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	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURNEY SENIOR LIVING OF MERRILLVILLE LLC	7900 RHODE ISLAND STREET MERRILLVILLE, IN 46410

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 7 and 8, 2021 Facility number: 013733 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/10/21.	R 0000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. The Administrator will ensure all corrective action in the following Plan of Correction has been completed.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certificate scheduled for 7 of 14 shifts reviewed. Finding includes: Facility staffing schedules for 8/29/21 through 9/4/21 were reviewed on 9/8/21 at 9:00 a.m. The schedules indicated there were no staff members who were CPR certified on the following dates and shifts: Day shifts (7a-7p): 8/29/21 and 9/4/21 Evening shifts (7p-7a): 8/30/21, 8/31/21, 9/1/21, 9/3/21, and 9/4/21 Interview with the Business Office Manager on 9/8/21 at 9:56 a.m., indicated she had no additional staff CPR certifications to provide.	R 0117	A. All nurses and QMAs will obtain CPR and First Aid certificates. First Aid assigned and to be completed immediately in Relias. B. To determine if other residents/employees may have been affected the Business Office Manager or his/her designee will audit all current employee files for the required CPR and first aid certificates. Any employee lacking this required training will be assigned first aid within the Relias Training System. All nurses and QMAs will immediately be set up for CPR training so that one awake staff person will have current CPR certification/First Aid and all others to follow. C. All nurses and QMAs will obtain CPR and First Aid at the beginning of employment or immediately following. The Business Office Manager will use an audit tool to monitor and document the completion for each required training. D. The Business Office Manager or his/her designee will bring the audit tool to the Executive Director or his/her designee monthly for review until a pattern of compliance is obtained. The audits will be reviewed quarterly at the Quality Assurance Committee	10/08/2021

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			meetings to assure ongoing compliance. E. All training and review will be completed by October 08, 2021.	
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			

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	supervising the orientation. Based on record review and interview, the facility failed to ensure a new employee had a specific job orientation checklist completed for 1 of 5 employees reviewed. (CNA 3) Finding includes: The employee records and inservices were reviewed on 9/7/21 at 1:47 p.m. CNA 3 was hired on 6/1/21. The employee's record lacked documentation that a specific job orientation checklist was completed by the person supervising the orientation. Interview with the Business Office Manager on 9/8/21 at 10:27 a.m., indicated she was unable to find a specific checklist completed by the person supervising the CNA's orientation.	R 0119	A. CNA 3 specified job orientation checklist to the facility has been completed late by the said employee and trainee on September 15, 2021. B. To determine if other residents/employees may have been affected the Business Office Manager or his/her designee will audit all current employee files for the required specific job orientation checklist to the facility. Any current employees lacking this required documentation will be completed late by the said employee and trainee by October 8, 2021. C. The Business Office Manager or his/her designee will use an updated audit tool for all new hires to the community using the Personnel File Audit Checklist which will include specific job orientation checklist. The Business Office Manager will be in-serviced on specific job orientation checklist requirements. D. The Executive Director or his/her designee will review all Personnel File Audit Checklist monthly until a pattern of compliance is obtained. The Personnel File Audit Checklist will also be reviewed at the Quality Assurance meetings to ensure continued compliance. E. All training and review will be completed by October 08, 2021.	10/08/2021

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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 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	R 0120	A. QMA 1, CNA 1 and CNA 2	10/08/2021

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	facility failed to ensure annual inservices were completed for 3 of 5 employees reviewed. (QMA 1, CNA 1, and CNA 2) Finding includes: The employee records and inservices were reviewed on 9/7/21 at 1:47 p.m. QMA 1 was hired on 12/30/19. The staff member did not complete any resident rights inservice or dementia training in 2020. CNA 1 was hired on 10/28/16. The staff member did not complete any resident rights inservice or dementia training in 2020. CNA 2 was hired on 11/14/18. The staff member did not complete any resident rights inservice or dementia training in 2020. Interview with the Business Office Manager on 9/8/21 at 10:27 a.m., indicated she had provided all the completed training and inservices she had on file for the above staff members.		have all completed 2021 resident rights and dementia training. B. To determine if other residents/employees may have been affected the Business Office Manager will audit all current employee files for any missing resident rights and dementia training for the current year. Immediate action will take place if there is any missing required training. C. All new hires are required to complete the said training on Relias before starting on the floor at the facility. On all current employees the Business Office Manager or his/her designee will use the Relias Training System to track employees who are not in compliance with said training. If the employee fails to complete the training by the scheduled due date, the Business Office Manager will notify the appropriate supervisor to remove the employee from the schedule until the required training is successfully completed. D. A report of missed Relias Training is sent to the Executive Director weekly. The said list will be reviewed weekly with the managers at morning meeting to follow compliance of all current employees. It will also be reviewed at the Quality Assurance meetings to ensure continued compliance. E. All training and review will be completed by October 8, 2021.	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview, observation, and record review, the facility failed to obtain an arm sling for a resident with a fractured clavicle, as ordered by a physician for 1 of 3 residents reviewed for contracted services. (Resident 2) Finding includes: Interview with Resident 2 on 9/7/21 at 9:15 a.m., indicated she fell about 3 weeks ago and hurt her shoulder. She received therapy and was supposed to have a sling for her right arm. The resident was observed to not have a right shoulder sling in place. Record review for Resident 2 was completed on 9/7/21 at 9:30 a.m. Diagnoses included, but were not limited to, brain tumor, anxiety, cataracts, hypertension (elevated blood pressure), and Vitamin D deficiency. A Nurse Note, dated 8/23/21 at 5:00 p.m., indicated the resident was found to have a purple discoloration on her forehead. The resident indicated that she thought she had fallen. A Nurse Note, dated 8/24/21 at 2:00 p.m., indicated the resident had complained of pain and was unable to lift or move her right arm and shoulder. An X-ray Report, dated 8/25/21, indicated the right clavicle (shoulder) was fractured.	R 0240	A. The Executive Director had the sling purchased immediately after the ISDH brought it to her attention and the sling was put on resident number 2 before the ISDH departure. B. To determine if other residents may have been affected, all TAR records within the last 6 months will be reviewed by the Executive Director or his/her designee. Immediate action will take place if an order is deemed to be missing action. C. Executive Director or his/her designee will do weekly audits. Any noncompliance issues will be immediately addressed and noted. The Executive Director or his/her designee will in-service all staff members responsible for following physician orders through completion. D. Weekly audits will continue until a pattern of compliance is obtained. The charted audits will be reviewed quarterly at the Quality Assurance meetings to ensure continued compliance. E. All training and review of orders will be completed by October 8, 2021.	10/08/2021

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	A Physician order, dated 8/27/21, indicated for home health's Physical Therapy and Occupational Therapy to evaluate, treat, and fit for a right shoulder arm sling. The August 2021 Treatment Administration Record (TAR), indicated the resident should have a sling to right arm, when available. The September 2021 TAR lacked an indication for a sling to her right arm. Interview with LPN 1 on 9/7/21 at 1:50 p.m., indicated she was aware of the order for the sling, but did not know why the resident did not have it yet. The LPN telephoned the pharmacy and therapy provider was told they do not provide slings. Interview at 9/7/21 at 2:30 p.m. with the Executive Director, indicated the sling had now been purchased by the facility and placed on the resident.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure PRN (as needed) medications were administered upon	R 0246	A. Resident 7 no longer resides in the community B. During the annual survey, the	10/08/2021

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	authorization by a licensed nurse or physician for 1 of 7 residents reviewed for medications. (Resident 7) Finding includes: Record review for Resident 7 was completed on 9/7/21 at 10:35 a.m. Diagnoses included, but were not limited to, chronic Congestive Heart Failure, dementia, and Parkinson's. The July 2021 Physician's Order Summary indicated orders for lorazepam (anti-anxiety medication) 0.25 ml (milliliters solution) by mouth or sublingual every 4 hours as needed for agitation and restlessness, Morphine (pain medication) 0.25 ml sublingually every hour as needed for pain or air hunger and ondansetron (anti nausea) 4 milligram tablet, sublingually every 8 hours as needed for nausea and vomiting. The July Medication Administration Record (MAR), indicated: lorazepam was administered on: - 7/1 at 1:00 a.m. for restlessness by QMA 2 - 7/8 at 6:00 a.m. for restlessness by QMA 1 Morphine was administered on: - 7/1 at 1:00 a.m. for pain by QMA 2 - 7/8 at 6:00 a.m. for pain by QMA 1 ondansetron tablet was administered on: - 7/8 at 6:00 a.m. for nausea by QMA 1 The record lacked an indication of a co-signature of a licensed nurse who authorized the as needed medications. Interview with the Executive Director on 9/7/21		Executive Director and her designee started auditing all of August and September 2021 medication sheets. No other PRN medications given by QMA 1 and 2 were found to be lacking the approval of a licensed nurse. C. The Executive Director or his/her designee will in-service all nursing staff. The staff will be instructed to follow Journey Senior Living of Merrillville's Policy and Procedure regarding the administration of PRN medications by a QMA or licensed nurse. The Executive Director or his/her designee will audit all medication administration records monthly until a pattern of compliance is obtained. D. Monthly audits will continue until a pattern of compliance is obtained. The audit will be reviewed quarterly at the Quality Assurance meeting to ensure continued compliance. E. All training and review will be completed by October 08, 2021.	

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	at 11:55 a.m., indicated that either the Director of Nursing or the Executive Director (who is also a Nurse) would have authorized the resident to have received the as needed medications. The Director of Nursing (no longer employed with the facility) should have co-signed with the QMAs on the MAR. A policy titled, " 5. PRN Medication Use Policy and Procedure," was provided by the Executive Director on 9/7/21 at 2:00 p.m. The current policy indicated, "...Indiana Only:...5. Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift...."			
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 to properly prevent and or contain COVID -19, related to staff not wearing the appropriate personal protective equipment (PPE). This had the potential to affect 44 residents who resided in the facility.	R 0407	A. Executive Director provided LPN 1 eye protection immediately after it was brought to her attention by the ISDH employee. LPN 1 is no longer employed at the facility. B. To determine if other residents may have been affected during the annual survey the Executive	10/08/2021

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	Finding includes: On 9/7/21 from 11:41 a.m. to 12:19 p.m., LPN 1 was observed passing medications to Residents 2, 10, 11, and 13. During this time, LPN 1 was also observed completing blood glucose testing and administering insulin to Resident 12. LPN 1 was wearing a surgical mask but was not wearing any eye protection. On 9/7/21 at 1:56 p.m., the Administrator provided a list of facility staff who had not been fully vaccinated for COVID-19. LPN 1 was unvaccinated. Interview with the Administrator on 9/7/21 at 3:20 p.m., indicated she would provide the staff with eye protection. The IDOH "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure," updated 7/21/21, indicated "...Unvaccinated HCP must wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission...If the county positivity rates are > 5% with increased to moderate or high substantial community transmission then eye protection should be used by unvaccinated HCP for all residents within 6 feet when delivering essential direct care regardless of COVID 19 status..."		Director checked non-vaccinated staff members for proper infection control compliance. C. The Executive Director or his/her designee will in-service all non-vaccinated staff regarding proper infection control/PPE. The Executive Director or his/her designee will do weekly random audits on non-vaccinated staff to verify proper infection control/PPE is being worn. D. The charted weekly audits will be reviewed until a pattern of compliance is obtained. The audits will be reviewed quarterly at the Quality Assurance Committee meetings to assure ongoing compliance. E. All training will be completed by October 08, 2021.	