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	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00426020. Complaint IN00426020 - No deficiencies related to the allegations are cited. Survey dates: February 13 & 14, 2024 Facility number: 014916 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/22/24.	R 0000	.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Macklin	Executive Director	03/18/2024

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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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to attempt to hold a fire and disaster drill in conjunction with the local fire department every 6 months. This had the potential to affect 51 residents residing at the facility. Finding includes: During an interview on 2/13/2024 at 2:30 P.M. the Maintenance Director indicated he did not attempt to set up a fire drill with the fire department last year. He started the position in October 2023. During an interview on 2/14/2024 at 10:32 A.M., the Executive Director indicated that they did not attempt to set up a fire and disaster drill with the local fire department last year. On 2/14/2024 at 10:42 A.M., the Executive Director provided a policy titled, "Training, Fire & Emergency Evacuation Drills, Exercises", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Harmony at Elkhart shall provide training to the staff by credible and qualified persons within the organization or from other qualified resources. These resources include local emergency responders, qualified vendors, and consultants. The main objective for the development and maintenance of a reliable training program will be to provide staff with relevant information on emergency procedures and emergency	R 0092	R. 092 Administration and Management - Noncompliance Action Plan: a. Immediate: The MD, ED or designee will contact the local fire department and attempt to conduct a disaster and fire drill to be held in conjunction with the fire department and the community. Once date is established the MD, ED or designee will confirm date and attendance with the local fire department 24 hours to the scheduled date b. Immediate: The MD, ED or designee will implement in our preventative maintenance task platform “TELS”, bi-annual checkoffs to attempt to hold a joint fire and disaster drill. c. Long Term: The MD, ED or designee will contact the local fire department bi-annually to attempt to conduct a disaster and fire drill to be held in conjunction with the fire department and the community. Once each Bi annual event is completed the MD, ED or designee will sign checkoff ensuring completion and put in file. Responsible Party(ies)- MD,	04/07/2024

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	management in compliance with local, state, and federal guidelines, as well as nationally recognized standards and best practices. Outside resources, including local emergency responders, local emergency coordinator, and other appropriate persons and agencies should be invited to periodically participate in, observe, and evaluate internal exercises and drills...." 410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.		designee, ED for review	
R 0118 Bldg. 00	Based on record review and interview, the facility failed to ensure a Certified Nursing Assistant maintained her certification for 1 of 2 certified staff reviewed. Finding includes: Employee records were reviewed on 2/14/2024 at 10:58 A.M. CNA 4 certification was observed to have expired on 2/5/2024. The Nursing Department Schedule indicated CNA 4 worked 2/8/202 and 2/9/2024. During an interview, on 2/14/2024 at 12:31 P.M., the Health Care Coordinator indicated that Certified Nursing Assistants (CNA), Home Health Aides (HHA), Qualified Medication Assistants (QMA), and Licensed Practical Nurses (LPN) who	R 0118	R.118 Personnel-Deficiency Action Plan: a. Immediate: The BOM or designee will audit employee records to identify each employee holding a position that requires a license or certification. b. Immediate: The BOM or designee will verify each employee that was identified to require a license or certificate to have a current and active license or certificate. Any employee identified to not have a current license or certificate will be removed from working in a position that requires the license or certificate, until such license or certificate can be provided.	04/07/2024

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	work in the facility, are required to maintain certification or licensure to work at the facility. A policy was provided on 2/14/2024 at 2:00 P.M. by the Health Care Coordinator. The policy, titled, "Employee Files", indicated, " ...Employee files are required for each employee. An employee file will be created when an employee is hired and all paperwork pertaining to that employee must be maintained in the file ...Copy of state license and verification ...."		c. Long Term: The BOM or designee will monitor employee files each month for 6 months to ensure compliance of employees to have the required license or certification. Responsible Party(ies)- BOM, ED for review	
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 (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.			

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	(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 complete physical exams prior to hire for 3 of 5 employee records reviewed. (QMA 6, Cook 7 & CNA 9) Findings include: Employee records were reviewed 2/14/2024 at 10:27 A.M. A physical exam could not be found for QMA 6, Cook 7, and CNA 9. During an interview with the Business Office Manger, on 2/14/2024 at 12:41 P.M., he indicated he did not have any additional paperwork for the employees' files to provide. What he provided were the only forms available. A policy was provided on 2/14/2024 at 2:00 P.M. by the Health Care Coordinator. The policy titled, "Employee files are required for each employee. An employee file will be created when an employee is hired and all paperwork pertaining to that employee must be maintained in the file ...The following employee information must be	R 0121	R. 121 Personnel – Noncompliance Action Plan: a. Immediate: The BOM or designee will audit all associate files to identify which associates personnel files are not in compliance with regulations and company policies and procedures for employee related health screening. b. Immediate: Associates that have been identified as not in compliance will be required to become compliant with the regulations and company policies and procedures, and will have the employee related health screening completed by 3/22/24. c. Long Term: The BOM will use a check list to monitor all required steps are completed before an associate can begin their employment. Once all items are completed the employee will then be scheduled for orientation and	04/07/2024

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	maintained in a confidential medical file and must be kept separately from the personnel file ...Medical history/health physical/exam ...."		begin employment. This will include the employee health related screening. Responsible Party(ies): BOM or designee, ED for review	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure employee records included job descriptions, required education, and job specific orientation for 4 of 5 employee records reviewed. (QMA 6, Cook 7, Housekeeper 8 & CNA 9) Findings include: Employee records were reviewed 2/14/2024 at 10:27 A.M.	R 0123	R.123 Personnel – Nonconformance Action Plan: a. Immediate: The BOM or designee will audit all associate files to identify which associates personnel files are not in compliance with regulations and	04/07/2024

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	The following was missing from the files: - QMA 6 was missing a job description, job specific orientation, and dementia training. - Cook 7 was missing a job description and specific job orientation. - Housekeeper 8 was missing required education of resident rights, dementia, and abuse. - CNA 9 was missing a job description, specific job orientation, and dementia training. During an interview on with the Business Office Manger, on 2/14/2024 at 12:41 P.M., he indicated he did not have any additional paperwork for the employees' files to provide. What he provided were the only forms available. A policy was provided on 2/14/2024 at 2:00 P.M. by the Health Care Coordinator. The policy titled, "Employee Files", indicated, " ...Employee files are required for each employee. An employee file will be created when an employee is hired and all paperwork pertaining to that employee must be maintained in the file ...All employee files must consist of the following sections ...s. Job Description ...x. Training ...Job specific Orientation/Onboarding Documentation Checklist ...." The policy did not acknowledge the education required.		company policies and procedures regarding job specific orientation and job descriptions. b. Immediate: The BOM or designee will prepare and require all identified associates to complete the documentation by 4/7/24. c. Long Term: The BOM will use a check list to monitor all required steps are completed before an associate can begin their employment. Once all items are completed the employee will then be scheduled and begin employment. **Respoonsible parties: BOM or designee, ED for review**	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, record review, and interview, the facility failed to ensure nebulizer equipment was stored properly for 1 of 1 residents observed for respiratory therapy. (Resident 2)	R 0145	R. 145 Sanitation and Safety Standards - Deficiency Action Plan: a. Immediate: The HCD or	04/07/2024

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	Finding includes: A record review for Resident 2 was completed on 2/13/2024 at 2:09 P.M. Diagnoses included, but were not limited to: dementia, hypothyroidism, and hypertension. During an observation, on 2/13/2024 at 2:02 P.M., Resident 2's nebulizer mask was observed lying on the bedside table. The mask was not protected with a bag or dated when the mask was provided. During an observation, on 2/14/2024 at 7:56 A.M., the nebulizer mask was observed lying on the bedside table. The mask was not protected with a bag or dated when the mask was provided. A Physician's Order, dated 11/9/2023, indicated Resident 2 received ipratropium 0.5.milligram (mg) -albuterol 3 milligram (2.5 milligram base)/3 milliliter (ml) nebulization solution 1 vial twice a day and albuterol sulfate 2.5 milligram/milliliter (0.083%) solution for nebulization. During an interview, on 2/13/2024 at 2:42 P.M., the Health Care Coordinator indicated the nebulizer mask should be stored in a bag and labeled with the date and time the mask was provided. A policy was provided on 2/14/2024 at 2:00 P.M. by the Health Care Coordinator. The policy titled, "Technique for Inhalant Technique". The policy did not acknowledge nebulizer equipment storage or a date to be placed on the nebulizer equipment.		designee audited each apartment to identify residents that have nebulizing equipment. b. Immediate: Residents identified with having nebulizing equipment will have a plastic bag placed with the equipment to store the mask in once the treatment is complete and the nebulizer is not in use. c. Immediate: The HCD or designee will train all employees that are licensed to provide the treatments on the proper dating and storage technique for the nebulizing equipment. d. Long Term: HCD or designee will perform apartment audits to monitor compliance of nebulizing equipment storage. Audits will be completed weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 2 months. If we are found deficient during completion of the full audit the HCD will retrain staff on proper dating and storage technique for the nebulizing equipment and the full 6 month audit would start over and repeat. This is to ensure that the deficiency does not reoccur. Corrective Action Plan Completion Date: April 7, 2024	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy			

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	manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain an admission weight, for 1 of 7 records reviewed. (Resident 5) Finding includes: A record review for Resident 5 was completed on 2/14/2024 at 10:46 A.M. Diagnoses included, but were not limited to: diabetes mellitus, hypothyroidism, and cerebral vascular accident (stroke). Resident 5 was admitted to the facility on 10/30/2023. An admission weight could not be located in the medical record. On 2/14/2023 at 11:11 A.M., the Health Care Coordinator provided a document, dated 11/16/2023, from a hospitalization at the local hospital. She indicated this was the closest weight to the admission date she could locate in the medical record. During an interview, on 2/14/2024 at 11:13 A.M., the Heath Care Coordinator indicated that an	R 0216	R. 216 Evaluation - Noncompliance Action Plan: a. Immediate: The HCD or designee will audit each resident chart for compliance of admission weights. b. Immediate: Residents identified to not have admission will have their current weight taken and documented with date of compliance. c. Long Term: HCD or designee will audit all admissions within 72 hours of admission to ensure compliance of documentation of the admission weight. The HCD or designee will audit each new resident admission weekly for 6 months. If we are found deficient during completion of the full audit the HCD will train staff on proper resident intake, documentation, admission weight and procedures and the full 6 month audit would then start over and repeat. This is to ensure that the deficiency does	04/07/2024

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	admission weight should have been obtained. A policy was provided on 2/14/2024 at 2:00 P.M. by the Health Care Coordinator. The policy titled, "Nutritional Status/Weight Monitoring", indicated, " ...7. Staff will weigh residents upon admission and monthly thereafter and document resident's weight in the resident's record ...."		not reoccur Responsible Party(ies) - HCD or designee, ED for Review	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of			

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	the services to be provided. Based on interview and record review, the facility failed to ensure service plans and semi-annual evaluation were signed by the resident or resident's representative for 5 out of 7 charts reviewed. (Residents 4, 9, 2, 8, & 3) Findings include: 1. The record for Resident 4 was reviewed on 2/14/2024 at 9:00 A.M. The diagnoses included, but were not limited to: hypertension, hyperlipidemia, depression, anemia and arthritis. The Resident was admitted on 2/1/2023. During an interview, on 2/14/2024 at 12:31 P.M., the Health Care Coordinator indicated Resident 4's service plan was not signed and could not explain why it was dated 3/9/2024. 2. The record for Resident 9 was reviewed on 2/13/2024 at 10:30 A.M. Diagnoses included, but were not limited to: major depression disorder, heart disease, atrial fibrillation and hypertension. During an interview, on 2/14/2024 at 12:45 P.M., the Health Care Coordinator indicated his service plan and semi-annual evaluation was not signed and should have been signed. 3. A record review for Resident 2 was completed on 2/13/2024 at 2:09 P.M. Diagnoses included, but were not limited to: dementia, hypothyroidism, and hypertension. A Service Plan, dated 9/7/2023, was not signed by the resident or the resident representative. During an interview, on 2/13/2024 at 2:40 P.M., the Health Care Coordinator indicated the Service Plan should be signed by the resident or the resident representative.	R 0217	R. 217 Evaluation - Deficiency Action Plan: a. Immediate: The HCD or designee will audit the resident's clinical chart to identify the residents that are missing the required signed Service Plan. b. Immediate: The HCD or designee will complete the Service Plan on the residents that are identified as not having a current Service Plans. The Service Plan will be reviewed and signed by community designee and POA/resident. c. Long Term: The HCD or designee will conduct audit on 15 resident charts each week and correct as findings occur until all Service Plans are completed. Responsible Party(ies)- HCD or designee, ED for review	04/07/2024

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	4. A record review for Resident 8 was completed on 2/13/2024 at 11:28 A.M. Diagnoses included, but were not limited to: dementia, coronary artery disease, and hypertension. A Service Plan, dated 1/24/2024, was not signed by the resident or the resident representative. During an interview, on 2/13/2024 at 2:40 P.M., the Health Care Coordinator indicated that the Service Plan should be signed by the resident or the resident representative.5. A record review was completed on 2/13/2024 at 1:10 P.M., Resident 3's diagnoses included, but were not limited to: Alzheimer's and hyperlipidemia. A Service Plan, dated 11/14/2023, lacked the resident/responsible party, facility staff signatures and dates for Resident 3. A Service Plan, dated 1/19/2024, lacked the resident/responsible party, facility staff signatures and dates for Resident 3. During an interview, on 2/14/2023 at 10:26 A.M., the Director of Nursing indicated the Service Plan should have been signed by all parties. On 2/14/2024 at 2:00 P.M., the Health Care Coordinator provided a policy titled, "Resident Assessment and Service Plan", revised 11/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Each resident shall have a written, signed and dated heath assessment by a physician or other licensed health care professional, not more than sixty (60) days prior to the resident's admission, or no more than five (5) working days following admissions, and at least annually thereafter....."			

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		A. BUILDING 00 B. WING	02/14/2024

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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 provide sanitary food service to 4 of 16 residents observed for food delivery service. Finding includes: On 2/13/2024 at 11:54 A.M., dining room service was observed in the memory unit dining room. CNA 3 was observed to have her thumb beyond the rim of the plate. CNA 3 was observed with a long painted fingernail when serving the residents main plate. On 2/13/2024 at 12:01 P.M., dining room service was observed in the memory unit dining room. CNA 3 was observed again to have her thumb beyond the rim of the plate. CNA 3 was observed with a long painted fingernail when serving the residents main plate. During an interview, on 2/13/2024 at 12:24 P.M., CNA 3 indicated no one has ever told her the correct way to carry the plates. During an interview, on 2/14/2024 at 10:17 A.M., the Executive Director indicated the servers should not have their thumb over the edge of the plate while serving the residents. On 2/14/2024 at 10:45 A.M., the Director of Nursing provided the policy titled, "Personal Hygiene", dated 9/25/2018, and indicated the policy was the one currently used by the facility.	R 0273	R. 273 Food and Nutritional Services – Deficiency Action Plan: a. Immediate: The DSD, HCD or designee will provide training to all employees that may be providing meal service to the residents. The training will include Infection Control Policies and Procedures, as well as the Personal Hygiene Policy for employees. b. Immediate: The DSD, HCD or designee will ensure that all employees that may be providing meal service to the residents are scheduled to receive the training by 3/31/24. c. Long Term: All employees that may be providing meal service to the residents will receive training on the Infection Control Policies and Procedures as well as the Personal Hygiene Policy when in General Orientation as a new hire employee. Audits will be completed once each meal time weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. If we are found deficient upon completion of the full audit the DSD, HCD or designee will retain staff on infection control	04/07/2024

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	The policy indicated"...Fingernails must be kept short and clean at all times. Nail polish is not permitted...."		policies and personal hygiene policy and the full 6 month audit would then start over and repeat. This is to ensure that the deficiency does not reoccur. Responsible Party(ies)-DSD, HCD or Designee	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency binder was complete and accurate, with all required resident information, for 5 of 5 residents whose emergency information was reviewed. (Residents 3, 7, 2, 8 and 9) Findings include: On 2/13/2024 at 1:46 P.M., the Health Care	R 0356	R. 356 Clinical Records - Noncompliance Action Plan: a. Immediate: The HCD, ED or designee will audit the Emergency Profile Binder to identify each residents' personal information, hospital preference, POA name and contact information, Physician's name and contact	04/07/2024

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	Coordinator provided the Emergency binder for the facility. 1. A record review for Resident 3 was completed on 1/13/2024 at 1:34 P.M. Diagnoses included, but were not limited to: Alzheimer's disease and hyperlipidemia. A review of the emergency file information for Resident 3 indicated a photo, hospital preference and advanced directives was not available in the file. 2. A record review for Resident 7 was completed on 1/13/2024 at 1:46 P.M. Diagnoses included, but were not limited to: Hypertension and peripheral artery disease. A review of the emergency file information for Resident 7 indicated a hospital preference was not available in the file.3. A record review for Resident 2 was completed on 2/13/2024 at 2:09 P.M. Diagnoses included, but were not limited to: dementia, hypothyroidism, and hypertension. A review of the Emergency File binder indicated the records did not include the physician's name and phone number, and hospital preference. During an interview on 2/13/2024 at 2:41 P.M., the Health Care Coordinator indicated that the Emergency File should include a hospital preference, but the local Emergency Medical Service would not pass the local hospital for preference of the resident. Therefore, hospital preference was not listed on the provided face sheet in the Emergency File. She indicated the physician's name and phone number should be on the face sheet provided in the Emergency File.		information, POA or Family member contact information for emergencies, a photograph of the resident, and the advance directive if available. b. Immediate: The HCD, DSM, ED or designee will ensure completion of the resident Emergency Profile for the identified residents from the audit as well as all new residents. c. Long Term: The HCD, ED or designee will monitor and perform an audit on 15 residents Emergency Profile each week and correct as findings occur by April 7, 2024. Once the full binder is updated audits will be completed weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 2 months. If we are found deficient upon completion of the full audit the HCD, DSM, ED or designee would then require all 3 signatures on the weekly audit. The full 6 month audit would start over and repeat. This is to ensure that the deficiency does not reoccur. Responsible Party(ies)- HCD, DSM or designee, ED for review	

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	4. A record review for Resident 8 was completed on 2/13/2024 at 11:28 A.M. Diagnoses included, but were not limited to: dementia, coronary artery disease, and hypertension. A review of the Emergency File binder indicated the records did not include the physician's name and phone number, and hospital preference. During an interview on 2/13/2024 at 2:41 P.M., the Health Care Coordinator indicated that the Emergency File should include a hospital preference, but the local Emergency Medical Service would not pass the local hospital for preference of the resident. Therefore, hospital preference was not listed on the provided face sheet in the Emergency File. She indicated the physician's name and phone number should be on the face sheet provided in the Emergency File.5. The record for Resident 9 was reviewed on 2/13/2024 at 10:30 A.M. Diagnoses included, but were not limited to: major depression disorder, heart disease, atrial fibrillation and hypertension. A review of the emergency information file binder indicated the name and phone number of the resident's physician and hospital preference was not available. During an interview, on 2/13/2024 at 2:41 P.M., the Health Care Coordinator indicated that the emergency information file should contain face sheet, med list, photo, and hospital preference, but the EMS (Emergency Medical Service) will not bypass a hospital, so the closest local hospital was where the residents were taken, regardless of hospital preference. On 2/14/2024 at 2:00 P.M., the Health Care Coordinator provided a policy, titled, "Resident			

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	Assessment and Service Plan", revised 11/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Each resident shall have a written, signed and dated health assessment by a physician On 2/14/2024 at 2 P.M., the Health Care Coordinator provided the policy titled, "Emergency Medical Plan", dated 04/2021 and indicated the policy was the one currently being used by the facility. The policy indicated"...4. The Emergency Medical and Health information shall include: a. The resident's name and birth date b. The resident's Social Security number c. The resident's medical diagnoses d. The resident's physician name and telephone number e. Current medication, including dosage and frequency f. A list of allergies g. other relevant medical conditions h. Insurance or third party payer and identification number i. The power of attorney for health care or health care proxy, if applicable j. The resident's designated person with current address and telephone number k. Personal information and related instructions regarding advance directive, do not resuscitate orders or organ donation. 5. If possible, the resident's choice of hospital and/or transport they want to be used in the emergency will be accommodated...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to			

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	analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to establish an infection control program that included, but was not limited to, a system that enables the facility to analyze patterns of known infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect all 51 residents who reside in the facility. Finding includes: During an interview on 2/14/2024 at 1:58 P.M., the Health Care Coordinator provided an infection control log binder for the year, with blank pages, and indicated she could not find the log for the past year. The staff member who was responsible for the log no longer worked for the facility. On 2/13/2023 at 1:30 P.M., the Health Care Coordinator provided a policy, titled, "All Infection Control", revised 3/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...The infection control program addresses methods of surveillance, prevention and the control of infections in written form available to all staff which includes: Isolation of infecting organisms, tracking and reporting to the appropriate agencies....."	R 0407	R. 407 Infection Control - Noncompliance Action Plan: a. Immediate: The HCD and ED will receive and review training on the Infection Control Policy and Procedures by 3/15/24. b. Immediate: The HCD will implement Infection Control policies and procedures to include monitoring and tracking of infections throughout the community. This will be completed by 4/7/24. c. Long Term: ED will monitor with HCD the infection control tracking log to ensure compliance to the Infection Control Policy and Procedures and train associates ongoing as needed. Audits will be completed weekly for 4 weeks, Bi weekly for 4 weeks and monthly for 2 months. This will ensure all tracking is accurate and current. In the event an audit isi missed, the full 6 month monitoring audit would then start over and repeat. This is to ensure that the deficiency does not reoccur. Responsible Party(ies)-HCD or	04/07/2024

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R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to provide an annual health statement for 1 of 7 residents reviewed. (Resident 5) Finding includes: A record review for Resident 5 was completed on 2/14/2024 at 10:46 A.M. Diagnoses included, but were not limited to: diabetes mellitus, hypothyroidism, and cerebral vascular accident (stroke). An Admission Order's Form, dated 10/30/2024, did not have "Free of Communicable Disease" indicated with a yes/no answer. The Health Care Coordinator reviewed the medical record for the health statement. She could not find the statement within the medical record. During an interview, on 2/14/2024 at 11:11 A.M., the Health Care Coordinator indicated Resident 5 should have had an annual health statement indicating he was free of communicable diseases in an infectious state. A policy was provided on 2/14/2024 at 2:00 P.M. by the Health Care Coordinator. The policy, titled, "Pre-Move-In Process", did not address the need	R 0409	Designee R. 409 Infection Control – Noncompliance Action Plan: a. Immediate: The HCD, ED or designee will audit the resident charts to identify the residents that are not in compliance the regulation to identify that the resident is free of communicable diseases upon admission, and the need for an annual health statement indicating such. b. Immediate: The HCD, ED, or designee will send the required health screening form to each resident that is identified as not in compliance upon admission, or annually by 3/31/24. c. Long Term: HCD, and ED to collaborate with DSM to include the required health screening form with the pre-admission forms. HCD or designee will audit all admissions within 72 hours of admission to ensure compliance of documentation that resident annual health screening is complete. Audits will be completed two times a week for 4	04/07/2024

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	for an annual health statement that indicated the resident was free of communicable diseases in an infectious state.		weeks, bi-weekly for 4 weeks and once monthly for 2 months. If we are found deficient upon completion of the full audit the HCDUpdate, ED, HR and DSM will all have to sign off on the completed audit going forward and the full 6 month audit would start over and repeat. This is to ensure that the deficiency does not reoccur. Responsible Party(ies)- ED, Sales Director and HCD or designee.	