DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARK PLACE HEALTH AND WELLNESS CENTER	10820 PARK PLACE SAINT JOHN, IN 46373

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Licensure Survey. Survey dates: April 15, 16, and 17, 2025 Facility number: 017974 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/28/25.	R 0000	The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.	
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 2 of 7 residents reviewed. (Residents 8 and 7) Findings include: 1. Closed record review for Resident 8 was completed on 4/16/25 at 2:53 p.m. Diagnoses included, but were not limited to, dementia and	R 0215	Park Place of St. John Health & Wellness assures that residents' pre-admission evaluations are completed per regulation. **1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:**	05/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacquelyn Terpstra	Administrator	05/02/2025

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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	hypertension. The resident admitted to the facility on 8/8/24. There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility. During an interview on 4/17/25 at 11:19 a.m., the Director of Nursing (DON) indicated a Pre-Admission Evaluation was not completed before the resident admitted to the facility. 2. Resident 7's closed record was reviewed on 4/16/25 at 11:00 a.m. The resident was admitted to the facility on 8/8/24. Diagnoses included, but were not limited to, heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (COPD). The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 4/16/25 at 1:21 p.m., the Director of Nursing indicated a Pre-Admission Evaluation was not completed before the resident admitted to the facility.		Because Residents 7 and 8 were already admitted, a pre-admission evaluation could not be completed for these residents to correct this situation. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All newly admitted residents have the potential to be affected by the alleged deficient practices. There have been no new admissions since 4/17/25 and therefore no new Pre-Admission Evaluations have been completed. Administrator, DON, Clinical Services Manager, and Admissions Coordinator have been educated regarding completing Pre-Admission Evaluations for all residents admitting to the Residential Facility. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** Administrator or designee will monitor newly admitted resident records weekly for 12 weeks to ensure compliance. **4 Quality Assurance plans to monitor facility performance to make sure corrections are**	

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			achieved: Administrator or designee will monitor newly admitted resident records weekly for 12 weeks to ensure compliance that Pre-Admission Evaluations have been completed prior to admission. Pre-Admission Evaluation audit tools will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were signed and completed and/ or updated with changes for 6 of 7 service plans reviewed. (Residents 3, 8, 4, 6, 5, and 7) Findings include: 1. Record review for Resident 3 was completed on 4/15/25 at 2:32 p.m. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation, congestive heart failure, hypertension, and depression. The resident admitted to the facility on 1/22/25. A services list provided by the facility on 4/15/25 indicated the resident was on therapy services.	R 0217	**1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Service plans for Residents 4, 5, and 6 were audited to ensure they have been updated/completed/signed per regulation. Residents 3, 7 and 8 no longer reside at the facility and therefore no further corrective action can be taken at this time. **2 Actions taken to identify other residents that have the**	05/02/2025

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	A Service Plan, dated 3/10/25, did not include that the resident received therapy services. There was a lack of documentation in physician's orders, progress notes, or the service plan that indicated the resident was on therapy services. During an interview on 4/16/25 at 12:05 p.m., the Director of Nursing (DON) indicated the resident had been receiving therapy services since his admission. Therapy services was not listed on the service plan but should have been included. 2. Closed record review for Resident 8 was completed on 4/16/25 at 2:53 p.m. Diagnoses included, but were not limited to, dementia and hypertension. The resident admitted to the facility on 8/8/24. A Service Plan was completed on 9/9/24. The Service Plan was not signed by the resident or the resident's representative. During an interview on 4/17/25 at 11:19 a.m., the DON indicated the service plan was not signed by the resident's representative after it was completed but should have been signed. 3. Resident 4's record was reviewed on 4/15/25 at 2:46 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and hypertension. The resident was admitted to the facility on 8/8/24. A Service Plan Report, dated 3/27/25, had been signed by the resident's daughter. There was a lack of any documentation a Service Plan had been in place upon admission or reviewed and signed by the resident or responsible party until		**potential to be affected by the deficient practice:** All residents have the potential to be affected by the alleged deficient practices. All resident service plans have been audited to ensure they have been updated/completed /signed per regulation. DON, Social Services Designee and Administrator have been educated regarding updating/completing/signing service plans per regulation. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** Resident service plans were audited to ensure updating/completion/signing by resident or their responsible party. Director of Nursing/Designee will audit three records twice weekly for 12 weeks for any new orders, to ensure resident service plans are updated with changes/completed/signed per regulation. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:** Director of Nursing/Designee or designee will audit three records	

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	3/27/25. During an interview on 4/16/25 at 9:48 a.m., the Director of Nursing indicated all residents' service plans had been reviewed at the end of March and were signed by the resident or responsible party at that time. She was unable to provide any documentation of previous service plans. 4. Resident 6's record was reviewed on 4/16/25 at 9:46 a.m. Diagnoses included, but were not limited to, hypertension, and acute kidney failure. The resident was admitted to the facility on 8/1/24. A Service Plan Report, dated 3/27/25, had been signed by the resident. There was a lack of any documentation a Service Plan had been in place upon admission or reviewed and signed by the resident until 3/27/25. During an interview on 4/16/25 at 9:48 a.m., the Director of Nursing indicated all residents' service plans had been reviewed at the end of March and were signed by the resident or responsible party at that time. She was unable to provide any documentation of previous service plans.5. Resident 5's record was reviewed on 4/15/25 at 3:04 p.m. The resident was admitted to the facility on 9/11/24. Diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease (COPD). The Service Plan, initiated on 9/11/24, indicated the resident was independent with eating, bathing, dressing, grooming, and toileting. She required assistance with nebulizer treatments and medication administration. The Service Plan was not signed by the resident		twice weekly for 12 weeks to ensure compliance. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	

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	until 3/27/25. During an interview on 4/16/25 at 9:50 a.m., the Director of Nursing indicated she had all service plans signed in March of 2025. 6. Resident 7's record was reviewed on 4/16/25 at 11:00 a.m. The resident was admitted to the facility on 8/8/24. Diagnoses included, but were not limited to, heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (COPD). A Service Plan, initiated on 9/6/24, indicated the resident required assistance from staff with activities of daily living and medication management. The Service Plan was not signed by the resident and/or resident representative. During an interview on 4/16/25 at 1:21 p.m., the Director of Nursing indicated she was unable to provide a signed service plan for the resident.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on record review and interview, the facility failed to ensure physician's orders were followed, related to laboratory (lab) tests not completed as ordered, medications not given as ordered, and vital signs not monitored as ordered for 2 of 7 residents reviewed. (Residents 4 and 5) Findings include: 1. Resident 4's record was reviewed on 4/15/25 at 2:46 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and	R 0241	**1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Physician was notified of incomplete labs for R4 and orders received to complete labs. Labs have been completed and results reported to the Doctor on 4/28/25. Notified R5's physician of missed medications and transcription	05/02/2025

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hypertension.

A Physician's Order, dated 1/17/25, indicated CMP (complete metabolic panel) and CBC (complete blood count) laboratory tests were to be completed on 1/20/25. The record lacked documentation of CMP and CBC results and indication the laboratory tests had been completed as ordered.

During an interview on 4/16/25 at 1:17 p.m., the Director of Nursing indicated the January lab tests had not been completed. No further information was provided.2. Resident 5's record was reviewed on 4/15/25 at 3:04 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety.

The Service Plan, dated 3/27/25, indicated the resident independent for activities of daily living, used oxygen therapy independently, and required medication supervision.

A Progress Note, dated 3/11/25 at 3:59 p.m., indicated the resident had returned from the dentist with a new prescription for amoxicillin 875 milligrams every 12 hours for 7 days for an abscess where one of the posts were located for dental implants. The nurse practitioner and Director of Nursing were notified.

A Physician's Order, dated 3/11/25, indicated amoxicillin (antibiotic) tablet 875 milligram (mg) twice daily for infection for 7 days.

The March 2025 Medication Administration Record (MAR) indicated the amoxicillin medication was not signed out as administered in the morning on 3/12, 3/13, 3/14, 3/15, 3/16, and 3/17/25.

errors, as well as vital signs not being monitored related to medication administration, and orders were corrected.

2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:

Residents who have orders for lab work to be completed, as well as residents who receive medications and those requiring monitoring of vital signs prior to administration have the potential to be affected by these alleged deficient practices. Current resident records have been reviewed for lab orders, as well as medication orders for transcription errors including vital signs parameters. Medication Administration Records were audited for any undocumented medication administrations. Nurse staff educated regarding completion of labs as ordered; medication transcription; completion of medication administration record; and vital signs associated with ordered parameters.

3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:

Director of Nursing/Designee will audit three records twice weekly

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	A Progress Note, dated 3/15/25 at 10:44 a.m. indicated the amoxicillin was administered with morning medications. "The order was entered incorrectly in the electronic health record as early morning and evening. There was not a nurse on the unit during early morning hours. Please correct." A Physician's Order, dated 1/9/25, indicated alprazolam (anti-anxiety medication) 0.5 mg, 1 tablet in the evening. The March 2025 MAR indicated the alprazolam was not administered as ordered in the evening on 3/2, 3/4, 3/6, 3/28, 4/1, and 4/6/25. A Physician's Order, dated 1/30/25, indicated metoprolol tartrate (blood pressure medication) tablet 25 mg, give 0.5 tablet by mouth two times a day. Hold the medication for a heart rate (HR) less than 60. The record lacked documentation of the resident's HR being monitored when the medication was given for March and April 2025. During an interview on 4/16/25 at 9:50 a.m., the Director of Nursing indicated they had a nurse on the morning shift to pass morning medications, so she was unsure why the amoxicillin was not given to the resident as ordered. There was not a spot on the MAR for a HR to be documented, however the nurses' were to write progress notes with the information.		for 12 weeks regarding lab orders completed and resulted in charts; new medication orders correctly transcribed; medication administration records are complete including vital signs related to medication parameters. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:** Director of Nursing/Designee or designee will audit three records twice weekly for 12 weeks to ensure compliance. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on record review and interview, the facility	R 0354	**1 Corrective Actions taken**	05/02/2025

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	failed to ensure a transfer/discharge form was completed for 1 of 7 resident records reviewed. (Resident 8) Finding includes: Closed record review for Resident 8 was completed on 4/16/25 at 2:53 p.m. Diagnoses included, but were not limited to, dementia and hypertension. A Progress Note, dated 2/6/25 at 4:00 p.m., indicated an ambulance was at the facility to transport the resident to the hospital related to low hemoglobin and shortness of breath. The paperwork was sent with the resident's son. There was a lack of documentation to indicate a transfer form was completed and sent to the hospital that included the name of the receiving institution and date of transfer, nursing notes related to the resident, functional abilities and physical limitations, nursing care, medications, treatments, current diet, or resident condition upon transfer. During an interview on 4/17/25 at 12:56 p.m., the Director of Nursing (DON) indicated the resident was going to the hospital for a blood transfusion. The resident was supposed to come back to the facility but did not. They had only sent the resident's face sheet. They did not send any other transfer form that included the above documentation.		**for those residents alleged to have been affected by the alleged deficient practice are:** Because Resident 8 was already transferred and is no longer living in this facility, a transfer form could not be completed for this resident and no further corrective actions can be completed at this time. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All residents have the potential to be affected by the same alleged deficient practices. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** Nurses have been educated on proper discharge/transfer documentation, including when residents leave the facility for physician visits, ER visits, and transfers to other facilities or home. Processes have been implemented for nurses to properly document discharges/transfers from the facility. Director of Nursing/Designee will audit all discharges/transfers weekly for 12 weeks to ensure compliance.	

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			4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved: Director of Nursing/Designee or designee will audit all discharges/transfers weekly for 12 weeks to ensure compliance. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the Emergency Binder had complete resident information for 5 of 5 resident records reviewed. (Residents 2, 3, 4, 5, and 6) Findings include: The resident Emergency Binder was reviewed on 4/16/25 at 10:40 a.m. a. Resident 2 was missing the entire file in the binder. b. Resident 3 was missing hospital preference. c. Resident 4 was missing hospital preference.	R 0356	**1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Resident 3 no longer resides in the facility and therefore no further corrective action can be taken at this time. Emergency files for Residents, 2 4,5,and 6 have been updated to note each resident's hospital preference. Resident 2 had just moved into the facility. The resident's information is now in the binder. Resident 6's file was moved from	05/02/2025

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	d. Resident 5 was missing hospital preference. e. Resident 6 was missing hospital preference and current room number. During an interview on 4/16/25 at 11:00 a.m., the Director of Nursing was made aware of the missing items. No additional information was provided.		the second-floor binder to the first-floor binder where he recently moved to. His room number was updated appropriately. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All residents in the facility have the potential to be affected by the alleged deficient practice. All resident emergency files were audited to ensure all proper documentation is available in the binders. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** All resident emergency files in the emergency binders were audited and updated with hospital preference and correct room number. Administrator, Director of Nursing, Social Services Director, and Admissions have been educated regarding ensuring all resident documentation is accurate in the emergency binders. Administrator/Designee will audit emergency binders upon new resident admission for 12 weeks to ensure hospital preferences are identified, room numbers are correct.	

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			4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved: Administrator/Designee will audit emergency binders upon new resident admission for 12 weeks to ensure hospital preferences are identified, room numbers are correct. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure each resident had a signed annual health statement for 6 of 7 records reviewed for annual health statements. (Residents 3, 4, 6, 2, 5, and 7) Findings include: 1. Record review for Resident 3 was completed on 4/15/25 at 2:32 p.m. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation, congestive heart failure, hypertension, and depression. There was no documentation to indicate an	R 0409	**1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Annual Health Statements were documented in resident medical records to meet this requirement for residents 2,4,5, and 6. Residents 3 and 7 no longer reside at the facility and therefore no further corrective action can be taken. **2 Actions taken to identify**	05/02/2025

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(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
	annual health statement that the resident was free of communicable diseases had been completed. During an interview on 4/16/25 at 9:47 a.m., the Director of Nursing (DON) indicated they did not have an annual health statement for the resident completed. 2. Resident 4's record was reviewed on 4/15/25 at 2:46 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and hypertension. The resident was admitted to the facility on 8/8/24. There was a lack of any health statement in the record to indicate the resident was free of communicable diseases. During an interview on 4/16/25 at 9:48 a.m., the Director of Nursing indicated there was no annual health statement. 3. Resident 6's record was reviewed on 4/16/25 at 9:46 a.m. Diagnoses included, but were not limited to, hypertension and acute kidney failure. The resident was admitted to the facility on 8/1/24. There was a lack of any health statement in the record to indicate the resident was free of communicable diseases. During an interview on 4/16/25 at 9:48 a.m., the Director of Nursing indicated there was no annual health statement. 4. Resident 2's record was reviewed on 4/15/25 at 12:24 p.m. The resident was admitted to the facility on 4/11/25. Diagnoses included, but were not limited to, high blood pressure and dementia.		**other residents that have the potential to be affected by the deficient practice:** All residents have the potential to be affected by the alleged deficient practice. The facility has audited all resident records and has completed the required annual health statement for each resident. Director of Nursing has been educated regarding the need to have physician complete the annual health statement and document it in each resident's record. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** The facility has audited all resident records and has ensured that each resident record contains the required signed annual health statement. Director of Nursing or designee will audit all new admissions for 12 weeks to ensure initial health statements are completed and documented per regulation. Annual health statements will be updated at time of updating resident assessments and service plans. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:**	

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		A. BUILDING 00 B. WING	04/17/2025

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	The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 4/16/25 at 9:47 a.m., the Director of Nursing indicated the resident did not have an annual health statement. 5. Resident 5's record was reviewed on 4/15/25 at 3:04 p.m. The resident was admitted to the facility on 9/11/24. Diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease (COPD). The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 4/16/25 at 9:50 a.m., the Director of Nursing indicated the resident did not have an annual health statement. 6. Resident 7's record was reviewed on 4/16/25 at 11:00 a.m. The resident was admitted to the facility on 8/8/24. Diagnoses included, but were not limited to, heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (COPD). The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 4/16/25 at 1:21 p.m., the Director of Nursing indicated the resident did not have an annual health statement.		Director of Nursing or designee will audit all new admissions for 12 weeks to ensure initial health statements are completed and documented per regulation These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure residents had a documented	R 0410	**1 Corrective Actions taken for those residents alleged to**	05/02/2025

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	Mantoux test (test for tuberculosis) completed upon admission for 4 of 7 residents reviewed for Mantoux testing. (Residents 4, 6, 2, and 5) Findings include: 1. Resident 4's record was reviewed on 4/15/25 at 2:46 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and hypertension. The resident was admitted to the facility on 8/8/24. There was a Mantoux test, dated 6/6/22, documented as negative. There was a lack of documentation to indicate the resident had received a Mantoux test upon admission to the facility. During an interview on 4/16/25 at 11:03 a.m., the Director of Nursing indicated the only Mantoux test she could find was the one completed on 6/6/22. 2. Resident 6's record was reviewed on 4/16/25 at 9:46 a.m. Diagnoses included, but were not limited to, hypertension and acute kidney failure. The resident was admitted to the facility on 8/1/24. There was a lack of documentation to indicate the resident had received a Mantoux test upon admission to the facility. During an interview on 4/16/25 at 11:03 a.m., the Director of Nursing indicated she was unable to find any completed Mantoux testing for the resident.3. Resident 2's record was reviewed on 4/15/25 at 12:24 p.m. The resident was admitted to the facility on 4/11/25. Diagnoses included, but		**have been affected by the alleged deficient practice are:** Residents 2,4,5, and 6 have had new Mantoux tests completed and documented in their medical records. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All other residents have the potential to be affected by the alleged deficient practice. Facility completed audit of all resident Mantoux tests, and ensured all residents have completed up-to-date Mantoux tests. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** The facility has educated Director of Nursing, Infection Preventionist Nurse, and staff nurses, regarding completion of Mantoux tests prior to or at the time of admission. Facility completed audit of all resident Mantoux tests, and made sure all residents have completed Mantoux tests. Director of Nursing or designee will audit new admissions weekly for 12 weeks to ensure compliance. **4 Quality Assurance plans to**	

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	were not limited to, high blood pressure and dementia. There was a lack of documentation to indicate the resident had received a Mantoux test upon admission to the facility. During an interview on 4/16/25 at 11:15 a.m., the Director of Nursing indicated she was unable to find any completed Mantoux testing for the resident. 4. Resident 5's record was reviewed on 4/15/25 at 3:04 p.m. The resident was admitted to the facility on 9/11/24. Diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease (COPD). There was a lack of documentation to indicate the resident had received a Mantoux test upon admission to the facility. During an interview on 4/16/25 at 11:15 a.m., the Director of Nursing indicated she was unable to find any completed Mantoux testing for the resident.		**monitor facility performance to make sure corrections are achieved:** Director of Nursing or designee will audit new admissions weekly for 12 weeks to ensure compliance. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	
S 0000 Bldg. 00	This visit was for a Non-Certified Comprehensive (NCC) Licensure Survey. This visit included a State Residential Licensure. Survey dates: April 15, 16, and 17, 2025 Facility number: 017974 Census Bed Type:	S 0000	The services provided and arranged by Park Place of St. John Health and Wellness Center meet professional standards of quality. This plan of correction is submitted pursuant to the request of the Indiana Department of Health state requirements, and the statements made in this plan of	

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	Residential: 22 NCC: 15 Total: 37 Census Payor Type: Other: 15 Total: 15 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/28/25.		correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein; anything stated herein does not constitute a waiver of any rights or remedies Park Place of St. John Health and Wellness Center may choose to pursue in order to protect its rights. Park Place of St. John Health and Wellness Center respectfully requests a desk review for our response to these findings.	
S 9999 Bldg. 00	3.1-37 Quality of Care (a) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan. This state rule was not met as evidenced by: Based on record review, and interview, the facility failed to ensure residents received necessary care and services, related to not receiving medications as ordered, lack of documentation related to unknown skin injuries, and a lack of wound treatments documented for 3 of 7 residents reviewed for quality of care in NCC (Non-certified Comprehensive Care) beds. (Residents 3, 13, and 10) Findings include:	S 9999	**S9999 – Quality of Care 3.1-37** **1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Resident 3 no longer resides in the facility and therefore no corrective actions could be taken. When Resident 13's bruise was brought to the attention of the facility, the facility conducted a thorough investigation of the matter and reported their investigative findings to the surveyors at the time of the survey as well as to the State via the Gateway.	05/02/2025

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	1. Closed record review for Resident 3 was completed on 4/16/25 at 10:08 a.m. Diagnoses included, but were not limited to, Parkinson's, atrial fibrillation, congestive heart failure, hypertension, GERD (gastroesophageal reflux disease), hypothyroidism, and depression. The resident discharged from the facility on 1/22/25. The Admission Minimum Data Set (MDS) assessment, dated 1/14/25, indicated the resident was cognitively intact. The resident had received, antidepressant, anticoagulant, antibiotic, diuretic, opioid, and antiplatelet medications. The January 2025 Physician's Order Summary (POS) indicated orders for the following medications: - esomeprazole magnesium (heartburn medication) 20 mg one time a day for GERD - levothyroxine sodium (thyroid medication) 175 mcg (micrograms) one time a day for hypothyroidism - docusate sodium (stool softener) 100 mg every 12 hours for constipation - gabapentin (anticonvulsant medication) 300 mg every 12 hours - Sinemet (treat symptoms of Parkinson's disease) 37.5-150 mg every 4 hours The January 2025 Medication Administration Record (MAR), was blank and medications were not marked off as given for the following dates and times: - esomeprazole magnesium: morning on 1/6, 1/9, 1/14, 1/15, 1/16, and 1/20/25 - levothyroxine sodium: morning on 1/6, 1/9, 1/14, 1/15, 1/16, and 1/20/25 - docusate sodium: 6:00 a.m., on 1/16/25 - gabapentin: 6:00 a.m., on 1/16/25		Because Resident 10's skin issue has resolved, no further treatments are necessary. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All residents have the potential to be affected by the alleged deficient practices. Facility has reviewed medication administration records for completion and has addressed any additional instances of not administering medications as ordered with nursing staff. Additional identified instances of not administering medications have been reported to residents' physician. All residents have been assessed, with no new unknown skin injuries identified. All current residents with wounds have been identified and records reviewed for current orders. Administrator, Director of Nursing, Clinical Support Nurse, and nursing staff have been educated on ensuring medication administration documentation is complete; conducting timely investigations of unknown skin injuries. and importance that treatments are in place for skin issues. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:**	

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- Sinemet: 6:00 a.m., on 1/16/25

During an interview on 4/16/25 at 12:05 p.m., the Director of Nursing (DON) indicated she could not provide any documentation the medications were administered on the above dates and times.

2. Record review for Resident 13 was completed on 4/17/25 at 10:11 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, and dementia.

The Admission MDS assessment, dated 2/27/25, indicated the resident was cognitively impaired. The resident was dependent on staff for toileting, bathing, dressing, and transfers. The resident had skin tears.

A Care Plan, dated 4/4/25, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to dressing and transfers. Interventions included that the resident was totally dependent on staff for dressing and transferring.

A Care Plan, dated 2/21/25 and resolved on 3/10/25, indicated the resident had skin tears to the left forearm. Interventions included to educate resident and or representative about proper skin care to prevent skin breakdown, and encourage the resident to keep upper extremities covered as much as possible.

The April 2025 POS indicated the following orders:
- Monitor for the following behaviors (specify): itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing,

Director of Nursing or designee will audit three records twice weekly for 12 weeks to ensure compliance.

4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:

Director of Nursing or designee will audit three records twice weekly for 12 weeks to ensure compliance. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.

S9999 – Quality of Care 3.1-12

1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:

Because Resident 3 was already transferred, a transfer form could not be completed for this resident.

2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:

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	delusions, hallucinations, psychosis, aggression, refusal of care, episodes of crying, and isolating self every shift. Document: 'Y' if monitored. 'N' if not monitored. If behaviors observed, document Progress Note of findings. - Skin tear left hand: Clean with normal saline, apply xeroform gauze to wound, cover with transparent dressing. Change every 3- 4 days and PRN (as needed) when soiled until healed. Start date 2/26/25 and discontinued 4/9/25. The April 2025 MAR lacked any "Y" documentation indicating the resident had behaviors observed. A Progress Note, dated 2/21/25 at 12:24 a.m., indicated the resident was noted with a skin tear to her left forearm that measured 6 cm (centimeters) x 8.5 cm. There were also two skin tears to top of the left hand. One measured 2 cm x 1.5 cm and the other measured 2 cm x 1 cm. The resident was unable to offer the reason for the skin tears when questioned. A Progress Note, dated 4/12/25 at 7:00 p.m., indicated during shower assistance, the CNA notified the nurse of the resident's new skin issue. There was a dark purple bruise noted to the left upper forearm distal to the antecubital region that measured 6 cm x 6 cm. There was no swelling or tenderness and range of motion was within normal limits for the resident. The origin was unknown. The record lacked any documentation to indicate the facility had investigated how the resident received the unknown skin tears or the bruise. During an interview on 4/17/25 at 12:56 p.m., the DON indicated there was no investigation as to how the resident received the skin tears or the		All residents who are transferred/discharged have the potential to be affected by the same alleged deficient practices. All transferred/discharged residents since 4/17/25 have been reviewed for proper discharge/transfer documentation. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** Nurses were educated to ensure the "Notice of Transfer or Discharge" accompanies resident at time of their transfer/discharge, and to document transfers/discharges as per the facility policy and state regulation. Administrator/Designee will audit resident transfer/discharge forms weekly for 12 weeks to ensure completion/documentation per regulation. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved;** Administrator/Designee will audit resident transfer/discharge forms weekly for 12 weeks to ensure completion/documentation per regulation. These audit results will be reviewed and discussed by the Interdisciplinary Team through the	

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	bruise. The resident did sometimes become combative with care but staff should have documented those incidents if they occurred. She was unsure how the resident received the skin tears or the bruise. 3. Record review for Resident 10 was completed on 4/17/25 at 10:51 a.m. Diagnoses included, but were not limited to, chronic venous insufficiency, hypertension, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 2/26/25, indicated the resident was dependent on staff for assistance with bed mobility, toileting, dressing, and personal hygiene. A current Care Plan, updated 4/20/24, indicated the resident had impairment to his skin integrity. An intervention included, "wound care as ordered." A Progress Note, dated 2/16/25 at 10:29 p.m., indicated staff was getting the resident ready for bed and noticed a burst blister on his left shin. The area measured 9 cm (centimeters) by 8 cm. The on-call Nurse Practitioner was notified and gave orders to clean with normal saline, apply Xeroform (a wound dressing) and a dry dressing, and have wound care assess it. A Skin Check Progress Note, dated 2/16/25 at 10:20 p.m., indicated the resident had a new skin issue, a blister to the left shin measuring 9 cm by 8 cm by 0.1 cm. A Progress Note, dated 2/17/25 at 5:18 a.m., indicated there was a previous dressing in place to the resident's left leg and wound care was to		Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring. **S9999 – Quality of Care - 3.1-48** **1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Resident 10's documentation has now been updated and completed to per the regulation. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All residents receiving PRN medications have the potential to be affected by the alleged deficient practice. Facility has completed audit of all residents with PRN medication orders to ensure that prior to administration non-pharmacological interventions are attempted and are documented in a timely fashion. **3 The Measures the facility will take to ensure the problem will be corrected and will not**	

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	evaluate the wound today. A Physician's Order, dated 2/24/25, indicated to clean the left lateral lower leg wound with wound wash, pat dry, apply a non-adherent dressing, and cover with a dry dressing three times a week. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2025, lacked documentation any treatment was completed to the left shin wound until 2/24/25. During an interview on 4/17/25 at 2:58 p.m., the Director of Nursing was made aware of the concern and the policy was requested. No further information was provided. 3.1-12 Transfer and discharge rights (a) The transfer and discharge rights of residents of a facility are as follows: (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident's legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (9) For health facilities, the written notice specified in subdivision (7) must include the following:		**reoccur:** Nurses were inserviced to ensure that non- pharmacological interventions are attempted and are documented in a timely fashion prior to PRN medication administration per the regulation. Director of Nursing/Designee will monitor, twice weekly, three residents receiving PRN medications, to ensure that prior to administration non-pharmacological interventions are attempted and are documented in a timely fashion. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:** Director of Nursing/Designee will monitor, twice weekly, three residents receiving PRN medications, to ensure that prior to administration non-pharmacological interventions are attempted and are documented in a timely fashion. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	

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	(A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, "You have the right to appeal the health facility's decision to transfer you. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident had a transfer/discharge summary completed when the resident discharged from the facility for 1 of 7 resident records reviewed. (Resident 3) Finding includes: Closed record review for Resident 3 was completed on 4/16/25 at 10:08 a.m. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation, congestive heart failure, hypertension, GERD (gastroesophageal reflux disease), hypothyroidism, and depression. The resident discharged from the facility on 1/22/25. There was a lack of documentation that a discharge assessment or a transfer form was completed for the resident. There were no progress notes to indicate where the resident went or that he discharged from the facility on 1/22/25. During an interview on 4/16/25 at 12:05 p.m., the DON indicated the resident had discharged from their NCC facility and admitted into their Assisted Living facility on 1/22/25. They did not complete a discharge assessment or transfer form on the resident and one should have been completed. 3.1-48 Drug therapy		**S9999 Quality of Care- 3.1-35** **1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Resident 12's Care Plan has now been updated to include therapy orders (including use of bilateral resting night splints for hand contractures), activity of daily living needs, and anticoagulant, hypoglycemic, and diuretic medications per the regulation. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** Residents receiving therapy services; activity of daily living needs; or specific medications that require care planning/monitoring; have the potential to be affected by the alleged deficient practice. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** Nurses were educated to update care plans, upon admission and with changes in orders/treatments, for those receiving therapy services; activity of living daily needs; and for those receiving	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARK PLACE HEALTH AND WELLNESS CENTER	10820 PARK PLACE SAINT JOHN, IN 46373

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	(a) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (4) without adequate indications for its use; This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to administering PRN (as needed) pain medication for 1 of 7 residents reviewed. (Resident 10) Finding includes: Record review for Resident 10 was completed on 4/17/25 at 10:51 a.m. Diagnoses included, but were not limited to, chronic venous insufficiency, hypertension, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 2/26/25, indicated the resident was cognitively intact and dependent on staff for assistance with bed mobility, toileting, dressing, and personal hygiene. A current Care Plan, updated 5/18/24, indicated the resident had chronic pain related to diabetic neuropathy and venous insufficiency. An intervention included to encourage the resident to try different pain-relieving methods such as positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, and ultrasound. A Physician's Order, dated 1/17/25, indicated to give oxycodone-acetaminophen (an opioid pain medication) 7.5-325 mg (milligrams), every four hours as needed for pain.		certain medications that require care planning/monitoring. All current resident care plans were reviewed to ensure inclusion of therapy services; activity of living daily needs; and for those receiving certain medications that require care planning/monitoring. Director of Nursing or designee will audit three resident records twice weekly for new therapy orders; new medication orders; and changes in activities of daily living, as well as all new admissions, twice weekly for 12 weeks to ensure compliance. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:** Director of Nursing or designee will audit three resident records twice weekly for new therapy orders; new medication orders; and changes in activities of daily living, as well as all new admissions, twice weekly for 12 weeks to ensure compliance. These audit results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process monthly for six months, and any corrective action plans necessary will be put into place as indicated based on review, along with determinations related to ongoing monitoring.	

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	The Medication Administration Record (MAR), dated 4/2025, indicated the resident received the oxycodone-acetaminophen medication on 4/3/25 at 8:05 p.m., 4/6/25 at 8:40 p.m., 4/7/25 at 3:30 p.m., 4/8/25 at 7:30 p.m., 4/9/25 at 10:25 p.m., 4/10/25 at 8:30 p.m., 4/12/25 at 7:36 p.m., 4/15/25 at 9:58 p.m., 4/16/25 at 8:01 a.m. and 9:07 p.m., and 4/17/25 at 7:00 a.m. There was a lack of documentation to indicate any non-pharmacological interventions had been attempted prior to the administration of the pain medication. The Electronic Medication Administration Record (EMAR) Notes for the above dates and times lacked documentation to indicate any non-pharmacological interventions had been attempted prior to the administration of the pain medication. During an interview on 4/17/25 at 2:58 p.m., the Director of Nursing indicated non-pharmacological interventions should have been attempted and documented. 3.1-35 COMPREHENSIVE CARE PLAN (a) The facility must develop a written comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. (b) The care plan must describe the following: (1) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive care plan was		**S9999 - Special Care Needs – 3.1-47** **1 Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are:** Resident 9's PICC line has been removed and therefore no corrective actions can be taken at this time. **2 Actions taken to identify other residents that have the potential to be affected by the deficient practice:** All residents with PICC lines have the potential to be affected by the alleged deficient practice. Facility completed audit of all residents and none were found to have a PICC line. **3 The Measures the facility will take to ensure the problem will be corrected and will not reoccur:** Nurses were educated to request orders for PICC lines and follow orders in a timely fashion for monitoring of PICC lines and other special care needs. Facility completed audit of all residents and none were found to have a PICC line. Director of Nursing or designee will audit for 12 weeks all new admissions with PICC lines to	

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	developed and in place for therapy and medications for 1 of 7 residents reviewed for comprehensive care plans. (Resident 12) Finding includes: Resident 12's record was reviewed on 4/16/25 at 2:36 p.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat), high blood pressure, diabetes mellitus, and edema. The Admission Minimum Data Set (MDS) assessment, dated 3/19/25, indicated the resident was cognitively intact. He had impairment in range of motion for bilateral upper and lower extremities and used a wheelchair for mobility. He was dependent on staff for toileting, showering, personal hygiene, and transfers. He was incontinent of bowel and bladder. In the 7-day lookback period, the resident received an anticoagulant and hypoglycemic medication. The resident had only three care plans, which were related to the resident having a nutritional problem, diagnosis of anemia, and independence for meeting emotional, intellectual, physical, and social needs. The current Physician Order Summary (POS) indicated the resident was receiving therapy to evaluate and treat for bilateral resting night splints for hand contractures, hydrochlorothiazide (diuretic) capsule 12.5 milligram (mg) once daily, apixaban 5 mg (anticoagulant) tablet twice daily, and metformin (diabetic medication) tablet 500 mg daily. There was not a comprehensive care plan developed for the use of anticoagulant, hypoglycemic, and diuretic medication, activities		ensure orders are entered for flushing and proper care of the PICC lines, according to facility policy. **4 Quality Assurance plans to monitor facility performance to make sure corrections are achieved:** Director of Nursing or designee will audit for 12 weeks all new admissions with PICC lines to ensure orders are entered for flushing and proper care of the PICC lines, according to facility policy. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring.	

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of daily living needs, therapy and/or contractures.

During an interview on 4/17/25 at 1:00 p.m., the Director of Nursing indicated the care plans would be added now.

3.1-47 SPECIAL NEEDS
(a) The facility must ensure that the residents receive proper treatment and care by qualified personnel for the following special services if offered:
(2) Parenteral and enteral fluids.

This state rule was not met as evidenced by:

Based on record review and interview, the facility failed to care for a peripheral inserted central catheter (PICC) in accordance with professional standards of practice related to lack of measurements of the catheter length, dressing changes to the site, assessments of the site and flushes of the catheter for 1 of 1 resident reviewed for intravenous catheters. (Resident 9)

Finding includes:

Resident 9's record was reviewed on 4/17/25 at 2:00 p.m. The resident admitted to the facility on 4/14/25. The diagnoses included, but were not limited to, osteomyelitis (bone infection), discitis (infection of the intervertebral disc space), and paraplegia (paralysis of lower extremities).

An Admission Minimum Data Set assessment, dated 4/14/25, was still in progress.

The Baseline Care Plan, dated 4/14/25, indicated he required one person assist for personal

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	hygiene, toilet use, dressing, bathing, and transfers. He had a urinary catheter. The section for intravenous line was not checked. A Physician's Order, dated 4/16/25 at 1:00 p.m., indicated may remove PICC line in left upper extremity. There were no physician's orders for the PICC line, flushing the PICC line, nor for the care of the PICC line. The Medication Administration Record and/or Treatment Administration Record, dated 4/2025, had no information that indicated any care was provided to the PICC line. During an interview on 4/17/25 at 3:01 p.m., the Director of Nursing had no further information to provide. A current policy titled, "PICC or Midline Catheter Care; Central Vascular Access Device," indicated "...Procedure: obtain or confirm insertion documentation to include: type of central vascular access device...proper placement of catheter tip verified at the time of insertion...original insertion measurements in centimeters: total catheter length, external catheter length, arm circumference...assess daily and document the need...frequency of needless cap change...on admission...PRN whenever contaminated...frequent for site/extremity assessment, and flushing the catheter: before and after use, at least daily, during dressing changes..."			