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	01/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00388063, IN00389731, and IN00393727. Complaint IN00388063 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00389731 - Substantiated. State deficiency related to the allegations is cited at R0090. Complaint IN00393727 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: January 5, 2023 Facility number: 013733 Residential Census:38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/9/23.	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 regulations. The Administrator will ensure all corrective action in the following Plan of Correction had been completed.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure residents who resided in a	R 0052	A. Employee 1 was terminated once the administrator was	01/31/2023

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

Meriam Hillis | Executive Director | 01/19/2023

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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	Memory Care Facility, and were identified by the Director of Nursing as non-interviewable, were free from abuse, related to an employee using a video call while providing personal care to residents and an allegation of drug usage (marijuana) while caring for residents. The facility failed to ensure residents were kept safe from abuse, related to the alleged employee continuing to care for residents after the observations for 1 of 1 abuse allegation reviewed. (Residents E and F and Terminated Employee 1) Using the reasonable person concept, it is likely this led to the invasion of the residents' privacy, potential loss of dignity and self-worth, and mistreatment of the residents. Finding includes: During an interview with the Administrator on 1/5/23 at 1:09 p.m., she indicated there had been a concern with the odor of marijuana with Terminated Employee 1 in September. She indicated there was no facility policy for drug testing. A State reported Incident Report, dated 9/13/22, was reviewed on 1/5/23 at 1:14 p.m. The report indicated an incident on 9/4/22 occurred when an outside vendor and multiple employees reported Terminated Employee 1 was, "face timing" (video chat on phone) while he was providing care to residents in the bathroom behind a closed door and in the dining room. The Administrator viewed the videos for the hallway cameras from 9/2/22 and was able to substantiate Terminated Employee 1 was on a video call upon entering the bathroom in the hallway with a resident and upon exiting the bathroom with the resident. Terminated Employee 1 had admitted he had been on a video call while in the dining room while he assisted a resident with their meal. Terminated		notified on 9/4/2022. Residents E and F had no adverse effects related to the deficient practice. B. To determine if other residents may have been affected the Executive Director interviewed staff to see if any other residents have been affected by the same deficient practice. Immediate action and reporting will take place if same deficient practice is noted. C. All staff has been in serviced on zero tolerance drug policy and testing/HIPAA/Resident Rights/Cell Phones and Video chatting/social media/Abuse Policy/Invasion of Resident Privacy/Dignity and Self Worth/Types of Abuse and reporting abuse immediately to your supervisor and Executive Director. In-house 14 panel drug tests have been purchased for any staff member suspected of being under the influence of drug usage. D. All managers will do daily walk throughs and will report any abuse or violation of the above policies to the administrator immediately. All findings will be reported and reviewed quarterly at the quality assurance committee until a pattern of compliance is obtained. E. Date of Completion: January 31, 2023	

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	Employee 1 also admitted to brining marijuana into the facility. The Investigation Timeline, received from the Administrator with the Incident Report, indicated the allegation of Terminated Employee 1 being observed on a video call while care was provided to a resident was reported to the Director of Nursing (DON) on 9/2/22. On 9/3/22, the cameras were reviewed and statements were gathered. On 9/4/22, Terminated Employee 1 was suspended pending the investigation and on 9/6/22, he was terminated. A signed statement, dated 9/2/22 and written by Hospice Employee 5, indicated on 9/2/22 while she was in the Dining Room assisting a resident with a meal, Terminated Employee 1 was on a video call in the Dining Room. He then assisted a female resident into the bathroom while still on the video call. An undated, signed statement from Employee 4 indicated on 9/2/22, Terminated Employee 1 was observed on a video call with multiple people during the majority of the shift. He was observed assisting Resident E (female resident) into the bathroom (behind a closed door) while on a video call and she had monitored the door to see if he was still on the call when he exited the bathroom. On 9/3/22, Terminated Employee 1 was in the Salon and there was a strong odor of marijuana and his eyes were, "blood shot". There was also a strong odor of marijuana in the hallway where he had been working. An undated, signed statement from Employee 2 indicated Terminated Employee 1 exited the kitchen around 1 p.m. and was on a video call while walking from the dining room to the lounge.			

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	He then assisted Resident E to the Hallway Bathroom. Employee 2 was able to see the screen of the phone which indicated he was on a video call. At approximately 1:50 p.m., Employee 2 went into the "Woman's Bathroom" to provide resident care and observed Resident F with Terminated Employee 1 and he was again on a video call. An undated and unsigned statement, typed and dated 9/6/22, indicated on 9/3/22, Employee 3 observed Terminated Employee 1 in the Dining Room, then upon entering the bathroom with a resident, was on a video call. She was unable to identify which resident he had assisted into the bathroom. A typed and unsigned statement, dated 9/6/22, indicated Employee 6 had indicated Terminated Employee 1 had been in the bathroom for 45 minutes and upon exiting the bathroom, the room smelled like marijuana. During an interview on 1/5/23 at 1:52 p.m., Employee 4 indicated it was difficult to recall exactly everything that occurred since the incident occurred in September. She indicated she had witnessed Terminated Employee 1 being on a video call when he assisted a resident to the bathroom. She acknowledged what she had written on her statement was true. She indicated she reported the allegation to Employee 3 and Employee 3 had notified the DON. She indicated she had notified the Administrator on 9/4/22 about another subject and had asked the Administrator if she was aware of the incident with Terminated Employee 1 and was informed by the Administrator she was unaware of the incident. During an interview on 1/5/23 at 2:01 p.m.,			

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	Employee 3 indicated Hospice Employee 5 had informed her of the concern of Terminated Employee 1 using a video call while residents were being cared for. She then indicated she could not recall everything that had occurred. She indicated she had placed the statement from Hospice Employee 5 either under the DON's office door or in a drawer. She indicated it had been "too long ago" and was unsure if she had called anyone. Terminated Employee 1's time card was reviewed and indicated on 9/2/22 he had worked from 7 a.m. to 7 p.m. with a 1/2 hour break from 11:59 a.m. to 12:29 p.m., on 9/3/22 from 8:15 a.m. to 7 p.m. with a two hour break from 11:50 a.m. to 1:50 p.m., and 9/4/22 from 4:15 p.m. to 6 p.m. An undated facility Drug Free Workplace policy, indicated the use of illegal drugs were prohibited at the facility. The policy was enforced through the administration of a drug testing program, which included testing based on reasonable belief that the employee was using or may have been using drugs. The facility's undated Abuse Policy, received from the Administrator as current on 1/5/23 at 1:43 p.m., indicated the facility policy prohibited abuse, neglect, and mistreatment of all of residents. Abuse and/or mistreatment was to be stopped immediately and the employee was to be suspended and removed from the premises.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four			

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	(24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of			

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	two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting an abuse allegation to the Administrator, not protecting the residents from further abuse, and not reporting the abuse incident to the Indiana Department of Health (IDOH) in a timely manner, for 1 of 1 allegations of abuse reviewed. (Residents E and F, Terminated Employee 1, Employees 2, 3, and 4) Finding includes: A State reported Incident Report, dated 9/13/22, was reviewed on 1/5/23 at 1:14 p.m. The report indicated an incident on 9/4/22 occurred when an outside vendor and multiple employees reported Terminated Employee 1 was, "face timing" (video chat on phone) while he was providing care to residents in the bathroom and dining room. The Administrator viewed the videos for the hallway cameras from 9/2/22 and was able to substantiate Terminated Employee 1 was on a video call upon entering the bathroom in the hallway with a resident and upon exiting the bathroom with the resident. Terminated Employee 1 had admitted he had been on a video call while in the dining room while he assisted a resident with their meal. Terminated Employee 1 also admitted to brining marijuana into the facility. Written statements from Employees 2, 3, and 4 and Hospice Employee 5, indicated on September 2 and 3, 2022, Terminated Employee 5 had been providing care to residents while on video calls. A written statement from Employee 6, indicated on	R 0090	A. Employee 1 was pulled from the floor and suspended immediately after the Administrator was informed of the allegation. Employee 1 was terminated upon complete investigation. Administrator reported the incident late on 9/13/2022. Residents E and F had no adverse effects related to the deficient practice. B. To determine if other residents may have been affected all complaints/grievance forms over the last 12 months will be reviewed by the administrator or his/her designee. Immediate action will take place if a complaint/grievance report deemed needing further investigation. Action to include additional investigating by the Administrator or his/her designee and reporting of the incident to the proper authorities. The residents affected and his/her responsible party will be notified of any additional findings regarding the review of the grievance report. ISDH will also be notified immediately. C. All management staff responsible for investigating and reporting allegations of abuse, neglect and violation of Residents Rights have received proper	01/31/2023

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	9/3/22 (the number 3 was crossed out and number 4 had been written), there was an allegation an illegal drug was being used while on duty while caring for the residents. Interviews with Employees 3 and 4 indicated the Administrator had not been notified of the allegations until 9/4/22. During an interview on 1/5/23 at 1:45 p.m., the Director of Nursing (DON), indicated she had not been notified of the allegation on 9/2/22 or 9/3/22. During an interview on 1/5/23 at 1:50 p.m.. the Administrator indicated the dates on the statements had been "all messed up". During an interview on 1/5/23 at 2:01 p.m., Employee 3 indicated Hospice Employee 5 had informed her of the concern of Terminated Employee 1 using a video call while residents were being cared for. She indicated she had placed the statement from Hospice Employee 5 either under the DON's office door or in a drawer. She indicated it had been "too long ago" and was unsure if she had called anyone. Terminated Employee 1's time card was reviewed and indicated on 9/2/22 he had worked from 7 a.m. to 7 p.m. with a 1/2 hour break from 11:59 a.m. to 12:29 p.m., on 9/3/22 from 8:15 a.m. to 7 p.m. with a two hour break from 11:50 a.m. to 1:50 p.m., and 9/4/22 from 4:15 p.m. to 6 p.m. During an interview on 1/5/23 at 1:45 p.m., the DON indicated as soon as she was aware of the allegations, she had placed Terminated Employee 1 on suspension. A State reported Incident Report was dated		training regarding Parkside's Policy and Procedures to include specifics for reporting within 24 hours of incident, identifying potential abuse, investigating alleged abuse, and preventing abuse by the Director of Operations. D. All complaints/grievances reports will be reviewed by the administrator or his/her designee to assure that any report of alleged abuse /neglect or violation of Resident's Rights is thoroughly investigated and reported per Parkside policy. Administrator of his/her designee will review every grievance report and report quarterly to the quality assurance committee the ongoing results of this review until a pattern of compliance is obtained. E. Date of Completion: January 31, 2023	

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	9/13/22, was reviewed on 1/5/23 at 1:14 p.m. The report indicated the allegation of abuse occurred on 9/2/22. During an interview on 1/5/23 at 1:45 p.m., the Administrator indicated the incident had not been reported to the IDOH timely. The facility's undated Abuse Policy, received from the Administrator as current on 1/5/23 at 1:43 p.m., indicated all allegations were to be reported immediately to the Administrator/Executive Director and other officials as required by Indiana State Law. The abuse/mistreatment was to be stopped immediately and the employee was to be removed from the premises. The allegation was to be reported to the a Supervisor and Administrator. The Administrator would provide an initial report within 24 hours to the IDOH. Cross reference R0052. This Residential tag relates to Complaint IN00389731.			