not perform hand hygiene. Interview with HHA 2 at that time, indicated she was not aware she had to wear a hair restraint while plating the food. She was aware she had to wear gloves to touch the food, however, she was not aware she had to change them once she touched something else. Interview with the Executive Director on 10/24/23			

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	at 1:15 p.m., indicated the HHA should have been wearing a hair restraint while serving food and she should have changed her gloves after touching non food items.			
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 record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to documentation of a fall, follow up assessment and documentation after a fall, skin tears, bruising, and as needed (PRN) medication administered only after nonpharmacological interventions were attempted for 3 of 11 residents reviewed for clinical records. (Residents K, F, and 2) Findings include: 1. The record for Resident K was reviewed on 10/23/23 at 2:44 p.m. Diagnoses included, but were not limited to, dementia, atherosclerotic heart disease, and hypertension. Nurses' Notes, dated 9/14/23 at 2:18 p.m., indicated the resident had refused her lab draw. The next entry in the Nurses' Notes was dated 10/12/23 at 3:39 a.m., and indicated the resident had no complaints of pain or discomfort related to a previous fall. The resident was educated on	R 0349	R 349 1 Residents were affected by these deficient practices. All of the respective service plans have been updated to reflect the events. 2 The Community realizes that all residents have the potential to be affected by the deficient practice. 3 The systemic change is that the Wellness staff have been educated. This education included but was not limited to the following: Falls documentation Fall follow-up documentation Skin tear documentation Bruising documentation Prn medication and administration after nonpharmacological intervention attempts 4 The Wellness Directo/designee will review the 24	12/08/2023

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	waiting for assistance before attempting to ambulate long distances. There was no documentation related to the resident falling. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated no documentation had been completed related to the resident's fall. 2. The record for Resident F was reviewed on 10/23/23 at 1:45 p.m. Diagnoses included, but were not limited to, syncope, mild protein-calorie malnutrition, orthostatic hypotension, history of falling, hypertension, Depression, acute cystitis without hematuria and atrial fibrillation. The resident was admitted on 7/21/22. Nurses' Notes, dated 9/3/23 at 11:49 p.m., indicated the resident was observed sitting on the floor in her room. The resident sustained a dime sized skin tear to the left knee. The site was cleansed and a bandaid was applied. The next documented Nursing Progress Note was on 9/5/23 at 4:02 a.m., regarding the fall follow up assessment. There was no documentation on 9/4/23 regarding the resident's condition after the fall. Nurses' Notes, dated 9/9/23 at 2:33 a.m., indicated the resident was observed with a purple-bluish bruise to the abdomen above the left hip and left knee that may have developed from the last fall on 9/3/23. A communication document was faxed to the physician. Nurses' Notes, dated 9/12/23 at 3:08 p.m., indicated the NP (Nurse Practitioner) responded to communication sent regarding the discoloration		hour report daily to identify any such events And then review the documentation for completeness and accuracy until 100$ compliance is achieved for three consecutive months.	

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	to the left abdomen, hip, and knee. The NP would see the resident next time they were at the facility. A Nurses' Note, dated 9/12/23 at 3:11 p.m., indicated the skin tear to the left knee was healed. There was no documentation or follow up assessment regarding the skin tear from 9/3 to 9/12/23. There was no documentation or follow up assessment regarding the bruised areas. Interview with the ED (Executive Director) on 10/24/23 at 1:15 p.m., indicated there was no other monitoring of the skin tear or bruised areas after they were first noted. There was also no fall follow up documentation on 9/4/23 after the fall with injury on 9/3/23. 3. The record for Resident 2 was reviewed on 10/23/23 at 1:00 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, high blood pressure, and hypothyroidism. Physician's Orders, dated 5/18/23, indicated Trazodone (an antidepressant medication) 50 milligrams (mg) every 6 to 8 hours PRN (as needed) for behavioral outbursts. The 6/2023 Medication Administration Record (MAR) indicated the Trazodone was signed out as being administered on 6/1 at 8:10 p.m., and on 6/18/23 at 8:01 p.m. The 8/2023 MAR indicated the Trazodone was signed out as being administered on 8/17 at 10:00 a.m. On 10/25/23 at 11:25 a.m., the medication cart was observed on the Oaks memory care unit with			

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	QMA 1. There was a full medication card with 30 tablets of the Trazodone with the date delivered of 9/29/23. Another card was observed with 28 of 30 tablets and had the delivery date of 10/19/23. The 10/2023 MAR indicated the Trazodone was not signed out as being administered. There was no documentation in nursing notes for the months of 6/2023, 8/2023 and 10/2023 of any nonpharmacological interventions tried first before administering the PRN Trazodone. Interview with the ED on 10/24/23 at 1:15 p.m., indicated there was no additional information regarding the PRN Trazodone.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review and interview, the facility failed to ensure a glucometer (blood testing machine for glucose levels) was cleaned prior to use and after use with the appropriate germicidal sanitary wipe for 1 of 1 glucometer procedures observed. (Resident 12 and LPN 1) This had the potential to affect the 2 residents who used the glucometer on the Assisted Living floor. Finding includes: During Medication Pass, on 10/24/23 at 8:20 a.m., LPN 1 donned clean gloves to both hands and removed the glucometer, strips, and a lancet from	R 0406	1. No residents were affected by the deficient practice. 2. The Community realizes that two residents had the potential to be affected by the deficient practice. 3. LPN 1 is no longer employed at the Community. Wellness staff have been re-educated on the appropriate standard operating procedure. The education included but was not limited to the following: -Thorough hand washing and glove use.	12/08/2023

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	the medication cart. She did not perform hand hygiene prior to donning the gloves, nor did she clean the glucometer prior to use. After checking the resident's blood sugar, the LPN threw away the lancet and strip in the sharps container and removed the insulin pen from the wrapper. She administered the insulin in his right arm and discarded the needle in the sharps container and removed her gloves. She reached for a container of Hand Sanitizing Wipes and was going to clean the glucometer with those wipes. The wipes did not indicate they were germicidal containing wipes approved to clean the glucometer. The LPN did not perform hand hygiene after the removal of the gloves. Interview with LPN 1 at that time, indicated she did not perform hand hygiene before donning clean gloves and she did not clean the glucometer prior to use. The glucometer was used for multiple residents and she had no idea if the last person to use the glucometer had cleaned it after they were finished. The Hand Sanitizing Wipes were the only wipes available to clean the machine. The True Metrix Owners Booklet indicated, "If the meter is being operated by a second person who provides testing assistance, the meter and lancing device should be disinfected prior to use by the second person. Do not clean the meter during a test. To Clean and Disinfect the Meter: 1. Wash hands thoroughly with soap and water. 2. To Clean: Make sure meter is off and a test strip is not inserted. With ONLY PDI Super Sani Cloth Wipes, rub the entire outside of the meter using 3 circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter. Discard used wipes. 3. To Disinfect: Using fresh wipes, make sure that all outside surfaces of the meter remain wet for 2		-Ensure meter is off and a test strip is not inserted -Only use germicidal and rub the entire outside of the meter and ensure the outside of the meter remains wet for two minutes and let air dry before testing again. 4. The Wellness Director/designee will perform weekly observations of the staff during the glucometer disinfection process. Anyone observed with less than 100% competency will receive on the spot re-training and will be observed for three additional concurrent disinfection procedures to ensure competency. In addition, the Wellness Director/designee will continue weekly audits for eight weeks. The audits will continue until 100% compliance is achieved for three consecutive months.	

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		A. BUILDING 00 B. WING	10/24/2023

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	minutes. 4. Let meter air dry thoroughly before using to test. The current and undated "Infection Control Standard Precautions" policy, provided by the Executive Director on 10/24/23 at 3:50 p.m., indicated hand washing shall be in accordance with policies and procedures. Wash hands before putting gloves on and after removing gloves. Re-usable equipment shall be disinfected with a company approved disinfectant prior to use with another resident. Interview with the Executive Director on 10/24/23 at 10:45 a.m., indicated the glucometer was to be cleaned with a germicide wipe prior to and after each use.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to lack of documentation for tracking and trending infections during the review of the facility infection control process. This had the potential to affect all 96 residents residing in the	R 0407	1 No residents were affected by the deficient practice. 2 2. The Community realizes that all residents have the potential to be affected by the deficient practice. 3 The Wellness	12/08/2023

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	facility. Finding includes: The Infection Control binder was reviewed on 10/24/23 at 1:45 p.m. The logs indicated the resident name, apartment number, start date, medications/directions, and diagnosis. There was also a facility floor map which was color coded with the rooms who had the infections for tracking and trending purposes. The infection control log was completed 10/2022 through 4/2023. There was a typed note on the outside of the binder which indicated "The infection control logs for tracking and trending were current through 4/21/23...." The typed note was from the former Director of Nursing who left in 4/2023. There were no other Infection control logs available for review for the months of 5/2023 through 10/2023. Interview with the Executive Director on 10/24 23 at 1:45 p.m., indicated the logs were completed by the previous DON who left in 4/2023 and that was all that was available for review.		Director/designee who was appointed on November 1, 2023, will ensure Infection Control Guidelines are in place and will track and trend infections beginning in the month of November and will be updated going forward for every month. 4 The Executive Director will inspect the Infection Control Binder monthly. This will be an on-going practice.	
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			

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	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 tuberculin skin tests were completed three (3) months prior to admission or upon admission and annually thereafter for 5 of 11 resident records reviewed. (Residents D, 6, F, 4 and 11) Findings include: 1. The record for Resident D was reviewed on 10/23/23 at 1:00 p.m. Diagnoses included, but were not limited to, dementia and constipation. The resident was admitted to the facility on 10/28/18. There was no documentation of an annual tuberculin (TB) skin test and/or annual TB Risk Assessment. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated the resident was originally admitted to independent living and she transferred to the Memory Care Unit in March of 2023. There was no documentation of a TB skin test or Assessment.	R 0410	1 The residents identified were not adversely affected by the deficient practice. 2 The Community Realizes that all residents have the potential to be affected by the deficient practice. 3 An admission checklist will be implemented that will include Tuberculin skin tests. The Community will ensure that Tuberculin skin tests were completed three (3) months prior to admission or upon admission and annually thereafter. The Wellness staff will be educated regarding this practice. 4 The Wellness Director /designee will review every admission checklist going forward.	12/08/2023

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	2. The record for Resident 6 was reviewed on 10/23/23 at 1:58 p.m. Diagnoses included, but were not limited to, non-Hodgkin's lymphoma, oxygen dependent, and respiratory failure. The resident was admitted to the facility on 8/31/22. There was no documentation of an annual tuberculin (TB) skin test and/or annual TB Risk Assessment. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no documentation that an annual TB skin test and/or annual TB Risk Assessment had been completed. 3. The record for Resident F was reviewed on 10/23/23 at 1:45 p.m. Diagnoses included, but were not limited to, syncope, mild protein-calorie malnutrition, orthostatic hypotension, history of falling, hypertension, Depression, acute cystitis without hematuria and atrial fibrillation. The resident was admitted on 7/21/22. There was no annual TB health assessment or skin test for review. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no annual TB assessment or skin test completed. 4. The record for Resident 4 was reviewed on 10/23/23 at 1:12 p.m. . The resident was admitted on 8/31/23. Diagnoses included, but were not limited to, Dementia, depression, malnutrition (inadequate diet), and hypertension (high blood pressure). There was no documentation the resident had received a first and second step tuberculin test upon admission. Interview with Executive Director on 10/24/23 at			

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	2:48 p.m., indicated the resident should have had a first and second step tuberculin test completed on admission. 5. The record for Resident 11 was reviewed on 10/24/23 at 9:00 a.m. The resident was admitted on 4/18/23. Diagnoses included, but were not limited to, arthritis, dizziness, hypertension (high blood pressure), chronic obstructive pulmonary disease (respiratory disease), and cirrhosis (liver disease). There was no documentation the resident had received a second step tuberculin test upon admission. Interview with Executive Director on 10/24/23 at 2:48 p.m., indicated the resident should have had a first and second step tuberculin test completed on admission.			