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	02/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 a State Residential Licensure Survey. Survey dates: February 19 and 20, 2020. Facility number: 013733 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/25/20.	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 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident			

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

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	understands. Based on record review and interview, the facility failed to ensure a resident and/or responsible party was made aware of their resident rights for 1 of 7 residents whose records were reviewed. (Resident 4) Finding includes: Record review for Resident 4 was completed on 2/20/2020 at 9:21 a.m. Diagnoses included, but were not limited to, dementia, heart failure, hypertension, arthritis. The resident was admitted to the facility on 2/14/2020. There was a lack of documentation in the record to indicate the resident and/or responsible party had received or signed the resident rights acknowledgment. Interview with the Director of Nursing on 2/20/2020 at 11:43 a.m., indicated she was unable to find documentation the resident and/or responsible party had received and signed the resident rights information.	R 0026	A) Responsible party for resident 4 has been notified that the community needs to provide a written copy of resident rights for her review and required signature verifying documentation of receipt. Required signatures obtained. B) All current residents residing in the community will have admission documents audited by the Administrator or designee for a signed acknowledgement of resident rights receipt. C) The Business Office Manager will audit all new admissions to the community using the resident file checklist which includes checking for resident rights signed acknowledgement of receipt. D) The Business Office Office Manager will bring all resident admission checklists to the Administrator or their designee monthly for review until a pattern of compliance is obtained. The audits will be reviewed quarterly at the QAPI meeting to ensure ongoing compliance. E) 3/30/2020	03/30/2020
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the			

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	following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form.			
	Based on record review and interview, the facility failed to have a current disclosure form for the Alzheimer's/Dementia Special Care Unit. Finding includes: The Alzheimer's/Dementia Special Care Unit disclosure form was reviewed on 2/20/20 at 8:50 a.m. The form had been completed on 2/19/20. Interview with the Administrator on 2/20/20 at 8:51 a.m., indicated she could not find any previously completed disclosure form. She had just completed the form yesterday.	R 0030	A) The Administrator has completed and submitted the Alzheimer's/Special Care Unit disclosure form. B) The Regional Director of Operations will in-service the Administrator on the completion and annual due date(December 31st) of submission for the Alzheimer's/Dementia Special Care Unit disclosure form. C) The Regional Director of Operations will require notification of submission on or before the required submission date	03/30/2020

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			(December 31st) by the Administrator or their designee until a pattern of compliance is obtained. D) The annual completed copy of the submitted Alzheimer's/Dementia Special Care Unit disclosure form will be kept in the Administrator office and reviewed annually at the QAPI meeting. E) 3/30/2020	

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R 0086 Bldg. 00	410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for			

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	the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the facility failed to have a current CLIA (Clinical Laboratory Improvement Amendments) waiver (waiver to perform laboratory testing). Finding includes: On 2/19/20 at 11:00 a.m. the Administrator provided a payment confirmation, dated 6/27/19, for the CLIA waiver. Interview with the Administrator at that time indicated she had paid for the waiver but never received it. She was going to call and try to get clarification. The list of resident special care needs, provided by the facility, indicated there were two residents in the facility who required blood glucose testing. Continued interview with the Administrator on 2/20/20 at 1:49 p.m., indicated she was unable to figure out what happened with the CLIA waiver. There was not one on file for the facility and she had been sent another form to fill out to apply for one.	R 0086	A) The Administrator has completed and submitted the CLIA waiver. B) The Regional Director of Operations will in-service the Administrator on the completion and renewal of submission for the CLIA waiver C) The Regional Director of Operations will require notification of submission on or before the required renewal date of the CLIA waiver by the Administrator or their designee until a pattern of compliance is obtained. D) A completed copy of the submitted CLIA waiver form will be kept in the Administrator office and reviewed annually at the QAPI meeting. E) 3/30/2020	03/30/2020

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			A) The Administrator has completed and submitted the Alzheimer's/Special Care Unit disclosure form. B) The Regional Director of Operations will in-service the Administrator on the completion and annual due date(December 31st) of submission for the Alzheimer's/Dementia Special Care Unit disclosure form. C) The Regional Director of Operations will require notification of submission on or before the required submission date (December 31st) by the	

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			Administrator or their designee until a pattern of compliance is obtained. D) The annual completed copy of the submitted Alzheimer's/Dementia Special Care Unit disclosure form will be kept in the Administrator office and reviewed annually at the QAPI meeting. E) 3/30/2020	

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one			

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	(1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure employees received the required tuberculin skin testing (mantoux) for 2 of 10 employee records reviewed. (Housekeeping 1 and LPN 1) Findings include: The personnel files were reviewed on 2/20/20 at 9:05 a.m.	R 0121	A) Two-step Mantoux completed by 5/11/2020 for housekeeping 1. LPN 1 no longer works with the community. B) All current employee files will be audited by the Administrator or their designee to ensure all employees have a current completed mantoux.	03/30/2020

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	Housekeeping 1's start date was 1/6/2020. A first step mantoux test was completed on 1/6/20. There was no documentation a second step mantoux test had been completed. LPN 1's start date was 1/8/20. A first step mantoux test was completed on 1/8/20. There was no documentation a second step mantoux test had been completed. Interview with the Administrator on 2/20/20 at 8:57 a.m., indicated she could not find any documentation the second step mantoux tests had been completed. A facility policy, titled, "Tuberculosis Prevention & Control", received as current, indicated, "...Procedure: 1. Within the first three days of hire the community nurse will administer the first step of the TST. The test is accomplished by injecting a small amount of tuberculin into the inner surface of the forearm. Test results must be read by the nurse 48 to 72 hours of the injection. If the results are not read within the noted time frame the test must be immediately repeated. 2. If the results are negative the nurse will schedule the second step testing within 7 to 21 days of when the first results were read. Again, the results of the second TST must be read within 48 to 72 hours of injection..."		C) Business Office manager will audit all new employees to the community with the JSLM Personnel File Checklist, which includes verifying for completed Mantoux test. This will be completed upon hire and before the employee is scheduled on the work schedule. D) Business office manager will bring all completed new hire checklist to the Administrator or their designee before employee is placed on work schedule to ensure all mantoux tests are completed until a pattern of compliance is obtained. Audits will be reviewed quarterly at QAPI meeting to ensure ongoing compliance. E) 3/30/2020	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to maintain proper food sanitation related	R 0273	A) Dining Services Director met with Cook 1 to reinforce that a	03/30/2020

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	to not properly sanitizing a thermometer before taking food temperatures, and not serving food under sanitary conditions related to not wearing a beard guard while plating food. This had the potential to affect the 24 residents who are served from the kitchen. Finding includes: During an observation on 2/19/2020 at 11:47 a.m., Cook 1 was observed checking the food temperatures prior to lunch service. He obtained a food thermometer, checked the temperature of bread pudding, dipped the thermometer into a sanitation bucket, and wiped it on a wet rag. He then checked the temperature of mashed potatoes, dipped the thermometer into a sanitation bucket, wiped it on a wet rag, checked the temperature of brown gravy, dipped the thermometer into a sanitation bucket, wiped it on a wet rag, checked the temperature of mixed vegetables, dipped the thermometer into a sanitation bucket, wiped it on a wet rag, checked the temperature of roast beef, dipped the thermometer into a sanitation bucket and wiped it on wet rag. The cook was then asked to test the sanitation level of the sanitation bucket. The cook tested the sanitation level with test strips. The sanitation level read 0. The cook indicated the tests strip may be defective. The cook was asked to prepare a new sanitation bucket and use the same strips to test the new sanitation bucket. The new sanitation bucket was tested and the sanitation level was 150. The cook indicated the proper sanitation should be at least 150. The sanitation bucket he had used to sanitize the thermometer was not at the correct sanitation level.		beard guard will be worn at all times while preparing, serving food and in the kitchen area. B) Dining Services Director will in-service all dietary staff on the proper use of hair coverings. C) Dining Services director will do daily observation audits when on duty to monitor for compliance. D) Daily Audits will be reviewed by the Administrator or their designee monthly until a pattern of compliance achieved. Dining Services Director will provide all observation audits to the quarterly QAPI committee meeting for compliance. E) 3/30/2020 A) Sanitation bucket was immediately emptied and refilled to obtain proper sanitation level. B) Dining Services director will inservice all staff on the proper procedures for the sanitation bucket and corresponding appropriate levels. C) Dining Services Director will do daily audits on sanitation bucket levels to monitor for compliance. D) Daily audits will reviewed by	

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	After the cook tested the food temperatures he then began to plate the resident's food. The cook had a beard and a mustache and was not wearing a beard cover. Interview with the cook indicated he only had to wear a beard guard if his beard was longer than it was. Interview with the Administrator on 2/19/2020 at 1:40 p.m., indicated the cook should have been wearing a beard guard while in the kitchen, and should have checked the sanitation bucket level prior to using it to sanitize the thermometer. She further indicated they did not have a specific policy of how to sanitize the thermometer prior to checking food temperatures. A policy titled, "Food Service Policy" and received as current from he Administrator on 2/19/2020, indicated, "...Food Handling in Dietary Department..." "...All persons who enter the kitchen for any reason must have their hair covered with a hair net and all men with a beard must have their beard covered...."		the Administrator or their designee monthly until a pattern of compliance is achieved. Dining Services director will produce all audit sheets quarterly to the QAPI committee for compliance. E) 3/30/2020	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to ensure clinical records were monitored and maintained related	R 0349	A) Nursing notes in resident 3's chart were updated with late entries.	03/30/2020

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	to follow up documentation for a resident following a fall for 1 of 7 resident clinical records reviewed. (Resident 3) Finding includes: On 2/20/20 at 11:40 a.m., Resident 3 was observed seated in the dining room. She had a dark purple and blue discoloration around her right eye, eyebrow, and cheekbone, and a hematoma (bump) on the right side of her forehead. Her eyes were closed and she did not respond to voice. The clinical record for the resident was reviewed on 2/20/20 at 11:30 a.m. Diagnoses included, but were not limited to, dementia, osteoarthritis and anxiety. The resident was receiving hospice services. A Nursing Note, dated 2/16/20 at 5:30 a.m., indicated the resident was showing no signs of pain from a recent fall and staff were continuing to monitor her. A Nursing Note, dated 2/16/20 at 9:00 p.m., indicated the resident had dark purple bruising to the side of her face and showed no sign of pain. A Nursing Note, dated 2/17/20 at 2:48 a.m., indicated there was bruising and no sign of pain. There were no additional Nursing Notes or details about the fall in her record. Interview with the Director of Nursing (DON) on 2/20/20 at 1:45 p.m., indicated the resident had been found on the floor on February 14, at 1:00 a.m. by a CNA during rounds. The DON indicated the nurse on duty had performed an assessment on the resident when she fell, but the assessment was part of an internal (company) document and not included in the record.		B) All nurses were in-serviced on charting protocols regarding incidents/accidents including falls. C) Director of Nursing or designee will audit weekly on a nursing audit checklist to ensure all incidents/accidents including falls have proper documentation following policies and procedures until a pattern of compliance is established. D) The director of Nursing or designee will bring completed audits to the Administrator monthly for review until a pattern of compliance is obtained. The audits will be reviewed quarterly at the QAPI committee meeting to ensure ongoing compliance. E) 3/30/2020	

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		A. BUILDING 00 B. WING	02/20/2020

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	Continued interview with the DON at 3:00 p.m., indicated a fall with a head injury should have neurological assessments completed as part of the post fall monitoring. The monitoring should be documented in the clinical record every shift for 72 hours. She indicated the resident's record lacked the required neurological assessments and 72 hour charting.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review and interview, the facility failed to ensure infection control was maintained related to not covering a dressing which was saturated with drainage and not washing hands or keeping items clean during a wound dressing change for 1 of 7 residents reviewed. (Resident 2) Finding includes: On 2/20/20 at 10:40 a.m., Resident 2 was observed seated in the dining room in his wheelchair. His right foot was wrapped in gauze and had a greenish, yellow substance soaking through the gauze on the bottom of his foot. His foot was resting directly on the carpet. At 11:20 a.m., the resident was taken to his room by staff. The gauze wrapped foot that was soaked with greenish yellow substance continued to touch the carpet from the dining room to his room as he was propelled in his wheelchair. An observation was made on 2/20/20 at 11:33	R 0406	A) Director of Nursing met with LPN and in-serviced on proper hand washing and hygiene. Resident currently resides in the facility and had no adverse effects related to the deficient practice. B) All nursing staff will be in-serviced on proper hand washing and hand hygiene related to infection control/cross contamination. C) All nursing staff responsible for skin integrity/infection control will be in-serviced on proper hand hygiene/hand washing in the prevention of cross contamination. The Director of Nursing or his/her designee will do weekly observation audits with the skim integrity nurse to verify proper hand hygiene and infection	07/31/2020

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	a.m. of Resident 2's dressing change with LPN 3. The LPN took the resident into his bathroom in his wheelchair. She applied gloves without washing her hands first. She began to cut the gauze dressing off his right leg, she set the scissors down on the bathroom floor, unwrapped some gauze, cut some more and again set the scissors on floor. She unwrapped some gauze, cut some more, and set the scissors on the floor once more. When the gauze was removed she changed her gloves but did not wash her hands. The LPN removed the soiled gauze from underneath the resident's heel and set his heel directly on the bathroom floor. When the dressing was completed, the LPN returned the resident to his room. She removed her gloves and did not wash her hands. Interview with the Director of Nursing (DON) on 2/20/20 at 11:50 a.m., indicated she understood the infection control concerns. The LPN was new and this was a learning experience. The document titled, "Hygiene Policy," was provided by the DON on 2/20/20 at 1:55 p.m. The current policy indicated, "...Indications for hand washing with an antimicrobial soap and warm water...After removing gloves when handling soiled clothing, towels or washcloths...Handling trash and/ or trash cans...." The policy also indicated hand sanitizer should be used, "...Immediately after removing gloves and before providing any other care or touching any other objects..."		control measures are being implemented during skin integrity. D) All audit tools will be reviewed by the Administrator or his/her designee weekly to assure proper techniques are being followed. Administrator or his/her designee will review all skin integrity issues and report quarterly to the quality assurance committee the ongoing results of this review until a pattern of compliance is obtained. E) All training will be completed by July 31, 2020	
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission.			

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	Based on record review and interview, the facility failed to ensure a resident had a chest x-ray completed no more than six months prior to admission for 1 of 7 residents reviewed. (Resident 6) Finding includes: Resident 6's record was reviewed on 2/19/20 at 1:00 p.m. Diagnoses included, but were not limited to, hypertension and heart failure. The resident was admitted to the facility on 5/29/19. A chest x-ray was completed 6/5/19. There was lack of documentation to indicate a chest x-ray had been completed prior to admission. Interview with the Director of Nursing (DON) on 2/20/20 at 1:42 p.m., indicated she was unable to find any chest x-ray results prior to admission.	R 0408	A) Director of Nursing at time of admission for resident 6 is no longer working at the co community. Current Director of Nursing in-serviced on policy and regulations pertaining to diagnostic chest x ray completed prior to admission. B) All current resident charts will be audited for diagnostic chest x ray prior to admission (within 6 months prior). C) Director of Nursing will use admission audit tool upon each new admission to ensure diagnostic chest x ray completed prior to admission. D) Administrator will review admission audit tool after Director of Nursing review and sign off prior to move-in to ensure compliance. Audit checklists will be reviewed quarterly at QAPI committee meetings to ensure ongoing compliance. E) 3/30/2020	03/30/2020
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of			

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	induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident received a tuberculin (TB) test on or prior to admission for 1 of 7 residents reviewed. (Resident 4) Finding includes: Record review for Resident 4 was completed on 2/20/2020 at 9:21 a.m. Diagnoses included, but were not limited to, dementia, heart failure, hypertension, arthritis. The resident was admitted to the facility on 2/14/2020. There was a lack of documentation in the record to indicate a TB test had been completed on or prior to the resident's admission. Interview with the Director of Nursing on 2/20/2020 at 11:43 a.m., indicated she was unable to find documentation a TB test had been completed on or prior to the resident's admission to the facility.	R 0410	A) Resident 4 received his Mantoux test immediately on 2/20/2020. Director of Nursing in-serviced nursing staff on policy and regulations pertaining to Mantoux tests. B) All current resident charts will be audited for mantoux test completion. C) Director of Nursing will use admission audit tool to ensure mantoux completed prior to admission. D) Administrator will review admission audit tool after Director of Nursing review and sign off prior to admission to ensure compliance. Audit checklists will be reviewed	03/30/2020

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			quarterly at QAPI committee meetings to ensure ongoing compliance. E) 3/30/2020	