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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/17/2023 |
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| NAME OF PROVIDER OR SUPPLIER BELVEDERE SENIOR HOUSING | STREET ADDRESS, CITY, STATE, ZIP CODE 343 E 90TH DRIVE MERRILLVILLE, IN 46410 |
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| R 0000 Bldg. 00 | <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00404254 completed on 3/22/23.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00405363</p> <p>Complaint IN00404254 - Not Corrected.</p> <p>Complaint IN00405363 - State deficiencies related to the allegations are cited at R0149.</p> <p>Survey date: May 17, 2023</p> <p>Facility number: 014178</p> <p>Residential Census: 123</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 5/19/23.</p> | R 0000 | <p>This Plan of Correction constitutes our written allegation of compliance for the deficiency cited, however, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the established state and federal law.</p> | |
| R 0090 Bldg. 00 | <p>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:</p> <p>(1) Informing the division within twenty-four (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</p> | | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| Sandra Erickson | Executive Director | 06/05/2023 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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| | <p>twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(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.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(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.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure allegations of mistreatment were reported timely to the Administrator for 1 of 2 residents reviewed for abuse. (Resident F)</p> | R 0090 | <p>Belvedere Senior Housing Facility #: 014178 Survey Date: 0 5/17/2023 Plan of Correction-Re-visit</p> | 06/13/2023 |

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| | <p>Finding includes:</p> <p>The record for Resident F was reviewed on 5/17/23 at 12:36 p.m. Diagnoses included, but were not limited to, anxiety, bipolar disorder, depression, high cholesterol, and high blood pressure.</p> <p>A Nurses' Note, dated 5/8/23 at 6:44 p.m., indicated "Resident came to nurses station visibly upset, complaining of mistreatment by dietary employee. Resident was informed she can make a complaint with administrator, and informed me she would follow-up with management."</p> <p>An incident report, dated 5/9/23, indicated the incident date and time was 5/8/23 at 5:01 p.m. The resident reported a dietary aide had allegedly mistreated her in the dining room while serving.</p> <p>Interview with the Director of Nursing on 5/17/23 at 2:45 p.m., indicated the nurse did not inform the Administrator or herself on 5/8/23 after the resident reported the allegation. The nurse was inserviced regarding abuse and reporting on 3/25/23 as part of their plan of correction from the previous complaint survey.</p> <p>This State Residential tag was cited on 3/22/23. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> | | <p>R – 090 Administration and Management -Deficiency</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> 1. No Residents were harmed by the alleged deficient practice. Nurse on duty was re-educated on 05/24/2023 regarding immediate reporting of any allegations of abuse to include allegations of mistreatment immediately to the Administrator per state regulations. 2. All residents have the potential to be affected by alleged deficiency. Staff will monitor for signs of changes in behaviors/conditions and report to the Administrator immediately for further assessment and/or investigation. 3. Staff were rein-serviced on 5/23/2023 on the policy/procedure on ensuring any allegations of abuse to include mistreatment are reported immediately to the Administrator or designee. The Director of Nursing/Executive Director will review daily the 24 hour nursing communication log and/or CareMerge will also be utilized to assure allegations of abuse are reported timely. The facility will conduct any interviews with staff, residents and family to ensure allegations have not been missed on the 24 hour report and reported timely to Administration. | |

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

PRINTED: 06/09/2023
FORM APPROVED
OMB NO. 0938-039

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| | | | <p>4. A QA audit will be conducted by the DON/Executive Director or designee to ensure allegations of abuse are reported to the Administrator immediately and reported to IDOH per state regulations. Audits will be conducted daily X 2 weeks, weekly x 4 weeks and then monthly for 6 months. Audits will be reviewed at the monthly QA meeting for 6 months and recommendations will be presented for any need for continued auditing.</p> <p>Completion Date: 6/13/2023</p> | | |