S. HRG. 118–306

ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

JANUARY 25, 2024

Serial No. 118–14

Printed for the use of the Special Committee on Aging

ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS

S. HRG. 118–306

ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

JANUARY 25, 2024

Serial No. 118–14

Printed for the use of the Special Committee on Aging

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

55–769 PDF WASHINGTON : 2024

SPECIAL COMMITTEE ON AGING

ROBERT P. CASEY, JR., Pennsylvania, *Chairman*

KIRSTEN E. GILLIBRAND, New York
RICHARD BLUMENTHAL, Connecticut
ELIZABETH WARREN, Massachusetts
MARK KELLY, Arizona
RAPHAEL WARNOCK, Georgia
JOHN FETTERMAN, Pennsylvania

MIKE BRAUN, Indiana
TIM SCOTT, South Carolina
MARCO RUBIO, Florida
RICK SCOTT, Florida
J.D. VANCE, Ohio
PETE RICKETTS, Nebraska

ELIZABETH LETTER, *Majority Staff Director*
MATTHEW SOMMER, *Minority Staff Director*

C O N T E N T S

ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., Room 106, Dirksen Senate Office Building, Hon. Robert P. Casey, Jr., Chairman of the Committee, presiding.

Present: Senator Casey, Blumenthal, Warren, Kelly, Warnock, Fetterman, Braun, Rick Scott, Vance, and Ricketts.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., CHAIRMAN

The CHAIRMAN. The Senate Special Committee on Aging will come to order. As Chairman of the Aging Committee, my top priority is keeping our promises to older Americans and to Americans with disabilities.

We owe it to every older adult, every person with a disability, and their families to have the necessary information to decide when, where, and how to receive care as they age. That has motivated my advocacy, for example, for home and community-based services.

Every American who wants to receive care at home should be able to do so, and the workers providing that care must be paid, in my judgment, a living wage.

It has similarly motivated my work to ensure that nursing homes are providing safe, quality care for all of their residents. We need to address the chronic underfunding and understaffing for the state agencies that conduct nursing home oversight, so they can effectively protect the health and safety of residents. This core mission of the Aging Committee brings us to today's topic, the topic of assisted living and that landscape. It has been 20 years since this Committee held a hearing on assisted living.

With the dramatic growth of the assisted living industry in recent decades, it is long past time for Congress to reexamine this model and ensure that it is meeting our Nation's needs. The best estimates reveal that nearly one million Americans live in more than 30,000 assisted living facilities across our Nation, and that is almost certainly an undercount of that number.

Assisted living facilities are state regulated residences that support assisted living while offering help with the activities—with activities of daily living, like bathing and medication management.

They also often provide meaningful engagement and activities for their residents. Assisted living was first envisioned as a social model for residents who needed lower levels of support, but today, people living in assisted living facilities are older, require more care, and have health care needs similar to that of those who reside in a nursing home, and the needs of the assisted living population change. As those needs change, we need to know that—if assisted living facilities are meeting the needs of those residents or the needs of their families. One major issue I hear a lot about is cost. Assisted living facilities are widely unaffordable to the average American and their family.

A recent survey found that 80 percent of older adults would be unable to afford, unable to afford, four years in an assisted living facility. The average annual cost is $54,000 a year, but the costs can be substantially higher depending upon the location and the type of care that a resident requires.

The more assistance and care a resident needs, the more they pay. In some cases, residents and their families don't know the total cost until they receive their monthly bill. These substantial costs and often hidden fees make it nearly impossible for older adults and their families to accurately budget for long-term care.

Now, that is one of the reasons why I am starting today, I am asking Pennsylvanians and people across the country to share their stories and their bills with us. I want to hear from you about the true cost of assisted living and understand whether families have the information that they need to make difficult financial and health care decisions.

I am just going to hold up the—website address for those who need it. You can go to aging.senate.gov/assistedlivingbills, all one word, assistedlivingbills, to share your stories. I think it is very important that we hear from people, hear from people about their own experience as family members, as people who are paying the bill and also expecting the promises that are made when someone becomes a resident of an assisted living facility.

It is only by hearing those stories, only by hearing those—hearing about those experiences, can we bring the needed change that I know we all agree has to come. The assisted living industry is also facing the same workforce crisis that we see across other long-term care settings, and even beyond long-term care.

It is also true in the context of childcare and so many other parts of our healthcare and care landscape. Workers are often struggling to support their own families because direct care workers are paid an average of just $15 an hour nationwide.

Workers provide a higher level of care to support residents' growing needs, especially residents with dementia, but training requirements and worker support look very different in each state.

As we will hear from our witnesses, these challenges make it harder for families to find the information that they need about assisted living facilities, including how much it will cost, the quality of the services they receive, and how safe their family member will be.

A recent Washington Post investigation found that since 2018, more than 2,000 people have left assisted living facilities unsupervised and have been left unattended outside. Tragically, 98, 98 of

these 2,000 incidents have resulted in the death of the resident, and those are just the cases that have been reported.

The findings of the post investigation demonstrate how urgent it is that Congress better understand this industry. There has also been significant reporting by the New York Times and in KFF in a series written before the end of last year.

To help in our understanding, I have sent letters to three of the largest corporate owners of America's assisted living facilities. These letters request information about costs, workforce, safety, and availability of information about quality and services in assisted living facilities.

I hope these letters, or I should say the response to the letters, will improve transparency in the assisted living industry and help to inform policy solutions to address some of these concerns.

As families are making difficult decisions about where to age, they deserve to know that their loved ones are safe. I think we can all agree on that, and assisted living providers making promises they cannot keep is a violation of trust.

As we continue to increase the quality of the continuum of long-term care for older adults, it is time we prioritize efforts to improve the assisted living care option. If we say we are, as a Nation, the United States, the greatest country in the world, then we have to have the best, not second, not third, the best long-term care in the world, and we are not there yet.

Older adults and people with disabilities who call assisted living facilities home, we have to remember this is their home, their residence, where they live, where their families come to see them—if those older adults and people with disabilities are calling those facilities home, they should have quality, affordable care.

I look forward to hearing from our witnesses today, and I will turn to Ranking Member Braun for his opening statement.

OPENING STATEMENT OF SENATOR MIKE BRAUN, RANKING MEMBER

Senator BRAUN. Thank you, Chairman Casey. You know, in 2050, you think the problem is bad now, one in four Americans will be 65 years of age or older.

With an aging population that we know is coming at us, thank goodness we have hearings like this to highlight what you are going to do about it. Sometimes the market doesn't do the job. I do want to say that ideally, these things are crafted through the market and probably with states leading the way, and I say that for one big reason.

I am on the Budget Committee, and the biggest thing that challenges this place is how you would add something even further to the list of things you want to do when we are now borrowing $1 trillion every six months instead of annually, and that has just changed over the last five years, so we have to be careful, but it still has nothing to do with a problem or an issue that is out there, and this is about highlighting who can do it best and how you get there.

Chronic workforce shortage. When I travel, visit all 92 counties in Indiana—pre-COVID, that was the number one issue, and it is about double now the number of jobs in my own State. I think it

is close to 130,000. It was 65,000. Caregivers, large percentage of whom are—that assistance is given by independent contractors, you know, small business owners.

We need to figure out how to enable that, make it easier how you actually have your curriculums in various states and school systems that show the full spectrum of what jobs are out there and where the needs are.

Senator Kaine and I introduced the Jobs Act here, which allows students to use Federal Pell Grants for high quality, short term, job training programs.

That is a good Federal program. Does not add much to it. It is increasing the flexibility of how you can use it. Senators Rosen, Collins and I also introduced the Train More Nurses Act, which reviews all nursing grant programs to find ways of increasing nursing pathways.

Happy to hear some things do work well here. That passed, I think, by unanimous consent last night in the U.S. Senate, so now we got to get it over to the House to do the same thing. The Federal Government should make it easier for people to enter the health care workforce and for families to take care of their loved ones by making sure that it is energizing the people that may be interested in it and in the places they are going to probably be doing the heavy lifting.

Right now, for instance, the Biden Administration is saying one thing and actually doing another, I come from the world of small business, independent contractors, retailers, individuals that make their living out of maybe running a small business. The independent contractor rule that is out there, which would make that more difficult, could eliminate many of the existing caregiver jobs for that reason, so you got to make sure you are not wanting to do something, and then you are working at a cross purpose through another agency that will make it even more difficult. Unlike nursing homes that are regulated by both Federal and State agencies, assisted living facilities are primarily regulated by states.

To increase safety and transparency, Indiana requires staffing ratios, dementia training, and maintains a website that discloses, reports and enforcement actions. States and assisted living facilities are also working to find creative ways to use existing resources to assist seniors. Indiana is using a combination of State and Federal tools to provide more affordable assisted living to Hoosiers.

As a result, Indiana has seen affordability and quality improve. However, there is always more work to be done. Some of my colleagues may be tempted to call for a shift toward increased Federal involvement and regulation.

I would say be careful. Help us get best practices out there. Help us have an environment to get it done where it is normally done more effectively and more affordably, at lower levels of Government. I believe that states are best positioned to meet that growing need.

I am glad we here at the Federal level, this is the big microphone that has to highlight the issues, that is what we are doing here today. Thank you to all the panelists for being here, and I am interested to see what we can come up with. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ranking Member Braun. We will next turn to our witness introductions. I am grateful for the time and the work that goes into an appearance from our witnesses.

Our first witness this morning is Ms. Patty Vessenmeyer from Gainesville, Virginia. Her first husband, John Whitney, had dementia and lived in an assisted living facility at the end of his life. She will share some of her and her husband's experiences, where she supported him in an assisted living setting.

Patty, we are grateful you are here today. Thank you. Our second witness is as Dr. Jennifer Kraft Morgan. Dr. Morgan is from Waleska, Georgia. Dr. Morgan is a Professor and Director of the Gerontology Institute at Georgia State University.

She studies issues related to long-term care dementia and the health care workforce. Thanks for being with us today, doctor. Our third witness is Julie Simpkins, and I will turn to ranking member Braun for that introduction.

Senator BRAUN. Julie Simpkins is the Co-President of Gardant Management Systems. She has been in the long-term care arena for nearly 30 years.

Ms. Simpkins focuses on affordable assisted living, and she advocates for both providers and older Americans in Gardant's 82 facilities across the country.

She leads on several state and national associations, including the Indiana Health Care Association Board of Directors and the National Center for Assisted Living Board of directors. Thank you for testifying here today.

The CHAIRMAN. Thank you, Ranking Member Braun. Our fourth and final witnesses is Richard Mollot. He is the Executive Director of the Long Term Care Community Coalition.

This coalition works to provide families with unbiased information about nursing homes, assisted living facilities, and other long-term care settings. Thanks for being with us today, and we will turn to our first witness, Patty Vessenmeyer.

STATEMENT OF PATRICIA VESSENMEYER, ADVOCATE, GAINESVILLE, VIRGINIA

Ms. VESSENMEYER. Good morning, Chairman Casey, Ranking Member Braun, and members of the Senate Special Committee on Aging.

My name is Patty Vessenmeyer and thank you for allowing me to share this testimony of my experience with assisted living for my husband, John Whitney, during his journey through the middle stage of dementia. I will focus on my experiences and observations that I believe are most relevant to your national focus.

In 2013, my husband was diagnosed with dementia with Lewy Body. Although this dementia is similar to Alzheimer's, it manifests itself a bit differently and it is important that caregivers be informed and trained to ensure the comfort, safety, and security of their patients.

Some key systems are loss of sense of smell, REM sleep behavior disorder, which causes individuals to violently act out dreams, often falling out of bed, visual hallucinations, marked fluctuations in attention and alertness, and gastrointestinal issues, including severe constipation, all of which my husband experienced.

Loss of memory often occurs much later in this disease process. I took several free courses on caregiving for individuals with dementia, including a virtual reality dementia experience, which helped me to understand the challenges that people with this disorder face, and most importantly, why they become fearful and combative.

I mentioned this to provide a basis for my ability to recognize problems with care as I saw it. These same courses are offered for professionals at reasonable costs. In June 2017, when my husband's disease was progressing more rapidly, I moved to Virginia to be near family.

I cared for him alone at home until January 26th, 2018, when he attempted to strangle me in my bed. The State determined that John should be placed in a long-term care facility. I found him a room in assisted living facility in Warrenton, Virginia that specialized in memory care. He moved in the first week of March in 2018.

I provided the management team with John's history, his diagnosis, and disease progression. The following is a list of issues that I observed in the Memory Care Unit during my daily visits with John. Poor facility design. There were blocks of rooms built around a large central room for group activities and TV.

The central room was extremely loud and high levels of noise can easily agitate dementia patients. Activity stations were set up for residents. One of these had various lengths of PVC pipe, not kidding, some longer than a baseball bat. These were weapons in waiting and you can guess what happened.

There was no quiet area for the residents other than their rooms. The hallways in the room blocks were isolated, making it difficult for staff to monitor. There were many incidents that I witnessed when there were no staff around. I will share one that I feel was very important.

A woman fell by tripping on a raised area on the floor where the rug abutted the hard flooring. Nobody saw her fall. I found her bloody and staggering down the hallway. A company knowledgeable about dementia care would not design a facility this way. They would certainly understand that people with dementia have problems with gait and balance, and do understand, there were video cameras in place, but they only used them for reviewing incidents after the fact. They were understaffed. Too many patients were assigned to each caregiver. In the morning, each caregiver needed to give their assigned residence—get them up and dressed and ready for breakfast.

Everybody ate at the same time, putting additional pressure on the staff. They only gave residents a shower when necessary, as they were always pressed for time. Caregivers needed extra time to spend on residents in more advanced—sorry, stages of dementia, as they required help to move from their bed to a wheelchair and be hand fed.

After lunch, the caregivers would place most of the resident in chairs in the main room while they worked getting the advanced stage patients back into their beds. Every day after lunch, my husband urgently needed to empty his bowels.

Several times when I was there, I tried to help him, but it was difficult for me as I had had a broken arm at the time. I could not

find anybody, so I did the best I could, and often when I was not there, he soiled himself while waiting for help.

I once believe I saved a man's life. I was with my husband in a room off the main activity area. I heard someone crying for help. I ran into the hallway and found an old man on the floor, trying to protect himself from being beaten with his own cane by another resident.

I called for help, quickly moving closer and redirecting the attacker's attention. I kept him busy while calmly calling for assistance, trying not to further agitate him. It took several minutes before a staff member finally heard me and came to help.

Night was no better as staff levels were lower as allowed by state regulations. They placed residents who had trouble sleeping in front of a TV while they dealt with other residents. Inadequate staff training.

Most of their caregivers staff were trained as nurse's aides, but nothing specific to memory care that I could see. I witnessed them providing new hires dementia training care in a conference room.

This consisted of a member of the management team showing them parts of Glen Campbell Zombie movie and pointing out some behaviors that demonstrated his dementia problems. I saw that movie and it was not appropriate for training purposes.

I observed several instances where caregivers and nurses displayed limited knowledge of working with dementia patients, particularly those in mid-stage of the disease, who became more fearful and combative.

Some examples: Nurses running toward the patient, causing the resident to become combative. Quick, erratic hand movements frightening the individual, and another example, the TV was on at 9:30 p.m. with extremely high volume. Several residents were seated in chairs and wheelchairs in front of the TV.

Anyone who understands dementia and sundowning would never do this. They were overstimulating these residents instead of allowing them to relax and quiet their minds for sleep, and finally, at one point, the director of this facility told me to spend less time there and let them do their jobs.

Well, I could not abide because I felt they weren't doing their jobs. In closing, unless things change, I could never recommend using this type of facility for a loved one unless things improve. I am hoping that you found my testimony helpful, and the Committee will find a way to set some national standards for appropriate levels of staffing and training for that staff.

This would be a huge step in improving assisted living. Thank you for your time.

The CHAIRMAN. Thank you very much, Ms. Vessenmeyer. I appreciate your testimony.

Dr. Morgan.

STATEMENT OF JENNIFER CRAFT MORGAN, PH.D., DIRECTOR AND PROFESSOR, THE GERONTOLOGY INSTITUTE, GEORGIA STATE UNIVERSITY, WALESKA, GEORGIA

Dr. MORGAN. Good morning, Chairman Casey, Ranking Member Braun, and the members of the Committee. I am honored and delighted to be here. Thank you, Patty, for sharing that story.

Assisted living is a large and growing long-term care residential option for individuals who need or want additional supports for activities of daily living.

There are approximately 30,600 AL communities in the U.S., with approximately 820,000 residents employing about 500,000 workers. AL, often seen by the public as interchangeable with skilled nursing homes, was built and is regulated as a social model of care. This community-based care is less restrictive and strives to be home like.

AL residents vary greatly in the amount of care they need from person to person. Rising acuity levels do mean that as residents age in place, they likely require more health services. While these services could overlay AL services, much like they would if the person was needing—needing care was at home, these are not provided directly by the AL communities.

The haphazard growth of this model and the tensions between social care and health care inherent have spurred calls by scholars for assisted living to be reimagined. Most AL residents need help with medications, and more than half need help with three or more activities of daily living.

AL residents depend on their care networks. The constellation of kin and non-kin involved in residents' lives to arrange medical care, to provide social support, to coordinate care, to engage residents, and activities, and bring needed supplies.

These care works also play an important role in advocating for residents and negotiating care with AL staff. About 42 percent of AL residents have a dementia diagnosis, but we can assume this is underreported as many older adults are not screened, tested, or diagnosed with dementia, despite showing symptoms and memory thinking or making decisions that impact everyday life.

Like all people with chronic disease, people living with dementia have good days and bad days. Person centered dementia care is needed to tailor care and support to individuals in ways that account for preferences, life experiences, communication styles, and support needs that change over time.

According to MCAL, the average monthly cost of AL is $4,500. As such, AL is inaccessible to most Americans. Yet on the spectrum of long-term care, it is often needed. Seen as a step between unpaid care by loved ones and nursing home care, AL provides an a very important long-term care option.

When the care of NE care needs of a loved one exceeds the capacity of their care network, the person and their care network is forced to navigate with little support or education, a variety of options, none of which are usually covered by health insurance.

If they have significant financial resources, AL is a useful and attractive option. If not, managing the care situation means they care partners reduce working hours, build precarious care or financial arrangements across families, hire piecemeal personal care support, or simply cross their fingers and hope that it all works out.

Sixty-six percent of the AL workforce are aides or direct care workers. Direct care workers in AL and across long-term care are predominantly women, people of color, and disproportionately immigrants. The typical direct care worker, a Senator Casey said,

makes about $15 an hour, works 36 hours a week in assisted living, and works for a for profit company.

AL workers, like most direct care workers, tend to go into this line of work to give back, to make a difference because they value elders or because it is a calling for them. Unfortunately, the system we have set up works against them.

Direct care workers in long-term care settings experience low wages, few benefits, heavy workloads, dangerous jobs, and little to no career mobility. In her book, Disrupting the Status Quo of Senior Living. A Mindshift, Jill Vitale-Aussem lays out what I think is the crux of the problems facing senior living.

AL is marketed to those who can afford it with a hospitality mindset. They advertise and compete on the basis of beautiful campuses, luxury food and furnishings, and concierge services. This model encourages residents and families to think about this next step as though they are going to a hotel or a resort.

This framing, where residents are guests and staff are encouraged to cater to their whims, increases what Dr. Bill Thomas of the Eden Alternative calls the three plagues of long-term care, helplessness, boredom, and loneliness. By encouraging passivity, we leave residents with few opportunities for giving back or creative pursuits.

Instead, long-term care that is person centered, community minded, and empowering for residents, staff, and care partners has a much better chance of success.

My recommendations include improve and standardize initial continuing education training—initial and continuing education training for direct care workers and all staff in assisted living. Professionalize the direct care workforce.

Incentivize and reward good employers who deliver high quality care. Increase access to assisted living. Improve care coordination and resources for people living with dementia and their care partners, and support standardization of monitoring and resources to increase state-based oversight and transparency. Thank you.

The CHAIRMAN. Thank you, doctor, very much for your testimony. Ms. Simpkins, you may begin.

STATEMENT OF JULIE SIMPKINS, CO-PRESIDENT, GARDANT MANAGEMENT SOLUTIONS, INDIANAPOLIS, INDIANA

Ms. SIMPKINS. Thank you. Chairman Casey, Ranking

Member Braun, and members of the U.S. Senate Special Committee on Aging, thank you for inviting me here today to be part of this important discussion on assisted living, a topic that is very near to my heart.

My name is Julie Simpkins, and I am the Co-President of Gardant Management Solutions. We are a provider that develops and operates senior living, assisted living, and memory care communities.

We are the fifth largest assisted living provider in the country and have communities in five states, Illinois, Indiana, Ohio, Maryland, and West Virginia. I have dedicated most of my life to senior living, with over 30 years to the assisted living sector.

This is my calling, and I would like to speak with you today about Gardant's unique model, as we share thoughts and how we

can work together on important issues facing those who need and work in assisted living.

Gardant is uniquely focused on offering affordable assisted living to low-income seniors. Our company was founded in 1999 after the creation of the Illinois Supportive Living Program, which is a home and community-based waiver program.

Now, as we expanded into four other states, our commitment to serving this population remains. Many residents living in Gardant communities rely on Medicaid for their assisted living care through these waiver programs.

Gardant has been limited in where we can offer our services due to the variability with state Medicaid waiver programs. It depends on the availability of state programs, of state reimbursement levels, and the number of available waiver spots.

Offering affordable assisted living exclusively or even for a majority of residents like Gardant requires an entirely different business model altogether. We have had to persistently seek out HUD loans and income tax credits to stay viable.

Therefore, we support efforts to make long-term care, including assisted living, more affordable to low and middle income individuals. With a rapidly growing elderly population, we need a public and private partnership to incentivize more providers to develop these models.

When we talk about assisted living, it is important to note that every state, every community, and every resident is different. Efforts to standardize all assisted living communities would be both unworkable and irresponsible for resident care.

State regulations recognize the diversity within assisted living by holding our profession accountable, and they are consistently updated to reflect the evolving nature of our sector and our residents.

Meanwhile, Gardant is committed to exceeding the state requirements when we believe it is in the best interest of our residents. We will take memory care as an example and something that is top of mind for this Committee, as well as our residents and family. Every staff member at Gardant's memory care communities receive education and training in dementia related diseases, as well as training as a certified dementia practitioner.

While elopements are rare, we all report to the state immediately, even something as technical as a resident walking out the door instantly returning with a staff member. We know they didn't leave our community and our staff immediately addressed the situation, but we still reported.

The recent reports of resident elopements that were ultimately fatal are heartbreaking, and my thoughts and prayers go out to the loved ones of those residents. I serve in leadership positions on numerous national organizations dedicated to long-term care, and I know these tragic incidents are extremely rare and not indicative of the assisted living experience.

The overwhelming majority of families and residents have a life affirming, safe experience. Assisted living providers are committed to upholding our policies and procedures, as well as continuing to learn all that we can about dementia care to prevent these incidents. It is critical that policies and regulations help protect resi-

dents while still supporting their freedom of movement and independence.

Assisted living is a critical aspect of the long-term care continuum and dedicated to delivering person centered care to our Nation's seniors. We need collaborative, comprehensive solutions that ensure our ability as assisted living communities to continue doing what we do best, providing safe, quality care to our residents.

From expanding more affordable long-term care options, to workforce programs, to addressing the growing caregiver shortages, these efforts could make a real difference.

We must all work together to ensure current and future assisting living resident is seen, safe, and served to enjoy the highest quality of life possible.

Thank you for your time and I look forward to answering your questions today.

The CHAIRMAN. Thank you, Ms. Simpkins, for your testimony, and we will turn to our fourth and final witness, Mr. Mollot.

STATEMENT OF RICHARD MOLLOT, EXECUTIVE DIRECTOR, LONG TERM CARE COMMUNITY COALITION, NEW YORK CITY, NEW YORK

Mr. MOLLOT. Good morning, Chairman Casey, Ranking Member Braun, and members of the Committee. Thank you for inviting me to testify today on this important issue.

My name is Richard Mollot, and I am the Executive Director of the Long Term Care Community Coalition. LTCCC is a national, nonprofit, nonpartisan organization dedicated to improving care and quality of life for residents in nursing homes and assisted living.

We conduct research on long-term care policies and the extent to which essential standards of care are realized in the lives of residents who are typically elderly and frail. In addition to conducting analysis and advocacy, we educate and engage residents, families, and those who work with them so that they are aware of their rights and are equipped to overcome the challenges that so many of our seniors face when they need residential care.

Our interest in assisted living is long standing, and we appreciate your commitments to ensuring that the promise of assisted living is realized in the lives of our growing senior population.

Assisted living emerged in the 1980's as an alternate to nursing homes for seniors who want or need to live in a congregate setting where they can get help with tasks like housekeeping, meal preparation, and access to activities and transportation.

Over the last 40 years, three developments have drastically changed the nature and character of the assisted living sector, with both positive and negative implications. They are one, the needs and frailty of assisted living residents have dramatically increased.

Two, assisted living operators have adopted increasingly sophisticated and large scale corporate models, including ownership by real estate investment trusts, private equity, and other sophisticated private investment structures, and three, public payment for and Government interest in assisted living has increased significantly. Assisted living facilities now care for people who in many ways

have the same needs and vulnerabilities as nursing home residents.

Assisted living residents are actually older on average and those in nursing homes. Approximately 40 to 70 percent of assisted living residents have Alzheimer's disease or some other cognitive impairment. Over half have hypertension.

One third or more have heart disease or depression. About half need help with dressing and, or walking, and two thirds need help with bathing. Over 10 percent of residents with dementia receive antipsychotic drugs.

Unfortunately, we as a country have failed to keep up with these trends. While some assisted living can be wonderful places to live and to work, too many take in or retain residents for whom they are unable to provide safe care and dignified living conditions. Too many residents and families are at risk for financial exploitation and even fraud.

Too many seniors and families get taken in by promises of "memory care" and aging in place, when in fact these are more often marketing terms than accurate representations of specialized care.

The absence of any Federal quality of safety standards, coupled with the virtual absence of reliable public information on the quality, safety, and cost of assisted living, have made assisted living a sector ripe for investment by sophisticated private enterprises who can shuffle around resources and take profits, with little regard for the promises made to seniors and their family.

These problems occur at every economic level, from $50,000 a month or more paid to luxury assisted living, to the 20 percent of seniors who access assisted living through public funds like Medicaid waivers. It doesn't have to be this way.

Forty years ago, when nursing homes were in crisis, Congress took action. From numerous GAO reports to the growing chorus of local and national news reports of neglect, disastrous "elopement," and financial shenanigans, it is clear that we have reached that point now with assisted living.

We recommend three things. One, establish and implement national standards to promote quality, safety, and integrity in assisted living. Two, establish a national assisted living data base with information and metrics that the public needs to evaluate both costs and quality, and three, promote resident and family engagement to ensure that assisted living is truly a home and community-based service.

As I mentioned earlier, assisted living experiences can range from positive to alarming, posing potential risks and exploitation. I think that we can all agree that the lives of seniors should not be left to chance, ambiguity, and insecurity. Thank you again for inviting me to testify today.

The CHAIRMAN. Thanks very much for your testimony, and I will begin the first-round of questions, but I want to note for the record, we have Senators that are in and out because Thursday is a pretty busy hearing morning, and so, we will have Senators come here. Some will be here and then ask questions, and folks will be appearing intermittently throughout the hearing, but so far, I know that Senator Rick Scott was here, and Senator Blumenthal was here,

and we will be awaiting others after my questions and those of the ranking member.

I wanted to start with you, Patty Vessenmeyer, about your own experience, and I want to start by saying how much I appreciate—I know the Committee appreciates your willingness to share a personal story.

That happens in hearings like this on a pretty regular basis, where an individual comes forward and talks about their own experience or that of their family, and from a distance it might seem easy, but I can't imagine how difficult it is to recount difficult, painful moments and doing it in the interest, of course, of helping others, so we are grateful for your willingness to do that, and telling your story is a very important part of the work we are trying to do together. I know that your husband was in an assisted living facility, and you were, as you indicated, paying privately for those services to make sure that he would get the care that he needed for dementia.

I know I have heard from my own constituents back home similar stories. For example, Angela, who is a constituent of mine from Johnstown, Pennsylvania, Cambria County, out in the Southwestern region of our State. She wrote to me and said that her father was in one facility that charged $7,200 a month.

I know that is not the average. It is very high. That works out to about $90,000 bucks a year, and Angela shared, and I am quoting her here, "there was always a sense that no one cared for the residents beyond their monthly payments." That is one experience and that is one person's personal experience.

Ms. Vessenmeyer, I wanted to ask, based upon your experience with your husband, did the facilities he lived in deliver on the care that they promised to provide?

Ms. VESSENMEYER. Thank you, Senator. Thank you for appreciating me coming and doing this, and I think the good news is it has been six years, and I am able to do it without getting overly emotional.

No, they did not deliver. They definitely over promised, and understand that they were absolutely a memory care facility, specialized in it, and knew what they were doing. His basic needs were not often met.

You could hear from some of the examples that I gave, and I observed other people the same way. They would actually recommend that you pay an additional private caregiver to come in to give them the care they really should have gotten, but their staff was just—there just wasn't enough staff for them to get it done, and do understand that their staff was friendly and caring and they were wonderful people who were not trained, and they were just overwhelmed, but they definitely did not deliver, and by the way, it did come out of my pocket because my husband had chosen not to do long care insurance, and that number that the woman gave you was low. That was my starting figure, was $7,900. It cost me closer to $13,000 a month.

The CHAIRMAN. We are grateful for you sharing your own story, your own experience.

I wanted to, next turn to Richard Mollot, you mentioned the need for more substantive and meaningful ways for residents who might

choose a particular facility or their families to know which services they receive, how much those services cost, the outcomes for residents living in a specific assisted living facility. For a family searching for care—and we hear about this all the time.

I am not sure there is—doubt there is anyone in this room who doesn't know someone who has had the experience of having to search for care and to try to navigate it. It is obviously difficult to find the information that folks need about assisted living facilities, and sometimes they only have the word of an assisted living provider, or maybe someone else who has had their own experience they can rely upon.

Can you elaborate more on the challenges that families have in finding both accurate information and unbiased information about services, about costs, about care outcomes for residents in assisted living facilities?

Mr. MOLLOT. Thank you. Essentially, there is no independent, validated information on assisted living for the consumers, for policymakers, or for the general public, so families, as you noted, have to rely on facilities and facility marketing materials. They also quite often rely on companies like A Place for Mom and the other so-called consumer resources, excuse me, that are not independent of the industry.

Companies like caring.com, A Place for Mom, that actually get money for—from facilities to be listed, so that is not independent either. That is not something that people can rely on as being necessarily an accurate information of what has happened, what they are going to pay for, and what they are going to get, and the state websites really are the last resource, and they tend to be very flimsy. I haven't looked at every single one, but the ones——

The CHAIRMAN. They tend to be, you said?

Mr. MOLLOT. Very flimsy, I am sorry.

The CHAIRMAN. Flimsy. Okay.

Mr. MOLLOT. Yes. Most often what we will see is they just list the facility. They may list the facility's administrator, their phone number, and the address. Sometimes there is a little bit of information, but you cannot, in my experience, ever get into finding out really what has—what the staffing is, what the costs are going to be, or what the quality has been and any issues.

The CHAIRMAN. I know that in your—going back to your testimony, you mentioned the three recommendations. The first one was, establish and implement national standards to promote quality, safety, and integrity in assisted living. The second was establish a national assisted living data base. Is that what you are referring to?

Mr. MOLLOT. Yes. Yes. Similar to care compare—you know, there is nursing home care compare, home health care compare, hospital care compare on the Medicaid website. There should be an assisted living compare.

The CHAIRMAN. Well, I think—and look, I think it is pretty fundamental that people should have the opportunity to place reliance upon a source that is objective, and to use your word, independent.

That is, I think that is true in any walk of life. Why would someone only—why should we settle for just relying upon assertions by those who are operating facilities?

I think that is pretty elementary, but we haven't reached that point yet in terms of a change in policy. I know I am over time, but I will turn to our Ranking Member, Ranking Member Braun.

Senator BRAUN. Thank you, Mr. Chairman. I want to start, first I want to ask Ms. Simpkins a question, but that idea of transparency and information, to me, I don't know how you could say that wouldn't be good.

I have been a proponent since I have been here that this place out of focus as much on that as anything, because we are a portal of information that if you collate it properly, that would seem to make sense.

I think that goes across the spectrum of health care as well. I have been the most vocal Senator that our health care system is broken. We do not have transparency. We do not have competition. It is kind of almost like an unregulated utility, and you get your bill at the—after you had a significant health care scrape or a bad accident. You got to hold your breath to see how much it is going to cost, or you can afford it. I like that idea.

Ms. Vessenmeyer, you mentioned that it was $7,200 a month and it could have been more, and that is in Virginia, correct? Is that where the——

Ms. VESSENMEYER. Yes, but that isn't the number that I gave you. That his room charge was $7,800 to—actually $7,900 to start, and it cost me close to $13,000 a month.

Senator BRAUN. $13,000 a month, okay.

Ms. VESSENMEYER. That is correct.

Senator BRAUN. That sounds unaffordable, so.

Ms. VESSENMEYER. If he hadn't passed away rather quickly by the time—the length of time he was in there, it would have used up all of my nest egg.

Senator BRAUN. That is the kind of stuff I have been appalled by from the time I took on health care reform in my own business 15, 16 years ago.

How lucky the industry would tell you it is only going up five to ten percent each year, you know, in your health care premiums. Sooner or later, people can't afford it and that has got—something has got to give.

I was noticing in your background, Ms. Simpkins, you focus on low-income because some people are going to be able to afford it despite the quality of care and the level, but most people will not.

In Indiana and the four other states where you operate, what would that range be per month as you would compare it to $7,000 to $13,000 bucks a month, and it seems like when it was all in, it was closer to that higher figure. Just curious.

Ms. SIMPKINS. Yes. Thank you, Ranking Member Braun, and the range that a resident or resident family would pay under the home and community-based services is really nothing. In Illinois, there is a small personal portion.

It is based on resident income and allowing them to do things and still have money in their pocket. In Indiana, there is no personal portion, so the State of Indiana will pay for those services through the State.

Senator BRAUN. In your facilities, for low-income individuals, there is basically very little out of pocket?

Ms. SIMPKINS. There is very little out of pocket. There might be some personal portion based on what they actually receive in income, but it doesn't go over what anything a Social Security amount is.

Senator BRAUN. How much would you be able to generalize that across the rest of the country?

Ms. SIMPKINS. To model that program? Oh, you can model the program.

Senator BRAUN. Are other states doing that?

Ms. SIMPKINS. There are other states that are doing it. Now, I will say that Illinois supportive living program and Indiana are probably—and Ohio are doing it really well, recognizing that there is a need within their State, there is an underserved population. There are people that cannot afford it, and so, that is what we were founded for. That is our business model is to say there is an unmet need and how are we going to do it, and we work with states that have the programs, Medicaid waiver programs in place along with rate reimbursement that makes sense.

Senator BRAUN. Mrs. Vessenmeyer, you would not have qualified for any low-income opportunities then. Is that what kept you in that, what seems to be outrageous in terms of the cost per month?

Ms. VESSENMEYER. That is correct, because even though we were both retired, they look at all of your savings, and if you have a decent IRA out there, that counts.

Senator BRAUN. It begs the question then, is the low-income stratum across the country being served adequately?

That almost would seem to be surprising to me if that were the case, but what we are seeing on the other side, and then it is a question, there just wouldn't be many families that could afford it, and you know, I don't know what the criteria or the cutoff is. Can you fill me in a little bit? It sounds like in Indiana, especially if there were other options to choose from other than just your organization, that the low to maybe middle income strata are being served well. Is that a fair statement or not?

Ms. SIMPKINS. That is a fair statement, Ranking Member Braun.

Senator BRAUN. Do you think that is the case across the country as well as you know, because you serve on some boards that—where I think you would have that information.

Ms. SIMPKINS. It is not across the country. Nationally, there needs to be programs in each state to—to provide access to affordable assisted living, and they are not all there yet.

Senator BRAUN. Generally—and that is at least a little bit surprising, and generally, it is a folks at the other end of the spectrum, the low and middle, especially low, that don't get adequate services.

I think that is something that you need to get those practices spread out to where we at least can get that in most other states, and then you got to tackle something like this, that I don't know how wealthy you would have to be to be able to afford that easily and for a long time.

Something has got to give there. I will rest with that right now, and I will have another round of questions if we do it.

The CHAIRMAN. Thank you, Ranking member Braun. We turn next to Senator Kelly.

Senator KELLY. Thank you, Mr. Chairman, and thanks to all our witnesses for being here today. Mr. Mollot, the Arizona Republic, the paper of record in my State, published a series of investigative reports last year about the State of long-term care facilities in Arizona, and these journalists spent more than a year on this investigation. They reviewed police reports. They reviewed footage in some facilities. They analyzed regulatory reports from the State, and they interviewed families and experts, and what they found was, I think it is fair to say, horrifying. They reported graphic stories of a resident dying after being attacked by a roommate who hadn't received her medication in time.

Another report of an assisted living resident being sexually assaulted by another resident, and incidents of violence among residents that often aren't reported because they aren't required to be reported under state law, and they highlighted the failure of state agencies to investigate these cases in a coherent, transparent way that would allow families looking for a safe place for their loved one to know what really goes on in these facilities, and I think a lot of us knew there were issues in the system. We knew that.

I don't think we knew how bad it was. Since these articles were published, Arizona's Governor has put together a strong legislative package to standardize inspections, promote transparency for residents and their families, and empower our adult protective services to investigate, and the State legislature is looking at proposals. Mr. Mollot, are these the type of steps that can help tackle these issues?

Mr. MOLLOT. I believe so. I mean, of course it all—the details matter. This is a very nuanced issues about caring for people with dementia and ensuring that that things are reported appropriately and that there is good oversight.

As much as possible, we would hope that the State would be looking to implement policies and practices that prevent bad things from happening, as well as, of course, ensuring that when they do happen that they are rectified and that they are reported appropriately.

Senator KELLY. Arizona can't be the only State that is facing these challenges.

Mr. MOLLOT. Not at all.

Senator KELLY. Should the Federal Government maybe consider having a role here and providing oversight for assisted living facilities?

Mr. MOLLOT. I think it is time for the Federal Government to step in. As I mentioned in my testimony, 40 years ago when nursing homes were in crisis, Congress stepped in. Congress took that, you know, initiated action, and we are here now with assisted living as well. The same population in terms of numbers of people are in assisted living as they are in nursing homes, but we don't know what is happening to them.

We don't know the care they are receiving. A lot of it is private pay, not all of it, but there is unfortunately a lot of fraud.

Senator KELLY. Apparently, more than 20 years ago, this Committee helped to facilitate the creation of an assisted living work group, which was made up of 50 organizations, and this work group was tasked with coming up with recommendations for best

practices in assisted living facilities to ensure a more consistent quality landscape across states.

The result was a 380 page report with a lot of recommendations, and these were hard to agree upon. Mr. Mollot, what has happened with these recommendations since this report was finished, if you are familiar with it?

Mr. MOLLOT. I haven't read it in a long time, but I am familiar with it. Frankly, on the Federal level, nothing has happened.

As Ms. Simpkins said, we do see some things going on in the states, but it is—generally speaking, the states are just not inclined, frankly, to take action on a lot of the work that they do.

Hopefully they will be different in Arizona, but it really is time, I believe, for the Federal Government to step in to ensure that wherever someone accesses dementia care, that means something. It is not just a term of art, and wherever they go for safety, they know that they can live safely, and wherever they are going into, they know what the expenses are going to be, that they are cognizable.

Senator KELLY. Well, thank you. I do want to note for my constituents a resource created by AARP Arizona and by the Arizona Republic following this investigative series that I mentioned. It is a backgrounder on long-term care, the definition—definitions of different terms, what family should look for, and what questions to ask, and folks can find this on the AARP Arizona website, and my office will be posting this on our social media accounts, and I am going to submit this for the record as well, Mr. Chairman, and I urge Arizonans or anybody else interested to check it out, and thank you.

The CHAIRMAN. Thank you, Senator Kelly. That will be submitted—accepted for the record, not just submitted.

Thanks very much. We will turn next to Senator Vance.

Senator VANCE. Thank you, Mr. Chairman. Thanks to you and the ranking member for hosting the Committee hearing today, and welcome to our witnesses. Thank you for being here, and welcome to all of our guests.

I want to direct my questions to you, Ms. Simpkins, and I appreciate you being here. I am particularly concerned by some of the estimates that I have seen about labor shortages at our long-term care facilities.

Not just now. I know there is sort of an immediate problem of not enough people at some of our elderly care facilities, but I saw an estimate that by 2030, we will need given—you know, obviously, people will retire, will drop out of the workforce, but then we also have changing demographics in this country.

We are becoming older as a country. I read that we will need an additional seven million long-term caregivers at these elder care facilities. That seems like a shocking estimate to me. It is hard to imagine how we could possibly hire effectively one million additional people per year at these facilities, given the already existing labor shortages.

I am curious if you think that estimate is within the reasonable range, and if it is not, how many more workers do we need over the next five to ten years?

Ms. SIMPKINS. Thank you for the question, Senator Vance. I have not heard seven million. I have heard five million, but I can certainly I would be interested in your information, and I will follow-up and send you the information I have.

In my response to that, we got hit by the pandemic really hard. Health care workers left, and they are never coming back. They said this was hard and we are not going to do it, and we have had to recover, and assisted living has recovered pretty well. What we also need to do is we need to build for this aging—our workforce is aging out and our seniors are aging, and we are doubling and tripling numbers when we get to 2040 and 2050, and so, having a really intense effort and what that means to both recruit and retain, and if you don't mind, I would like to share just quickly what we are doing.

Senator VANCE. Sure.

Ms. SIMPKINS. From a recruitment standpoint—so that is how we recovered. We were able to get really creative. We looked at people and said, what do you need? What is it going to help your household?

We knew we needed to increase wages, so even in an HCBS environment, you can have rate methodology that allows you to pay a living wage and higher than what a minimum wage is, and then we looked at retaining because, you know, as people—people come into the assisted living, and they stay because they are so passionate about it, and in honor of their passion, we need to create something for them. What we do is from the first interview, we asked them what they envision six months from today, one year from today, three years from today.

We want them to envision a future with us and at least a future with the assisted living industry, and then we have to meet that need by career pathing, career net mapping, and what we have—so we have done a lot of that and what we have realized through those interviews and people saying, this is my career path, is we also need to skill path.

We need to provide them with the resources, whether it is through a nursing grant, is through additional education that we are reimbursing them for, additional training that they need, so if you are going to commit to working within this space in a workforce, you also need to create and having a workforce that has continued to be passionate, make a living wage, and have the tools they need, and they will want to stay.

Senator VANCE. Got it. Appreciate that. You know, one just additional thought here is, you know, you hear about these cases of elopement at some of our eldercare facilities and they are mercifully rare.

You know, we have close to a million Americans in elder care facilities right now. You know, maybe 2,000 or so elopements happen per year. That is a small number, but that is—I worry, with increasing labor shortages, whether that number goes up.

I have heard some suggestions that you could fill the labor shortage gap by expanding certain immigration programs, certain visa programs, and the one worry that I have there, of course, is that, you know, if you take a person caring for an elderly citizen, you want to make sure there is not a language barrier there, especially

with people who are going through dementia and might be, you know, losing some of their cognitive capacity.

We really have to wrap our minds around this. I appreciate the work that you are doing on this, and I appreciate your answer to the question, but are you worried that we might see an increase in elopements over the next few years, or do you think not?

Ms. SIMPKINS. We need to plan for how our seniors are aging and the additional care needs, and we do that through person centered planning.

I believe Dr. Kraft Morgan mentioned that our person centered care plans revolve around what a resident needs, because and to Patricia's point too, somebody can have the same diagnosis and their needs are completely different, and if you are not having person centered plan for that individual, which is collaborative with their family, with the resident when—as much as they can participate in it, with their caregivers, you are not going to have the best plan to keep them as safe and secure as you possibly can.

On the immigration side, I would—you know, there is an opportunity here with unused visas to at least start bringing in—if you think about the workforce, start bringing in some health care workers.

Senator Vance, to your point, there are some markets within—that we are within, that have the residents who also have language barriers. Having staff who speak Spanish, we have staff that speaks Polish based on where the neighborhoods are.

Senator VANCE. Yes. Thank you. Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Vance. Senator Ricketts.

Senator RICKETTS. Thank you, Mr. Chairman. Again, thank you to all of our folks here that are testifying. Appreciate you taking the time to help us out here today. I represent the great State of Nebraska.

In Nebraska, we have nursing—skilled nursing facilities and assisted living facilities that are scattered throughout our State, and it is incredibly important to take care of the 20,000 people who require care in the 500 different facilities that we have, and they can get that care for about $3,875 a month.

Anybody who is providing assisted living services in the State of Nebraska that has four or more residents is designated as an assisted living facility that is regulated by the State and is licensed.

While I was Governor, I signed into law an Assisted Living Facility Act to update the standards and the requirements that we have for our assisted living facilities. They are just absolutely critical, especially in rural parts of Nebraska, and to be able to help take care of people, and we want to make sure that we continue to have that service for our folks.

Ms. Simpkins, as you know, assisted living facilities, as I mentioned, are a regulated at the state level, which allows states, you know, flexibility to be able to be responsive to local consumer demands.

Are there any states in particular doing an exceptionally good job that we can draw lessons from? States you say, hey, they have got some good programs or things that we should be adopting across the country?

Ms. SIMPKINS. Well, I can speak for the states in which we operate. Illinois, Indiana, and Ohio have exceptional programs, and with that, Senator Ricketts, one of the things we noted in reporting—all of those states will require reporting of any of the incidences that were talked about previously.

Senator RICKETTS. Are there other characteristics though that you think has led, or some of the approaches that you say that these states are doing a good job. What are they doing right?

What are the things that—so you mentioned the reporting. That is obviously an important factor. Are there other things that they are doing that you say, hey, this is why they have such good systems.

Ms. SIMPKINS. This is why there is a good system, because we have access within a state, in a state that is—where assisted living is regulated under the state.

I am going to talk particularly about home and community-based service, access to the regulators, access to families, access to everybody who—you know, you have this local model that can create and innovate and come up with best practices.

I am a big proponent, let's share our best practices because there is nothing proprietary when it comes to caring for a senior and caring for somebody, and that is what those states are doing well.

My fear is, if you move those conversations further away, we will no longer have those things. The states in which we serve, and I will talk about Indiana specifically, the state program, Medicaid waiver program and regulations are really dynamic.

They promote and encourage having a local model where there is collaboration and there is innovation, and that is where we come up with best practices, so that—I would say that that is also a model.

Senator RICKETTS. Great. Well, hey, thank you because that actually leads into another question I had then. Last May, this Committee held a hearing that highlighted the strained nursing home inspection system.

As you know, nursing homes are regulated at the Federal level and—are heavily regulated by the Federal level. Anyway, so if assisted living facilities are subjected to the same sort of one size fits all Federal type regulation, what can we do as lawmakers to ensure that assisted living facilities don't have the same sort of problems we are seeing in skilled nursing facilities? How do we protect that, what you talked about, that local model and best practices?

Ms. SIMPKINS. Well, from the state level, we encourage all of the states, so the things that we were talking about, if we even just talk about reporting in the—reporting of those critical events, reporting those up through the Federal Government.

Under the HCBS services, each State has really an obligation to report up in order to continue to have their federal funding. They also are well aware of the transparency that comes from and the opportunity—once those things the states report up, we have a transparency and the opportunity to see what home and community-based services are doing across the Nation, and we will have a window and more models that we can see, because I am sure there is more states that are doing it well. I just can't speak to those today.

Senator RICKETTS. Getting back to the idea of like if you have the Federal Government that is regulating those things, how do we preserve that ability of local folks to be able to really tailor how they are doing the regulation to make sure that we are not pushing a one size fits all answer?

Ms. SIMPKINS. You know, there has been—we need to—from our perspective, we need to tell our story much better. There are really good stories to tell from a state perspective on our home and community-based services, and we need to do a better job of talking about those stories and the things that are going on within the states.

The innovation that has happened. The times providers have been asked to sit at a table before there is a rule change and not just ask for comment, but sit face to face with somebody and say, if this rule changes, how does it impact the resident that you are caring for and your workforce who is caring for that resident.

Senator RICKETTS. Right. That interaction with—direct with the people who are doing the job——

Ms. SIMPKINS. Yes.

Senator RICKETTS. Before rule changes are made with the regulators so that we don't have unintended consequences with regard to the rules that are made that will harm the care that is being delivered in assisted living facilities. Is that fair?

Ms. SIMPKINS. That is fair, Senator. I like the way you put that. Thank you.

Senator RICKETTS. Great. Thank you very much. Appreciate it. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Ricketts, thank you, and we will turn next to Senator Warnock.

Senator WARNOCK. Thank you so very much, Chair Casey. I would be remiss in this moment if I didn't just take a moment to remember the legacy of the late first lady, Rosalynn Carter, whom I was privileged to know and whose mission was to center and uplift our caregivers.

Her extraordinary work demonstrates how a health care system that leaves so many drowning in caregiving costs, costs most of us will one day face, is a health care system that falls short of its basic obligations.

Dr. Morgan, in your experience as a gerontologist, how does the cost, the cost of assisted living burden seniors, their caregivers, and their families?

Dr. MORGAN. Well, the cost of assisted living is both financial and emotional and real for many, many Americans.

We have a system where there is not access to assisted living. In some states, there are Medicaid waivers that cover a larger portion of those who need it at the lower income, but there are also states that have virtually no waiver programs so that the only people that can afford assisted living are those who have those significant financial resources.

The middle tier of America tends to do things that I talked about in my testimony. They reduce their working hours. They set up these arrangements across families to pay for assisted living, if that is what they can do.

They bring in people who may not be trained to support their person living at home. They make these precarious work and family arrangements to be able to make it through whatever long-term care they have for their loved one.

If they are lucky enough to get into assisted living, then they are still coming after work and they are still bringing the incontinence supplies, and they are still bringing the snacks and engaging the residents.

It is another job on top of the job that they are trying to do if they are still working, if they are still able to work, and that is really important in young onset dementia as well, because in young onset dementia, these people are still earning, right, and they have young onset dementia and then the families have, very few options for thinking about their forward retirement, right.

Retirement isn't what we end up doing. We end up mortgaging everything to do the care and to, you know, clean out our savings in order to support this person living with dementia who may not be able to be at home. A lot of the young onset dementias have the sorts of things that Patty was talking about with Lewy Body dementia and front temporal dementia.

We have a different course of the disease, and it is really difficult for people to care for those folks at home, and so, even if they are able to afford assisted living for a time, they run out of resources, and then what do they do?

Sometimes they can get into nursing home placement, and sometimes there is good nursing homes to go to, but not always. It is awfully precarious for many folks.

Senator WARNOCK. Well, thank you. Your experience with this underscores the ways in which this cost not only to families, but all of us.

It has implications for our workforce and our economy, and so we have to have long range, comprehensive thinking about this. The chair has been a leader in this, and I am happy to join him, I was happy in joining him, to ask that the GAO look into how Federal health care affordability programs like Medicaid and Medicare, which you mentioned, interact with assisted living facilities, how we can do better there, and whether families choose an assisted living facility or in-home care, they need help meeting caregiving cost. The average cost of $4,500 a month, that is an average cost, but you rightly point out the ways in which, for example, with early onset dementia, people's retirement funds actually drain just taking care of the individual, and that is why I support efforts to lower caregiving costs for aging adults. It is a critical issue for our country, and I will continue to work with my colleagues on this Committee, informed by the expertise of people like all the folks on our panel, to improve access to long-term care for families across Georgia and across the country.

Thank you so much for your work in this area.

Dr. MORGAN. Thank you.

The CHAIRMAN. Senator Warnock, thanks very much for your questions, and we will now move—a little bit out of order, we will move to a second round as we are waiting for Senators to ask their first-round questions, some of whom are on their way.

I will start. I know Ranking Member Braun had some questions as well. Dr. Morgan, I will turn back to you. Your testimony provided a helpful overview of the importance of well-trained staff in assisted living facilities.

We heard that direct care staff can have as few as six or eight hours of training only before beginning their care duties. They might be responsible, in some cases, for 20 or more residents.

My—the constituent of mine that I mentioned earlier, Angela, said in part when she wrote to us, "when I mentioned my concerns about my father falling repeatedly, a facility her head nurse said, "falls are just part of aging.""

I would ask you, Dr. Morgan, are falls and other accidents in assisted living just part of aging, or are there procedures, strategies, rules that can be put in place to address the risks that older adults face?

Dr. MORGAN. Falls is a really important topic in aging. There are a lot of great tools that people can use. The National Institutes of Health has a great flier on this topic, six tips to help prevent falls. Falls is about—it is about prevention.

Educating AL staff on fall prevention is vital. There are plenty of environmental audits that can be made, and some of these—some ALs have this training in place, but certainly it is an important aspect of initial and ongoing training that the AL workforce should do.

The other thing that is tricky about falls is that there is a fear of falling that has a real impact in whether you are going to fall, and a fear from families who are scared that their mom or dad are going to fall, and one of the things that my father would say to his patients is if you don't use it, you will lose it, and in aging, it is important to keep up with balance, and balance exercises, and keep with strength training and doing those sorts of activities, and certainly, assisted living in other places could do that to really help with improving balance, because we know that balance is really important in terms of predicting mortality, and so, if we think about it and we support false prevention, that is what we—can really make a difference, and that is also educating families, that, you know, if you use your assisted devices, if you get up slowly, if you manage your medications, it make sense to really think about falls prevention, because a fall can really have an impact on the trajectory of aging for sure, and it is really important that long-term care take that seriously.

The CHAIRMAN. Doctor, thank you so much. I am going to cut myself short here. I have a little bit of a jump ball between Ranking Member Braun's second round question and Senator Warren's first-round question. I think I will start with someone who is arriving.

Senator WARREN. I will yield to the Ranking Member.

The CHAIRMAN. Thank you, Senator Warren.

Senator BRAUN. That is very gracious. I will actually yield back to you since you haven't done it, so. I will be here at the tail end.

Senator WARREN. All right. Well, thank you both, and thank you for holding this hearing. I appreciate that we are having this hearing. I appreciate your leadership on ensuring quality care for seniors in assisted living facilities.

This issue is not a new one for me. In July 2020, my office released the findings from the first national survey of COVID–19 in assisted living facilities, revealing that about 7,000 residents had died from COVID in just the first half of 2020.

In many ways, the threat of COVID in assisted living facilities was just as serious as it was in nursing homes, but these facilities received little help and little attention. Now, before that, in 2018, I released the first ever National Assessment of Quality Care Issues in Assisted Living Facilities, which was completed by the Government Accountability Office at my request.

That report revealed that over 20,000 serious health and safety problems occurring at assisted living facilities in just 22 states, from physical assaults to medication errors, to unexplained deaths. In the years since my office did that work, new studies have revealed additional problems in assisted living facilities.

Mr. Mollot, you lead the Long Term Care Community Coalition, which is dedicated to improving the quality and accountability of senior living facilities. Can you say a word about what kinds of threats seniors at assisted living facilities face, and how serious the risk is?

Mr. MOLLOT. Thank you. I think there are two major risks and both of them are serious. First, due to the increasing needs and vulnerability of people who go to assisted living, the risk of harm has gone way up.

People are vulnerable. People are depending upon assisted living for significant dementia care, etcetera, and we just don't know if they are getting it, and we often don't know when terrible things happen, as you noted from that GAO report, which was so important.

Second, due to the increased sophistication of operators, we have private equity, we have real estate investment trusts that are circling around this industry. The risk of financial exploitation has gone up tremendously in recent years.

Senator WARREN. You know, and your keyword, we just don't know. These are serious problems that have been going on for years, but we hear so much less about what is going on in assisted living facilities than we do in other facilities like nursing homes.

Mr. Mollot, why do you think assisted living facilities receive so much less attention than, say, nursing homes?

Mr. MOLLOT. It is a really interesting question. If I may, I think that, you know, in the 70's and the 80's, we had some tremendous scandals in the nursing home world, and that led Congress to pay attention and finally to take action.

I think that is where we are with the assisted living now, is that we are hearing more and more of these stories. The GAO reports of 1999 and the more recent report that you mentioned. Washington Post and Times reports that Senator Casey mentioned. Local news reporting from around the country.

Over and over, we are seeing that these issues are coming up, and now is really the time to take action.

Senator WARREN. With nursing homes, we put in Federal standards on this, got more Federal oversight, but assisted living facilities are governed by a patchwork of state laws without any meaningful Federal oversight, and that means no national standards

that assisted living facilities are expected to meet. That is particularly worrisome because private equity firms and real estate investment firms rates have gone on a buying spree of senior and assisted living facilities. We know how their model works.

Private equity comes in, strips the assets, cuts the staff, and sends the quality of care down the tubes. Mr. Mollot, your organization has looked carefully at the data, and you have heard from the residents of these facilities. When private equity comes into an assisted living facility and slashes jobs, what impact does that have on the residents?

Mr. MOLLOT. Well, workers are the most important component of care in any setting, especially in nursing homes and assisted living, so that could be devastating for residents, but we know, I mean, unfortunately, we don't have a lot of data directly on assisted living, we have some on senior care in general and of course on nursing homes and other care settings. We know that when private equity comes in to a sector, they often pillage it.

Senator WARREN. Yes. In other words, more people will suffer when private equity comes in. We need to do more here. At a minimum, the Biden Administration should require additional reporting on problems at living—assisted living facilities. In fact, that is a priority recommendation from the 2008 team GAO report.

While CMS is making progress on implementing this recommendation, they should finalize it quickly. This has gone on long enough without oversight, and Congress must look at ways to improve accountability, transparency, and quality of care in assisted living facilities.

Again, I want to say to the chair and to the ranking member, thank you for holding this hearing, and to the ranking member, thank you for graciously letting me do this. I am trying to cover two hearings simultaneously, and I appreciate you letting me ask these questions. Thank you all for being here.

The CHAIRMAN. Thank you, Senator Warren and Senator Braun is again seeing to a colleague, Senator Fetterman.

Senator FETTERMAN. Thank you, Mr. Chairman. Again, a credit to—Senator Warren. That is—outstanding questioning as well too. All right, anyway, thank you. Ms. Simpkins, your website states that your company's operating margins are consistently among the top in the country.

I understand that your company manages upwards $700 million from the low-income housing tax credit program, and a majority of your residents rely on Medicaid through Medicaid waiver. Ms. Simpkins, is it fair to say that, you know, your company is viable because of Government subsidies?

Ms. SIMPKINS. Thank you for that question, Senator Fetterman. It is available for a few reasons, and what is—because we do have investors, and we are grateful to those who want to invest in affordable assisted living across the country, otherwise we would not be providing to almost 6,000 seniors today who are in Medicaid waiver.

We also need a viable business plan, and it needs to be a business plan. When you talk about on the website, when it talks about our margins, our margins as compared when you look at affordable housing across the continuum, and it is because of our investors

that we are able to have margins that we continue to do, like certified dementia practitioner training and give education reimbursements and get—you know, look into different workforce opportunities, and the third thing that happens in a viable business is you have to have a service plan. You have to have a service plan that is going to—it is focused on quality outcomes, and it is focused on high resident satisfaction, and it is focused on high employee satisfaction, and what you will see in our website, and thank you for noticing that, because what we are we doing our website, and I will be glad to send you a link as soon as it is done, because we are going to start posting our quality outcomes and our residents and employee satisfaction results, and that should probably be in March, so I will send you a link.

Senator FETTERMAN. No, yes, of course I would be grateful, and also, true, I am glad that there are investors, and they are a critical part of it, but I think we are able to—it is safe to say that the subsidies from the Government is also very part—it is important too, right?

Ms. SIMPKINS. It is definitely important. We need both to have a viable business.

Senator FETTERMAN. Yes, and that is not a criticism or an attack. I am just wanting to establish that, so but you know, given the Government's undeniable role in this, in your operations, why do you believe that a company should not be able to use Federal dollars to make a profit?

I don't judge anyone, of course, you know, or earning a profit, but if you are making that kind of a profit, you know, but at—maintaining at the same time the Federal care standard.

Ms. SIMPKINS. Thank you for the question, Senator. You know, the Federal funds go into the state, and the state then decides and what that program is going to look like and what it is going to be.

The opportunity at the state level is that we can have conversations with our state regulators and improve upon practices, share best practices across the continuum. I know Senator Warren mentioned the 2020 report that she had on COVID, and we were part of that report, and our outcomes were really—you don't want anything to happen, but outcomes are really good in comparison to others, and we relied heavily on the state regulators and the resources within the state to help coach and educate and resource and everything we needed to do. I don't believe it could have happened at the Federal level, the amount of attention we were able to get from the state.

Senator FETTERMAN. Sure. I want to be very clear that if—earlier, of course, that we count on other investors to allow you to operate.

I don't have an issue with you, you know, generating a profit. I mean, that is one of the reason why people are in this, and of course, it is—in fact, that is why it works, and I am grateful that it is, and really this line of questioning wasn't an attack or isn't anything other than just to just establish that because we are partnering through the kind of subsidies that we really—I think we should maintain those kinds of Federal standards as well, too, and because all of them are—they combine together to allow this to

work and to provide that kind of—very important kind of a service, and that is really—do you—would you agree with that?

Ms. SIMPKINS. They are providing a very important service, and Senator, I actually appreciate your line of questioning, because if we didn't have these kinds of discussions and even differencing in opinion—opposing views and different views, that is where great ideas come from and that is where improvement and evolution comes from, so I do appreciate your questioning today.

Senator FETTERMAN. Okay and thank you.

The CHAIRMAN. Thank you, Senator Fetterman. We will now turn to Ranking Member Braun.

Senator BRAUN. What we have just been hearing here is just what I like about a committee like this. You are hearing a broad array of viewpoints. I have—health care has been something I wrestled with long ago, and the whole spectrum from early childhood through when you are needing to look at how you are going to spend your last years, it has been cloaked behind closed doors. Large insurance companies and hospitals where we spend most of our money on the way to maybe a nursing home, assisted living, or if you are lucky enough to live out in your own abode, it has got to be swamped with transparency and where we can see.

Ms. Vessenmeyer's story, how can something like that happen, and that was in Virginia, when we are hearing $3,800 a month in Nebraska. Every state is going to have a different cost of living, a different cost structure, but that idea, Mr. Mollot, of a transparency portal and at least some things that are going to make it easier to shine the light on issues that are out there. To me, when you are against that, you are just trying to hide something.

For instance, on the bigger picture, and this is an interesting combination of individuals, myself, Senator Sanders, Senator Grassley, Senator Smith, Senator Hickenlooper, it is two Republicans, three Democrats. I have been working on this since I have been in the Senate. Competition and transparency.

If you want to be in the biggest part of our economy, health care, and especially at the tail end of our lives, be out there, be open. Ms. Simpkins, I was wondering, because you have done a good job, and like Senator Fetterman said, your payor is coming through either State or Federal Governments, and you are aimed at low-income.

What is your cost, roughly, to do what you are doing, across those five states? Because we heard $3,800 here. I just asked my staff, so maybe closer to $4,500 in Indiana per month. What are you finding? You are servicing low-income residents, so what does that cost structure look like?

Ms. SIMPKINS. Thank you for the question, Ranking Member Braun. I am trying to——

Senator BRAUN. That would just mean in terms of your—you have a business——

Ms. SIMPKINS. Yes.

Senator BRAUN. Without giving any trade secrets away, what does it roughly cost in those states to provide a service? Your payor is mostly from Government. In the case over here, didn't have that advantage, and you saw what happened, and that was in a state

like Virginia, which I would have thought would have been maybe moderate on costs.

Ms. SIMPKINS. Yes. The thing I am struggling with is—and I certainly agree with the transparency. Those are things that we are going to be showing all the conversations here today of, you know, the cost of care and making sure there is no hidden fees. The expense side, what I am struggling with is the expense really depends on the state in which you are in. I would certainly be willing to——

Senator BRAUN. Let's just pick Indiana then. Keep it simple, and then, what do you charge the Governments that end up paying you mostly?

I am going to get an idea of what the variation is in cost across this country, and then that whoever is in any component of health care should be always willing to make it easy for us to understand, and on health care that leads up to assisted living or nursing homes, it is terrible. In in my own business, I tried to create health care consumers so you can actually manage your own well-being, and even when I attempted it, it wasn't easy, but we did it.

Ms. SIMPKINS. Okay. Thank you for the clarity. The cost of care, if we were looking at Indiana specifically, and I think the best gauge is probably, you know, our operating margin because the cost of care of insurance and workforce—and insurance cost have going up 15, 20 percent, and sometimes it is, you know—a little bit higher in a, you know——

Senator BRAUN. You can give me a range too.

Ms. SIMPKINS. I can give you a range, yes, so the operating margins are going to be, you know, roughly between like 20 and 28 percent. When everything is considered, that is also a debt load——

Senator BRAUN. That is operating margins.

Ms. SIMPKINS. Yes.

Senator BRAUN. I am talking about what the Government ends up paying per month.

Ms. SIMPKINS. I would be glad to send that to you, Senator Braun——

Senator BRAUN. Well, you can get that to me, and I don't want to——

Ms. SIMPKINS. Yes, I don't have that—I don't have the exact—yes——

Senator BRAUN. belabor the point, but just the difficulty of this, and you guys are doing a good job by all standards. We have got to have transparency across the spectrum of health care, and when you get to the tail end of life, I think as important as it is, along the way, and until the industry and everyone in health care embraces transparency and competition, don't be surprised if there is going to be more of an interest to show how to do it from the Federal level. I am a believer that that generally isn't necessarily a solution. It can end up even costing more.

Unless you at least embrace what is done in all other industries, which is make it easy for people that want to buy your services know what it is going to cost, embrace competition, don't try to keep people out of the business, you are never going to find solutions in health care. It is now up to 20 percent of our GDP.

You know, as recently as three or four decades ago, it was only five percent of our GDP. It is breaking the bank even through the programs we offer here that elderly depend on, Medicare and Social Security on their retirement. Something has got to give.

Ms. SIMPKINS. Okay. I understand, Senator. I will send you that information. It is not that I am not willing to share it. I am willing to share it wherever you want to share it. I just don't want to misspeak on what those numbers are.

Senator BRAUN. I respect that. Thank you, and thank the other panelists for enlightening us on this subject.

The CHAIRMAN. Thank you, Ranking Member Braun. We could spend a lot more hours, obviously, on these issues, so we are grateful for all of you helping us. I will have a closing statement and I will turn to Ranking Member Braun, and then we will wrap up. I know a vote is—if it hasn't started, it is about to start, but as we heard today, assisted living facilities are at a—or right now are growing piece of the, excuse me, the long-term care continuum, but more work is needed to ensure these facilities are quality facilities, that they are safe, and that costs are transparent and clear to families.

As Ms. Vessenmeyer stated in her testimony today, assisted living facilities must provide what older Americans need to be safe and to be healthy as they age. This hearing has demonstrated that assisted living facilities face similar challenges to other long-term care options, including maintaining a well-trained workforce, providing safety, high quality services, and being affordable.

Throughout my career, I have been working to improve care, to improve transparency and quality throughout the long-term care sector. We have a responsibility to make sure every American can age with dignity in a safe place of their choosing. That is why I have worked with my colleagues to expand access to home and community-based services, improve nursing home oversight, and strengthen the long-term care workforce, and now, we are going to continue our work on assisted living. As this sector grows, we must work to provide similar protections and safeguards that are in place for residents and their families as we have all strive to in the nursing home context.

We also want to ensure that any facilities and corporate owners that violate the trust of American families are held accountable. I look forward to working with my colleagues to ensure everyone who needs long-term care has safe and accessible options.

One way we will do that is to determine what the costs of assisted living are to families and how Federal dollars are being used. To ensure these funds are being used responsibly to pay for quality care, along with all of my Democratic Aging Committee colleagues, we have sent a letter to the Government Accountability Office asking them to conduct a study of assisted living costs and how available and transparent that information is to families, and as I said in my opening statement, I want to know more about what people are paying for assisted living and to have people tell their stories, as we heard some of the stories today.

Again, we will be asking people from across my home State, as well as the country, to share stories and to share your bills with us, if you would want to do that. We want to hear from you about

the true cost of assisted living and understand whether families have the information, the information that they need to make this difficult financial and health care decision for a family member and for the family.

I will turn to Ranking Member Braun now for his closing remarks.

Senator BRAUN. Thank you, Mr. Chairman, and thank you again to all the witnesses. This Committee is unique in that you really can't craft legislation out of it. A lot of it, though, from this discussion happens through other committees, so always keep that in mind.

We heard how critical it is that Federal policies support the caregiving workforce. Senator Vance pointing that out. Back in Indiana, I mentioned how workforce in general has a lot to do with our school systems, making sure that they emphasize career and technical education along with four-year pathways, because not like in—across the country, maybe a third of jobs need the four-year degree, and we need a better high school education for many of these issues so we can hit the ground running. It should be policies from here, I think should focus on boosting workforce. I think we all kind of agree on that.

Many bills are out there to do that, and to make careers in health care easier to attain. Got to make sure you don't work at cross-purposes. Like, some of the policies that are going through the labor agencies and that side of it that are wanting to get—make it harder for independent contractors, for individuals where a lot of this assisted living help comes from, so, we want to make sure we don't work at cross-purposes. We also heard how states and the providers themselves are doing things. Sadly, though, not all states seem to be doing it well because you cannot have many instances of that and say that you got an industry that is working. That should be the rare exception, never the rule, and then, when we are talking about how this place actually helps. When you are promoting transparency, it can bring on partners together. I have seen that. Two ends of the spectrum because no one should ever be against being able to have more information to make a good decision.

When it comes to standards, I think that is important, data bases. That is all something we can do, share it with all the states. I think those are good ideas. I am encouraged by the conversation we have had here today.

That is how you get better ideas, really good practices. This should be something—whoever is doing it the best, you need to shout it out so that the rest of the country can participate in it. Thank you again. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ranking Member Braun. I wanted to thank again our witnesses for contributing both their time and their expertise, and of course bringing your own personal stories, your own personal experience to this issue.

If any Senators have additional questions for the witnesses or statements to be added to the hearing record, the record will be open—kept open for seven days until next Thursday, February the 1st.

Thank you all for participating today. This concludes our hearing.

[Whereupon, at 11:42 a.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

PREPARED WITNESS TESTIMONY

Patricia Vessenmeyer

Good morning, Chairman Casey, Ranking Member Braun, and members of the Senate Special Committee on Aging. My name is Patricia (Patty) Vessenmeyer. Thank you for allowing me to share this testimony of my experience with assisted living for my husband, John Whitney, during his journey through middle-stage dementia. I will focus on my experiences and observations that I believe are most relevant to your national focus.

In 2013, my husband was diagnosed with Dementia with Lewy Body. Although this dementia is like Alzheimer's, it manifests itself a bit differently and it is important that caregivers be informed and trained to ensure the comfort, safety, and security of their patients. Some key symptoms are loss of sense of smell; REM sleep behavior disorder (RBD) which causes individuals to violently act out dreams, often falling out of bed, visual hallucinations, marked fluctuations in attention and alertness; and gastrointestinal issues including severe constipation, all of which my husband experienced. Loss of memory occurs much later in the disease process.

I took several free courses on caregiving for individuals with dementia, including a "virtual reality dementia experience" which helped me to understand the challenges that people with this disorder face, and most importantly, why they become so fearful and combative. I mention this to provide a basis for my ability to recognize problems with care. These same courses are offered for professionals at a reasonable cost.

In June of 2017, when John's disease was progressing more rapidly, I moved to Virginia to be near family. I cared for him at home until January 26, 2018, when he attempted to strangle me in my bed. The State determined that John should be placed in a long-term care facility. I found him a room in an assisted living facility in Warrenton, VA that specialized in memory care. He moved in the first week of March 2018. I provided the management team with John's history, his diagnosis, and disease progression.

The following is a list of issues I observed in the memory care unit during my daily visits with John.

Poor facility design

There were blocks of rooms built around a large central room for group activities and TV. The central room was extremely loud and high levels of noise can easily agitate dementia patients. Activity stations were set up for residents. One of these had various lengths of PVC pipe (not kidding), some longer than a baseball bat. These are weapons in waiting and you can guess what happened. There was no quiet area for the residents other than their rooms. The hallways in the room blocks were isolated, making it difficult for staff to monitor. There were many incidents that I witnessed when there was no staff around. I will share the one I feel is the most significant. A woman fell by tripping on a raised area where the rug abutted hard flooring and nobody saw her fall. I found her bloody and staggering down the hall. A company knowledgeable about dementia would not design a facility this way. They would certainly understand that people with dementia have problems with gait and balance. There were video cameras in place, but these were used to review incidents after-the-fact.

Understaffed

Too many patients were assigned to each caregiver. In the mornings, each caregiver needed to get their assigned residents up and dressed for breakfast. Everyone ate at the same time, putting more pressure on the staff. They only gave residents a shower when necessary, as they were always pressed for time. Caregivers needed extra time to spend on residents in more advanced stages of dementia, as they required help to move from their bed to a wheelchair, be hand fed, etc.

After lunch, the caregivers would place most of the residents in chairs in the main room while they worked getting the advanced-stage patients back into their beds. Every day after lunch, my husband urgently needed to empty his bowels. Several

times while I was there, I tried to find help as it was difficult for me to help him alone, since I had a fractured arm at the time. I could not find anyone, so I did the best I could. When I was not there, he often soiled himself while waiting for help.

I once saved a man's life. I was with my husband in a room off the main activity area. I heard someone crying for help. I ran into the hallway and found the old man on the floor, trying to prevent himself from being beaten with his own cane by another resident. I called for help and quickly moved closer and redirected the attacker's attention. I kept him busy while calmly calling for assistance, trying not to further agitate him. It took several minutes before a staff member finally heard me and came to help.

Night was no better, as staff levels were even lower, as allowed by state regulations. They placed residents who had trouble sleeping in front of the TV while they dealt with other residents.

Inadequate staff training

Most of their caregiver staff were trained as nurse aides, but nothing specific to memory care that I could see. I witnessed them providing some new hires dementia care training in a conference room. This consisted of a member of the management team showing them parts of Glenn Cambell's ″I'll be Me″ movie and pointing out behaviors that demonstrated his dementia problems. I saw the movie and it was not appropriate for training purposes. I observed several instances where caregivers and nurses displayed limited knowledge of working with dementia patients, particularly those in mid-stage of the disease who become more fearful and combative. Examples:

* Nurse running toward resident, causing resident to become combative

* Quick, erratic hand movements, frightening individual

* TV on at 9:30 PM, with extremely high volume. Several residents were seated in chairs and wheelchairs in front of the TV. Anyone who understands dementia and ″sundowning″ would never do this. They were over-stimulating their residents instead of allowing them to relax and quiet their minds for sleep.

At one point, the Director of the facility told me to spend less time there and let them do their jobs. I could not abide, because they weren't doing their jobs.

In closing, unless things change, I would never recommend using this type of facility for a loved one. I am hopeful that you found my testimony helpful and that the Committee will find a way to set national standards for appropriate levels of staffing and training for that staff. This would be a huge step in improving assisted living.

Thank you for your time.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

PREPARED WITNESS TESTIMONY

Dr. Jennifer Craft Morgan

Assisted Living in the U.S.

Assisted living (AL) is a large and growing long-term care residential option for individuals who need or want additional supports for activities of daily living. There are approximately 30,600 AL communities in the U.S. with almost 1.2 million licensed beds and 818,800 residents. This industry employs a total of 478,500 workers, 66% of which are direct care workers (DCWs) (NCAL 2023). These DCWs are the first line of care. AL, though often seen by the public as interchangeable with skilled nursing homes, was built and is regulated as a social model of care. This community-based care is less restrictive and strives to be home-like.

AL typically offers 1) 24/7 availability of supervision, 2) exercise, health, and wellness programming, 3) housekeeping and maintenance, 4) meals and dining services, 5) medication management or assistance, 6) personal care, and 7) arranging for transportation (NCAL 2023). This differs from nursing home care in that there is no promise of 24/7 access to medical services or constant supervision.

AL residents vary greatly in the amount of care they need from person-to-person (Kistler et al. 2017). Some AL residents are spouses who live with their partners whose care needs have become too great but are themselves much more independent. Some move into AL communes to support medication management, housekeeping and cooking and need little other support.

Rising acuity levels, meaning the average AL resident has increasingly more health conditions and functional limitations, do mean that as residents age in place, they likely require more health services. While these services could overlay AL services, much like they would if the person needing care was living at home, these are not provided by AL communities. These health care services include primary care, home health, physical and occupational therapies, and hospice and often are performed by contracted providers, sometimes associated with the AL and sometimes contracted or arranged by the resident's family. The haphazard growth of this model and the tensions inherent have spurred calls for Assisted Living to be reimagined (Zimmerman et al. 2022).

Assisted Living Residents

About half of AL residents are over the age of 85, most are women (70%), about three quarters are not married and about 90% are White. Most AL residents need help with medications, and more than half need help with three or more activities of daily living such as bathing, dressing, or toileting (NCAL 2023; Kemp, Ball & Perkins 2019). AL residents depend on their care networks, a constellation of kin and non-kin involved in resident lives such as friends, neighbors and church or other community members, to arrange medical care, provide social support, coordinate care, engage residents in activities and bring needed supplies such as medications, favorite snacks, health and beauty items, and incontinence pads. These care networks also play an important role in advocating for residents and negotiating care with AL staff (Kemp, Ball & Perkins 2013; Kemp et al. 2018; Kemp 2021).

Many residents living in AL have dementia. While the average older person living with dementia lives between four and eight years, they can live 20 years or more (Alzheimer's Association 2023). About 42% of AL residents have a dementia diagnosis (NCAL 2023) but we can assume this is underreported as many older adults are not screened, tested, or diagnosed with dementia despite showing symptoms in memory, thinking, or making decisions that impact everyday activities.

The variability in symptoms and experiences is part of what makes people living with dementia so difficult to care for. Like all people with chronic disease, people living with dementia have good days and bad days. Person centered dementia care is needed to tailor care and support to individuals in ways that account for preferences, life experiences, communication styles and support needs that change over time (Fazio 2018). People living with dementia experience stigma and often become isolated. Residential care is an important option for combatting social isolation and

exclusion often experienced by people with dementia and their care partners (Nguyen & Li 2020).

Assisted Living is an Important Long-Term Care Option

AL, unlike nursing home care, is almost entirely private pay. Only 18% of residents rely on Medicaid to pay for daily services (NCAL 2023). Most of these residents are very low-income and qualify for state Medicaid waiver programs that exist in 41 states and that often have waiting lists. According to NCAL (2023) the average monthly cost of AL is $4500. As such, AL is inaccessible to most Americans. Yet, on the spectrum of long-term care, it is often needed. Seen as a step of care between unpaid care by loved ones and nursing home care, AL provides an important long-term care option. When the care needs of a loved one exceeds the capacity of their care network, the person needing care and their unpaid care partners are forced to manage. This is often after an event. This event could be a hospitalization, a fall, a report of self-neglect, an unsafe situation, loss of driving ability or maybe mismanaged finances or medications.

Sometimes, after a hospitalization or after insurance-supported inpatient rehabilitation care, discharge planners help individuals with very high care needs and nursing home placement. If that doesn't happen, the care network is forced to navigate, with little support or education, a variety of options, none of which are usually covered by health insurance. If they have significant financial resources, AL is a useful and attractive option. If not, managing the care situation means that care partners reduce working hours, build precarious care or financial arrangements across families, hire piecemeal personal care support or simply cross their fingers and hope things turn out okay. Given the geographic dispersion of today's families, the lack of affordable residential care options often leaves American families in tough situations.

Assisted Living and Persistent Workforce Challenges

Sixty-six percent of the AL workforce are ″aides″ or direct care workers (DCWs) (NCAL 2023). DCWs in AL and across long-term care are predominately women, people of color and disproportionally immigrants (PHI 2022). The typical direct care worker in AL makes about $15 an hour, works 36 hours week in AL, and works for a non-profit company. About half have health insurance through their employer and about 22% get health insurance through Medicaid or another means tested program. About half live under 200% of the poverty line with household income at about $46,000 (Kelly et al. 2020).

DCWs also face dangerous working conditions, persistent occupational segregation, have limited access to paid leave, and experience very little career advancement (Dill & Duffy 2022; Dill et al. 2022). As stated by Scales & Lepore (2020) ″[direct care work] requires a mix of technical caregiving skills; health-related knowledge; infection prevention and control expertise; emotional intelligence and relational skills; and problem-solving and decision-making abilities, among other competencies (p. 173). ″ Despite highly meaningful jobs with high intrinsic rewards, the lack of extrinsic rewards including compensation, drive turnover (Dill, Morgan & Marshall 2013; Morgan, Dill & Kalleberg 2013). Turnover rates in long-term care have been persistently slow to recover since the start of the COVID 19 pandemic and the recovery has been most difficult for women and people of color (Frogner & Dill 2022). In this context, the use of agency staff, or those that are temporarily hired from staffing agencies to all staffng shortages, has remained persistently high. Use of agency staff makes relationship-based, person-centered care difficult. Many organizations have reduced the number of new residents because they do not have the staffng to accommodate them despite having available licensed beds. More than sixty percent of AL facilities have moderate to high staffng shortages (NCAL 2022).

Assisted Living Context and Pressures

While the scope of abuse and neglect in AL facilities is unknown, several media reports have called attention to severe cases of neglect and mistreatment and the significant and surprising out-of-pocket costs that face older adults as they age in AL (Teegardin 2019; Rowland et al. 2023; Rau 2023). Abuse and neglect of our Elders and people with disabilities is unacceptable and is far too prevalent. I will say, though, in our hundreds of interviews with DCWs and other staff across the sector, I have met no ″bad actors.″ While there are ″bad actors″ in all industries who are actively seeking to harm others, it is my experience that DCWs and AL staff go to work wanting to do the best they can, engage in meaningful relationships with their residents and promote their health and wellbeing. AL workers, like most direct care workers, tend to go into this line of work to give back, to make a diffierence, because they value Elders or because it is a calling for them (Kemp et al. 2010).

Unfortunately, the system we've set up works against them. DCWs working in all long- term care settings experience low wages, few benefits, heavy workloads, dangerous jobs, and little to no career mobility. These DCWs are managing heavy workloads with unrealistic expectations of what they can get done in one shift, put themselves and their families at risk of infectious disease, are called on to do heavy emotional labor, often managing multiple jobs to make ends meet and many are experiencing burnout after the multiple personal and collective traumas experienced during and after the pandemic. For a group that was already vulnerable, these workers faced grief, uncertainty, risk, high unpaid care demands and high work demands, and mental health needs that go largely unaddressed.

For AL management and owners, there is pressure to take or keep residents with high levels of acuity. Filling beds is an imperative to cover staffng costs and now rising agency staffng costs. Well-resourced families would rather have mom in a home-like or hotel-like AL rather than an institutional nursing home if given the choice.

We gerontologists advocate for aging in place so that older adults can create home and have familiar settings in which to age well. This supports autonomy, meaning-making, relationship-building and also supports people living with dementia to be in familiar settings to support their cognition. As a social model of care, the walls of the AL building are permeable. People go for walks, sign in and out, go visit families and go on outings. This engagement with the community is vital to the well-being of AL residents (Ciof, Kemp & Bender 2021). Overworked staff, lack of documentation, lack of meaningful oversight, higher acuity levels, lack of communication, and haphazard care coordination mean that residents are vulnerable without these wrap-around supports.

The tiered fee structure for additional services many Assisted Living communities offer, corresponds to the needs of residents and the need for providing additional staff to support those residents. Transparency in how those fees are determined and what impact they have on support for the residents who pay those premiums is certainly lacking. We know that 24/7 nursing home care and home health care are both, on average, more expensive than AL. The vast majority of AL services are private pay making it very difficult for residents and their care networks to plan for and understand how charges change over time.

Inconsistent Staffing and Training Requirements in AL

The AL direct care workforce is comprised of DCWs who are certified or registered (e.g., certified nursing assistants (CNAs)) and those who are not (e.g., personal care aides). AL communities make a choice between hiring CNAs, whose training and competency has been assessed by the State, or personal care aides with little to no formal training (Kemp at al. 2010). The CNA training is monitored by the state agencies responsible for facility licensure. Each state agency reviews CNA training programs for quality and state registries allow employers to verify credentials of DCWs who have completed this training and provide employers data on whether there are any outstanding complaints on file for a particular worker (Kelly et al. 2020). While many AL communities choose to hire CNAs, they lack this minimal oversight for initial training provided staff. In terms of initial and continuing education, states have sizable variability in the topics required (e.g. role of the PCA, consumer rights, ethics, and confidentiality, health care support, infection control) (Kelly et al. 2020). Several states have recently added training requirements for DCWs in AL, particularly in terms of dementia education, but these are generally loosely written and enforced with minimal oversight by state regulatory bodies.

Monitoring and Enforcement of Quality of AL

Monitoring and enforcement of quality of AL by states is inconsistent and not transparent. Kaskie et al. 2022, from their survey responses of state administrative agents, show that in half the states, monitoring and enforcement oversight of AL was dispersed across three or more agencies, staffing levels and budgets varied greatly. Fewer than 10 of the states shared information about their monitoring and enforcement procedures in a way that would be publicly accessible. Forty-five states conduct inspections at the time of licensure, 39 conduct annual or biannual inspections and only seven require AL facilities to submit an annual report (Kaskie et al. 2022).

A Mindset Shift is Needed

In her book, Disrupting the Status Quo of Senior Living: A Mindshift, Jill Vitale-Aussem (2019) lays out what I think is the crux of the problem facing senior living. AL is marketed to those who can afford it with a hospitality mindset. They advertise and compete on the basis of amenities, beautiful campuses, luxury food and furnishings, and concierge services. This model encourages residents and families to think about living in AL buildings as though they are going to a hotel or resort.

In reality, this framing, where residents are the guests and staff are encouraged to cater to their whims, increases what Dr. Bill Thomas of the Eden Alternative calls the three plagues of long-term care - helplessness, boredom and loneliness. By encouraging passivity, we leave residents with few opportunities for giving back, participating in the community or creative pursuits (Basting 2020). Instead, long-term care that is person-centered, community-minded and empowering has a much better chance of meeting the needs of residents, staff and care partners.

Person-centered care means that the person receiving care is in the driver's seat, to the extent they are able and for as long as they can. Ideally, the resident sets the goals of care collaboratively with both unpaid and paid care partners. Person-centered care practices have been associated with improved quality of life and quality of care for residents (Fazio et al., 2018; Poey et al., 2017). Shifting from a hospitality to a community mindset means that residents and the entire care network are valued members of the AL community. This shift encourages relationship building, transparent communication, interdependence and the promotion of citizenship where all members of the community have a role in improving quality of life. An open community mindset would also improve the safety culture of an AL by promoting communication, relationships and empowering all members to look out for one another.

Empowerment of residents and their care network is also vital to moving this sector forward. For residents, it's truly engaging them in their own care, using a strengths-based approach where individuals are supported to do as much for themselves for as long as possible no mater how slow the process (Yan et al. 2023). For workers, particularly DCWs, it is more complicated. Empowerment for workers means that we listen to, respect, pay, include, collaborate with, provide for the safety of, educate, and ultimately professionalize the workforce (Morgan and Ahmad 2023). The persons (e.g. resident, staff, care partner), not the task, is what we attend to first. This means that workers have the job quality they need to be whole and happy individuals who can then have the space in their work to be creative and engaged problem-solvers in the community. Empowerment for unpaid care partners includes education on dementia, support to continue to engage and support their loved one and an open invitation to be part of the communities in which their loved one resides (Kemp 2021).

Recommendations

•Support standardization of monitoring and resources to increase state-based oversight and transparency. Standardizing state transparency and oversight supports public awareness of the industry and promotes the ability of potential residents and their care networks to make informed decisions.

•Improve and standardize initial and continuing education training for DCWs in AL. This should include realistic job preview, interactive and engaging onboarding with peer mentorship and check-ins over the first three months, a training registry that supports both initial and ongoing training and promotes portability, stackability, and career progression. Training requirements should emphasize person-centered dementia care, meaningful engagement, living well with dementia, strength-based approaches, trauma- informed and self-care, communication skills, and non-pharmacological approaches to dementia care. See https://aging.georgia.gov/sites/aging.georgia.gov/files/GARD%20Competency%20Guide—PDF.pdf

•Professionalize the direct care workforce. This strategy needs to be engaged in collaboration across long-term care sectors. This is one workforce that moves between and across sector lines constantly. Professionalization includes: occupational credentialing that acknowledges competencies of incumbent workers, ties competency accrual to significant and meaningful career lattices that have transparent wage increases, credentialing that is stackable and leads to higher order credentials that support key areas of need including meaningful engagement of residents, person- centered dementia care, strength-based creative expression outlets (e.g. music, drama, arts, expression), health and wellbeing, trauma-informed approaches, and documentation and quality improvement practices.

•Incentivize and reward good employers who deliver high quality care. Employers can make incredible differences in the lives of their workers and residents and curb turnover and improve recruitment by enhancing hiring practices, increasing compensation, enhancing benefits, improving orientation and onboarding, increasing access to education and training and expanding career opportunities (See short micro-learning videos on these topics: https://www.youtube.com/playlist?list=PLXNnxuyRl8NQHl5kx6ukHxVHac—VjOCyn)

•Increase access to AL. Efforts should be made to increase affordable long-term care residential care options for middle class and working-class American families. This should include education about long-term care options, investment of resources in creating tools for navigating and making informed decisions about long-term care options, and incentives to develop and test inclusive models for rebalancing long-term care in ways that provides high quality care and system savings.

•Improve care coordination and resources for people living with dementia and their care partners. People living with dementia occupy many long-term care spaces. Regardless of space, they deserve high quality and coordinated care. People are not simply a diagnosis and holistic and integrated care approaches are possible and needed to support the growing number of people with dementia and their care networks. Models such as the GUIDE model (https://www.cms.gov/priorities/innovation/innovation-models/guide) have great potential to provide holistic care to people with dementia and their care partners in ways that reduce stigma, coordinate care, improve outcomes and provide needed supports for all involved.

References

•Basting, A. (2020). Creative Care A Revolutionary Approach to Dementia and Elder Care[Book]. HarperOne.

•Cartwright, J., Roberts, K., Oliver, E., Bennet, M., & Whitworth, A. (2022). Montessori mealtimes for dementia: A pathway to person-centred care. Dementia, 21(4), 1098-1119.Ciofi, J. M., Kemp, C. L., & Bender, A. A. (2022). Assisted living residents with dementia: Being out in the world and negotiating connections. The Gerontologist, 62(2), 200-211.

•Dill, J., & Duffy, M. (2022). Structural Racism And Black Women's Employment In The US Health Care Sector: Study examines structural racism and black women's employment in the US health care sector. Health Affairs, 41(2), 265-272.

•Dill, J. S., Morgan, J. C., & Marshall, V. W. (2013). Contingency, employment intentions, and retention of vulnerable low-wage workers: An examination of nursing assistants in nursing homes. The Gerontologist, 53(2), 222- 234.

•Dill, J., Morgan, J. C., Van Heuvelen, J., & Gingold, M. (2022). Professional certification and earnings of health care workers in low social closure occupations. Social Science & Medicine, 303, 115000.

•Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. The Gerontologist, 58(suppl—1), S10-S19.

•Frogner, B. K., & Dill, J. S. (2022, April). Tracking turnover among health care workers during the COVID-19 pandemic: a cross-sectional study. In JAMA Health Forum (Vol. 3, No. 4, pp. e220371-e220371). American Medical Association.

•Kaskie, B., Xu, L., Taylor, S., Smith, L., Cornell, P., Zhang, W., ... & Thomas, K. (2022). Promoting quality of life and safety in AL: A survey of state monitoring and enforcement agents. Medical Care Research and Review, 79(5), 731-737.

•Kelly, C., Morgan, J.C., Kemp, C. L., & Deichert, J. (2020). A profile of the assisted living direct care workforce in the United States. Journal of Applied Gerontology, 39(1), 16-27.

•Kemp, C. L. (2021). # MoreThanAVisitor: Families as ″essential″ care partners during COVID-19. The Gerontologist, 61(2), 145-151.

•Kemp, C. L., Ball, M. M., Hollingsworth, C., & Lepore, M. J. (2010). Connections with residents: ″It's all about the residents for me.″ In Mary M. Ball, Molly M. Perkins, Carole Hollingsworth, & Candace L. Kemp (Eds.), Frontline Workers in Assisted Living (pp. 147-170). Baltimore, MD: Johns Hopkins University Press.

•Kemp, C. L., Ball, M. M., Morgan, J. C., Doyle, P. J., Burgess, E. O., & Perkins, M. M. (2018). Maneuvering Together, Apart, and at Odds: Residents' Care Convoys in Assisted Living. The Journals of Gerontology: Series B, 73(4), e13-e23. https://doi.org/10.1093/geronb/gbx184

•Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. Journal of Aging Studies, 27: 15-29. doi: 10.1016/j.jaging2012.10.002

•Kemp, C. L., Ball, M. M., & Perkins, M. M. (2019). Individualization and the health care mosaic in AL. The Gerontologist, 59(4), 644-654.

•Kistler C. E., Zimmerman S., Ward K. T., Reed D., Golin C., Lewis C. L. (2017). Health of older adults in AL and implications for preventive care. The Gerontologist, 57, 949-954.

•NCAL (2022) https://www.ahcancal.org/News-and-Communications/Fact-Sheets/Fact-Sheets/AL-Survey- June2022.pdf

•Morgan J.C. & Ahmad W. (2022) Lifting them up: Building Person-Centered Organizations. CSA Journal, Vol 87 (4).

•Morgan, J.C., Dill, J., & Kalleberg, A. L. (2013). The quality of healthcare jobs: can intrinsic rewards compensate for low extrinsic rewards?. Work, employment and society, 27(5), 802-822.

•National Center for Assisted Living (NCAL) (2023) Facts & Figures. (n.d.). https://www.ahcancal.org/Assisted- Living/Facts-and-Figures/Pages/default.aspx

•Nguyen, T., & Li, X. (2020). Understanding public-stigma and self-stigma in the context of dementia: A systematic review of the global literature. Dementia, 19(2), 148-181.

•PHI (2023) Direct Care workers in the United States: Key Facts 2023 - PHI. (2023, September 11). PHI. https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/

•Poey, J. L., Hermer, L., Cornelison, L., Kaup, M. L., Drake, P., Stone, R. I., & Doll, G. (2017). Does person-centered care improve residents' satisfaction with nursing home quality?. Journal of the American Medical Directors Association, 18(11), 974-979.

•Rowland, C., Frankel, T.C., Torbati, Y., Weil, J.Z., Whoriskey, P. & Rich, S. (2023, December 17). An alarming number of assisted-living residents die after wandering away unnoticed. Washington Post. https://www.washingtonpost.com/business/interactive/2023/assisted-living-wander-patient-deaths/

•Rau, J. (2023, December 1). What to know about Long-Term Care Insurance. The New York Times. https://www.nytimes.com/2023/11/22/health/long-term-care-insurance-explained.html

•Scales, K., & Lepore, M. J. (2020). Always essential: Valuing direct care workers in long-term care. Public Policy & Aging Report, 30(4), 173-177.

•Teegardin, B. S. C. (2019, September 29). Suffering behind the facade. AJC. https://www.ajc.com/news/state--regional/suffering-behind-the-facade/gEMTySxJUMEQ6GhD1OQiFO/

•Vitale-Aussem, (2019) J. Disrupting the Status Quo of Senior Living: A Mindshift. Health Professions Press, ISBN 978- 1938870828, 216 pages.

•Yan, Z., Traynor, V., Alananzeh, I., Drury, P., & Chang, H. C. (2023). The impact of montessori-based programmes on individuals with dementia living in residential aged care: A systematic review. Dementia, 14713012231173817.

•Zimmerman, S., Carder, P., Schwartz, L., Silbersack, J., Temkin-Greener, H., Thomas, K. S., ... & Williams, K. B. (2022). The imperative to reimagine assisted living. Journal of the American Medical Directors Association, 23(2), 225-234.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

PREPARED WITNESS TESTIMONY

Julie Simpkins

Chairman Casey, Ranking Member Braun, and members of the U.S. Senate Special Committee on Aging, thank you for inviting me here today to be a part of this important discussion on assisted living, a topic that is near and dear to my heart. My name is Julie Simpkins, and I am the co-president and chief operating officer of Gardant Management Solutions, a provider that develops and operates senior living, assisted living, and memory care communities. We are the fifth largest assisted living provider in the country and have communities in five states - Illinois, Indiana, Ohio, Maryland, and West Virginia.

I have dedicated most of my life to senior living, spending 30 years working primarily in assisted living. This is my calling, and I'd like to speak with you today about Gardant's unique model and share thoughts on how we can work together on important issues facing those who need and work in assisted living.

Gardant is uniquely focused on offering affordable assisted living to low-income seniors. Our company was founded in 1999 after the creation of the Illinois Supportive Living Program, a home- and community-based Medicaid waiver program. Now, as we have expanded into four other states, our commitment to serving this population remains. The majority of residents living in Gardant communities rely on Medicaid for their assisted living care through these waiver programs.

Gardant has been limited in where we can offer our services due to the variability with state Medicaid waiver programs. It depends on the availability of state programs, state reimbursement levels, and the number of available waiver spots. Offering affordable assisted living exclusively - or even for a majority of residents like Gardant - requires an entirely different business model altogether. We have had to persistently seek out HUD loans and income tax credits to stay viable. Therefore, we fully support efforts to make long-term care, including assisted living, more affordable to low- and middle-income seniors. With a rapidly growing elderly population, we need a public and private partnership to incentivize more providers to develop these models.

When we talk about assisted living, it's important to note that every state, every facility, and every resident is different. Efforts to standardize all assisted living communities would be both unworkable and irresponsible for resident care. State regulations recognize the diversity within assisted living while holding our profession accountable, and they are consistently updated to reflect the evolving nature of our sector and our residents.

Meanwhile, Gardant is committed to exceeding state requirements when we believe it is in the best interest of our residents. Take memory care as an example, and something that is top of mind for this Committee as well as our residents and families. Every staff member at Gardant managed memory care communities receive education and training in dementia and related diseases as well as training as a Certified Dementia Practitioner training. While elopements are rare, we overreport any to the state immediately - even something as technical as a resident walking out the door and instantly returning after a staff member sees them. We know they didn't leave our facility and our staff immediately addressed the situation, but we still report it.

The recent reports of resident elopements that were ultimately fatal are heartbreaking, and my thoughts and prayers go out to the loved ones of those residents. I serve in leadership positions on numerous national organizations dedicated to long-term care, and I know these tragic incidents are extremely rare and not indicative of the assisted living experience. The overwhelming majority of families and residents have a life-affirming, safe experience. Assisted living providers are committed to upholding our policies and procedures, as well as continuing to learn all that we can about dementia care to prevent these incidents. It is critical that policies and regulations help protect residents while still supporting freedom of movement and independence for residents living with dementia.

Assisted living is a critical aspect of the long-term care continuum, dedicated to delivering person-centered care to our nation's seniors. We need collaborative, comprehensive solutions that help ensure our ability, as assisted living communities, to continue doing what we do best - providing safe, quality care to our residents. From expanding more affordable long-term care options, to workforce programs to address the growing caregiver shortage, these efforts could make a real difference. We must all work together to ensure every current and future assisted living resident is seen, safe, and served to enjoy the highest quality of life possible.

Thank you for your time and I look forward to answering your questions today.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

PREPARED WITNESS TESTIMONY

Richard Mollot

Introduction

Good morning, Chairman Casey, Ranking Member Braun, and Members of the Committee. Thank you for inviting me to testify today on this important issue.

My name is Richard Mollot. I am the executive director of the Long Term Care Community Coalition (LTCCC). LTCCC is a national non-profit, non-partisan organization dedicated to improving care and quality of life for residents in nursing homes and assisted living. We conduct substantive research on long-term care policies and the extent to which essential standards of care are realized in the lives of residents, who are typically elderly and frail. In addition to conducting systemic analysis and advocacy, we educate and engage residents, families, and those who work with them, so that they are aware of their rights and are equipped to overcome the challenges that so many of our seniors face when they need residential care.

While timelines vary, essentially, assisted living emerged in the 1980s as an alternate to nursing homes for seniors who want or need to live in a congregate setting where they an get help with tasks like housekeeping, meal preparation, and access to activities and transportation.[1] Over the last 40 years, three developments have drastically changes the nature and character of the assisted living sector, with both positive and negative implications.

1. The needs and frailty of assisted living residents have dramatically increased;

2. Assisted living operators have adopted increasingly sophisticated and large-scale corporate models, including ownership by Real Estate Investment Trusts, Private Equity, and other sophisticated private investment structures;[2] and

3. Public payment and support for assisted living services has increased dramatically.

The subsequent discussion delves into some of the ramifications of these trends, followed by recommendations aimed at fostering a sustainable business model for assisted living that effectively meets the evolving needs of our expanding senior population.

The Growing Needs and Expectations of Our Expanding Senior Population to Live Safety and with Dignity

Assisted living facilities (ALFs) are increasingly viewed by seniors and their families as a desirable option for residential care, particularly for those who wish to avoid the institutional environment that typically defines life in a nursing home. In fact, assisted living is the fastest growing form of senior housing in the United States.[3] While too often overlooked by policymakers and oversight agencies, assisted living facilities house a comparable number of individuals to nursing homes in the United States.

Importantly, ALFs do much more than just providing accommodations and assistance with housekeeping and prepared meals, as they largely did in the past. They now provide a range of health and support services to residents with increasing needs (and vulnerabilities):

---

[1] Wilson, K.B., "Historical Evolution of Assisted Living in the United States, 1979 to the Present," The Gerontologist, Volume 47, Issue suppl—1, Pages 8-22 (December 2007). https://doi.org/10.1093/geront/47.Supplement—1.8.

[2] See, for example, Fenne, M., "Private equity's growing presence in senior living," The Private Equity Stakeholder Project (blog post). (December 2023). https://pestakeholder.org/news/private-equitys-growing-presence-in-senior-living/.

[3] Castillo, L., "Assisted Living Industry Statistics," GITNUX Marketdata Report 2024 (December 2023). https://gitnux.org/assisted-living-industry-statistics/#::text=Assisted%20care%experiences%20the%20highest%20growth%in%20terms,fastest%20growing%20segment%20of%20the%20senior%20housing%20market.

1. Approximately 40 - 70% of assisted living residents have Alzheimer's Disease or some other cognitive impairment.[4]

2. More than half of ALF residents are 85 or older (compared to 42% in nursing homes).[5]

3. Over 50% have hypertension.[6]

4. One-third or more have heart disease or depression.[7]

5. About half need help with dressing and/or walking and 64% need help with bathing.[8]

6. Over 10% of ALF residents with dementia are administered antipsychotic drugs, which carry a FDA ″black box″ warning against use on elderly people, due to significant risks of heart attack, stroke, Parkinsonism, falls, and death.[9]

In summary, the evolving care requirements of assisted living residents have grown increasingly intricate over the years. As seniors experience longer lifespans with chronic conditions, notably dementia, the susceptibility of this demographic has heightened. Despite the escalating needs and vulnerabilities, the federal government has consistently adopted a ″hands-off″ stance, and state regulations are generally characterized by weakness and lax enforcement. Consequently, the assisted living sector operates under a caveat emptor - let the buyer beware - principle. We can and must do better for American seniors and their families.

We can and must do better for American seniors and their families.

The Imperative to Improve Transparency About Quality and Safety

While the notion of ″buyer beware″ is already disconcerting for seniors and their families, the situation is exacerbated by the pervasive lack of transparency that extends to virtually every facet of assisted living. In any typical consumer scenario, one would rightfully anticipate clear information about the services to be provided, costs, quality, and safety. However, in the realm of assisted living, obtaining crucial indicators is challenging, if not impossible. Who's providing care? How much will living and services cost? What happens when/if I need more care and services? What happens if I run out of money? What is the quality record of this facility? If a facility has had issues, how do I find out what they were and, most importantly, what was done to address them?

In the world of assisted living, the answers to these vital questions are not only hard to find, they are often purposefully obfuscated by both operators and the state agencies that are supposed to be protecting residents. Unlike nursing homes, for which vigorous, professional assessments are required upon entrance and periodically, to a large extent ALFs are free to accept - and retain - whomever they want. Licensed nurses may or may not be on hand to supervise care for residents with higher needs, respond to a fall, or ensure that medications are given correctly. Care, monitoring, and dignity for individuals with dementia may be wonderful or slipshod, depending on the facility or, even, the operator's profit goals for the quarter. While approximately 75% of ALFs claim to have a ″memory care unit,″[10] this term is often more a marketing strategy than an accurate representation of specialized care. Seniors and their families may lean on this term when placing an individual with dementia, despite potentially disastrous disparities in actual care quality.

---

[4] Estimates vary, and the lack of firm data on this important point is a result of the lack of transparency in the assisted living industry (including the needs of those they serve and the capacity of those providing care and services).

[5] Zimmerman S, Sloane PD, Wretman CJ, et al., ″Recommendations for Medical and Mental Health Care in Assisted Living Based on an Expert Delphi Consensus Panel: A Consensus Statement,″ JAMA Network Open (2022). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796840.

[6] Zimmerman, S., Wenhan, G., et al., ″Health Care Needs in Assisted Living: Survey Data May Underestimate Chronic Conditions,″ Journal of the American Medical Directors Association, Volume 22, Issue 2, 471 - 473 (December 2020). https://www.jamda.com/article/S1525-8610(20)31022-7/fulltext.

[7] Id.

[8] National Center for Assisted Living, Assisted Living Facts & Figures. https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx.

[9] Zhang, T., Thomas, K., et al., ″State Variation in Antipsychotic Use Among Assisted Living Residents With Dementia,″ JAMDA, Volume 24, Issue 4 (February 2023).https://www.jamda.com/article/S1525-8610(23)00088-9/fulltext.

[10] Bretschneider, A., ″Understanding the Cost of Memory Care″ (December 2023). https://www.seniorly.com/resource-center/senior-living-guides/how-much-does-memory-care-cost#.

The Case for Federal Interest and Engagement in Safeguarding Quality and Integrity in the Assisted Living Industry

Although assisted living is commonly seen as a private enterprise functioning with a non-governmental payment model, it is essential to recognize the growing importance of public funding and the escalating demand for federal involvement. The government's interests have expanded over the years, emphasizing the need to ensure robust consumer protections and foster a healthy assisted living industry.

1. Close to 20% of assisted living residents currently rely on Medicaid to pay for services.[11]

2. Forty-seven states plus the District of Columbia provide access to Medicaid assisted living.

3. The U.S. Supreme Court's landmark 1999 Olmstead decision established that the unjustified institutional isolation of people with disabilities is a form of discrimination under the Americans with Disabilities Act (ADA). The court declared that states are required to make reasonable modifications to publicly funded programs to accommodate qualified individuals who desire to live in the most integrated setting.[12] To meet this requirement, states have been ″rebalancing″ access to publicly-funded long-term care services over the last 25 years, favoring home and community-based services, which can encompass assisted living, over nursing home placement.

4. The U.S. Department of Housing and Urban Development (HUD) provides advantageous loans to finance the purchase, refinance, new construction, or substantial rehabilitation of assisted living.

5. The Government Accountability Office (GAO) has focused on the need to improve safety and accountability in assisted living numerous times over the last 25 plus years. Unfortunately, the persistent failure to take substantive action to implement most of the GAO's recommendations over the years has resulted in untold numbers of residents suffering harm, including financial exploitation, sexual assault, and even death, due to substandard care and lack of promised supervision.

6. The LTC Ombudsman Program, which monitors care and helps residents resolve complaints under the authority of the Older Americans Act, has been authorized to monitor assisted living and provide services to residents since 1981.

7. Numerous news reports, in both local and national media, have uncovered the painful and heart-breaking problems that can occur as a result of the lack of federal standards and weak state oversight. A recent report from The Atlanta Journal-Constitution is emblematic:

″During a routine room check, an 88-year-old resident told workers that hours earlier she had been sexually assaulted by another resident.″ Three weeks later, an investigation by the Georgia Department of Community Health found that Savannah Court of Lake Oconee ″failed to provide supervision consistent with the residents' needs.″

″While the incident would be distressing on its own, its timing adds a layer of alarm. The assault took place two months after the state sent Savannah Court of Lake Oconee a notice that it planned to revoke its license, and while such an action should imply serious safety concerns, the department's efforts to move the process along and ensure residents are free from harm have lacked urgency. ...Court documents and inspection reports reviewed by The Atlanta-Journal Constitution show that, since 2021, Savannah Court of Lake Oconee has accrued over 70 state violations, including two incidents where residents died.″[13]

A senior or their family would have trouble finding out this history. Savannah Court's website provides no inkling about any of these problems (no matter what steps, if any, were taken to address them). It paints an entirely rosy picture of ″an

---

[11] National Center for Assisted Living, Assisted Living: A Growing Aspect of Long Term Care.https://www.ahcancal.org/Advocacy/IssueBriefs/NCAL—Factsheet—2023.pdf.

[12] Long Term Care Community Coalition, Single Point of Entry for Long Term Care and Olmstead: An Introduction and National Perspective for Policy Makers, Consumers and Advocacy Organizations (2005).https://nursinghome411.org/single-point-of-entry-for-long-term-care-and-olmstead-an-introduction-and-national-perspective-for-policy-makers-consumers-and-advocacy-organizations/.

[13] Gross, A., ″Possible closure of Georgia senior home reveals flaws in state oversight,″ The Atlanta Journal-Constitution (January 2024).https://www.ajc.com/news/possible-closure-of-georgia-senior-home-reveals-flaws-in-state-oversight/RWJRB3GBABFUPJ7RFFBANW7FMI/#.

ideal place for your loved ones to age in place while also providing you with the peace of mind that comes with knowing they are well cared for."[14] The state's "Find a Facility" page only provides a single row of information with the facility's address, phone number, bed capacity, and administrator.[15] One has to do a separate search in a separate database of inspection reports to find any record of what has transpired in the facility.

Beyond highlighting the imperative for substantive measures to enhance safety and quality, the substantial variances among assisted living facilities, encompassing staffing levels, services provided, and costs, underscore the need for decisive action to improve both quality assurance and transparency.

Recommendations

1. Establish and Implement National Standards to Promote Quality, Safety, and Integrity in Assisted Living:

•For years, the states have functioned as an incubator for developing assisted living policies. While this has not resulted in a high-quality system, there are many lessons that can be learned, and existing state requirements provide a logical basis for promulgating federal rules.[16]

•A system of regular inspections and oversight at the facility and corporate levels should be developed to ensure compliance with these standards.

2. Establish a National Assisted Living Database:

•Create a centralized and standardized database that includes key metrics on assisted living facilities' performance, include: staffing (levels and competencies), ownership, charges for residential and care services, and citation history (including how those citations were corrected and any penalties that were imposed).

•This database should be easily accessible to the public, empowering families with the information needed to make informed decisions.

3. Promote Resident and Family Engagement:

•Develop rules for the rights of resident and family councils in assisted living.

•Strengthen the involvement of residents and their families in the internal policies and operation of their assisted living facility (such as by strengthening requirements under the Home and Community-Based Settings regulations promulgated in 2014).

Conclusion

Improving transparency, quality, and accountability in assisted living is not only a matter of public interest but a moral imperative. Now more than ever, federal action is needed to ensure that older Americans receive the care and support they deserve while fostering a system that promotes transparency and accountability within the industry.

I appreciate the Committee's commitment to addressing these critical issues, and I am available to provide any additional information or answer questions that may arise during or after the hearing.

Thank you for your consideration of my testimony and the issues raised herein.

---

[14] https://www.savannahcourtlakeoconee.com/. Accessed January 22, 2024.
[15] https://forms.dch.georgia.gov/HFRD/GaMap2Care.html.
[16] See, LTCCC, Assisted Living: Promising Policies and Practices (2018). https://nursinghome411.org/ltccc-report-assisted-living-promising-policies-and-practices/.

Questions for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

QUESTIONS FOR THE RECORD

Patricia Vessenmeyer

Chairman Robert P. Casey, Jr.

Question:

What recommendations do you have to ensure that assisted living workers can provide residents with the type and quality of care that they need?

Response:

Caregiving for dementia patients is extremely difficult. There appears to be ample training options available, of which many of these facilities are not taking advantage. I would recommend that caregivers be required to take additional training classes to become certified as dementia-patient caregivers. They should also receive compensation commensurate with this higher level of training. Perhaps a program where the facility operators also reimburse the caregivers for their training costs would encourage more to enter the field.

Question:

What regulations or policies would you like to see in place to ensure that assisted living facilities are delivering on the services they promise?

Response:

Decreasing the maximum number of patients per caregiver would be very helpful. Right now, that number is controlled at the state level, and I understand that this would be a challenge to change on a national basis. However, as I mentioned in my testimony, many of these caregivers want to do a good job, but simply have too many residents in their care. Also, perhaps there could be a way to oversee performance and hold these organizations accountable.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

QUESTIONS FOR THE RECORD

Dr. Jennifer Craft Morgan

Chairman Robert P. Casey, Jr.

Question:

Please share with us the profile of the assisted living direct care workforce, workplace supports, and opportunities for job growth, or lack thereof. Can you share any policy recommendations on increasing retention and creating opportunities for job advancement, including federal policies, or state policies that could be replicated?

Response:

A full profile of workforce demographics and training can be found in the linked article below (Kelly, Morgan & Kemp 2020). Like direct care workers across long-term care, AL DCWs are predominately women, about half are people of color and about 20% are immigrants. The typical direct care worker in AL makes about $15 an hour, works 36 hours week in AL, and works for a for-profit company. About half have health insurance through their employer and about 22% get health insurance through Medicaid or another means tested program. About half live under 200% of the poverty line with household income at about $46,000 (Kelly et al. 2020).

DCWs also face dangerous working conditions, persistent occupational segregation, have limited access to paid leave, and experience very little career advancement (Dill & Duffy 2022; Dill et al. 2022). As stated by Scales & Lepore (2020) "[direct care work] requires a mix of technical caregiving skills; health-related knowledge; infection prevention and control expertise; emotional intelligence and relational skills; and problem-solving and decision-making abilities, among other competencies (p. 173)." Despite highly meaningful jobs with high intrinsic rewards, the lack of extrinsic rewards including compensation, drive turnover (Dill, Morgan & Marshall 2013; Morgan, Dill & Kalleberg 2013). Turnover rates in long-term care have been persistently slow to recover since the start of the COVID 19 pandemic and the recovery has been most difficult for women and people of color (Frogner & Dill 2022). In this context, the use of agency staff, or those that are temporarily hired from staffing agencies to fill staffing shortages, has remained persistently high. Use of agency staff makes relationship-based, person-centered care difficult. Many organizations have reduced the number of new residents because they do not have the staffing to accommodate them despite having available licensed beds. More than sixty percent of AL facilities have moderate to high staffing shortages (NCAL 2022).

Improve and standardize initial and continuing education training for DCWs in AL:

Policies to implement include increased requirements for initial training and continuing education of workers and implementing a coordinated way to share best practices and offer technical assistance. These practices and topics should include realistic job preview, interactive and engaging onboarding with peer mentorship and check-ins over the first three months, a training registry that supports both initial and ongoing training and promotes portability, stackability, and career progression. Training requirements should emphasize person-centered care, meaningful engagement, living well with dementia, strength-based approaches, traumainformed and self-care, communication skills, and non-pharmacological approaches to dementia care. Several states including Florida (430.5025 F.A.C.) have increased the required content for initial and continuing education for DCWs in Assisted Living. Also, while AL workers do not have to be CNAs, many of them are, so legislation that increased the continuing education requirements for the CNA workforce would raise requirements for initial and continuing education across much of long-term care.

Professionalize the direct care workforce:

This strategy needs to be engaged in collaboration across long-term care sectors. States such as Wisconsin (https://wiscaregivercna.com/) have created partnerships across provider associations and state government to establish education and career pathways for direct care workers. This is one workforce that moves between and across sector lines constantly. Professionalization includes: occupational credentialing that acknowledges competencies of incumbent workers, ties competency accrual to significant and meaningful career lattices that have transparent wage increases, credentialing that is stackable and leads to higher order credentials that support key areas of need including meaningful engagement of residents, person-centered care, strength-based creative expression outlets (e.g. music, drama, arts, expression), health and wellbeing, trauma-informed approaches, and documentation and quality improvement practices.

The Journal of Applied Gerontology has made this article publicly available upon my request: https://journals.sagepub.com/doi/full/10.1177/0733464818757000.

Question:

Please share with us how assisted living facilities work to ensure that residents are supported in their activities of daily living, as well as being emotionally and intellectually supported?

Response:

Person-centered care means that the person receiving care is in the driver's seat, to the extent they are able and for as long as they can. Ideally, the resident sets the goals of care collaboratively with both unpaid and paid care partners. Person-centered care practices have been associated with improved quality of life and quality of care for residents (Fazio et al., 2018; Poey et al., 2017). Empowerment of residents and their care network is also vital to moving this sector forward. For residents, it's truly engaging them in their own care, using a strengths-based approach where individuals are supported to do as much for themselves for as long as possible no matter how slow the process (Yan et al. 2023). Assisted Living organizations create dense activity calendars that offer things for Assisted Living residents to do, but to engage residents emotionally and intellectually, we have found that these approaches are the most successful (particularly for residents with dementia): 1) Knowing the person, 2) Connecting with and meeting them where they are, 3) Being in the moment and 4) Realizing that every interaction is an opportunity for engagement (Kemp et al. 2021).

Question:

Please share with us strategies that states use to hold assisted living facilities accountable and how they could do a better job?

Response:

Standardizing state transparency and oversight supports public awareness of the industry and promotes the ability of potential residents and their care networks to make informed decisions. This should include publishing of quality data similar to that of the nursing home sector (https://www.medicare.gov/care-compare/). This will need to include regulation and oversight where states have to report survey results and individual AL communities will have to regularly report on quality indicators, incidents and deficiencies. Coordination of technical assistance and supportive resources for providers to meet standards and implement best practices will likely be necessary (Kaskie et al. 2022).

Question:

Would you support a set of federal regulations for assisted living facilities? If so, what issues would be most critical to have federal regulations address?

Response:

I would support federal regulations for assisted living facilities that support information sharing, transparency, public access to quality data and oversight data. These aspects are key to supporting high quality. Several states have made significant improvements to regulation(https://www.ahcancal.org/Assisted-Living/Policy/Documents/2023—reg—review.pdf). Technical assistance and support states to improve their regulation, quality data and documentation quality would be useful. The most critical issues to address are: worker initial and continuing training, career advancement, resident abuse, quality improvement efforts, efforts to combat social isolation, infection control, and strategies to support resident safety.

Senator Kirsten Gillibrand

Question:

Staffing shortages in assisted living facilities are reaching crisis levels and are exacerbated by insufficient pay and benefits, strenuous workloads, limited training and advancement opportunities, and stigma. MY National Domestic Workers Bill of Rights Act extends common workplace rights to assisted living facilities workers while at the same time creating new protections and stronger ways of enforcing them.

Is the current assisted living facilities workforce prepared to care adequately for residents with cognitive impairment and Alzheimer's Disease? Are programs or certifications available so that our ALF workforce may improve the quality of their care delivery?

Response:

No. Training is inconsistent across Assisted Living organizations and is not universally required (https://www.ahcancal.org/Assisted-Living/Policy/Pages/state-regulations.aspx). There are several training certifications that are useful but not widespread. These include but are not limited to the Eden Alternative's Certified Eden Associate Training and Dementia Beyond Drugs, Teepa Snow's Positive Approach to Care Training Certifications, and training offered by the National Council of Certified Dementia Practitioners.

Question:

How would direct care worker protections like adequate breaks during work hours and training programs also protect assisted living facility residents? Would addressing factors that contribute to assisted living facility direct care worker burnout also benefit organizations and residents?

Response:

These protections would help a great deal. Burnout is real and pervasive in these and most long-term care organizations. Resources and requirements that hold employers accountable and reward good employers are important. Employers can make incredible differences in the lives of their workers and residents and curb turnover and improve recruitment by enhancing hiring practices, increasing compensation, enhancing benefits, improving orientation and onboarding, increasing access to education and training and expanding career opportunities (See short micro-learning videos on these topics:

(https://www.youtube.com/playlist?list=PLXNnxuyRl8NQHl5kx6ukHxVHac—VjOCyn). Greater access to mental health resources is sorely needed. This could be done through Employment Assistance programs or other collaboratives among organizations. High quality, low-cost mental health services are needed for all members of the care network, including residents. Destigmatizing and normalizing mental health and well-being promotion is vital for this industry. It is important to realize how interconnected residents, paid and unpaid care partners are in the AL context. The support of each impacts the other. Better supports for staff means they will be better positioned to provide care (Kemp 2021, Kemp et al. 2018).

Question:

What issues does marketing an assisted living facility as a ″memory unit″ create for consumers with cognitive impairment?

Response:

There should be standards attached to the ability to market dementia care services to potential residents and families. In my opinion, this would include environmental supports (e.g. lighting, built environment, privacy, community, safety), social supports (e.g. community engagement, meaningful engagement, avenues for contributing), and training supports (e.g. person-centered dementia care training, strengths-based & Montessori-based training, communication training, quality improvement and team training).

References

•Dill, J., & Duffy, M. (2022). Structural Racism And Black Women's Employment In The US Health Care Sector: Study examines structural racism and black women's employment in the US health care sector. Health Affairs, 41(2), 265-272.

•Dill, J. S., Morgan, J. C., & Marshall, V. W. (2013). Contingency, employment intentions, and retention of vulnerable low-wage workers: An examination of nursing assistants in nursing homes. The Gerontologist, 53(2), 222-234.

•Dill, J., Morgan, J. C., Van Heuvelen, J., & Gingold, M. (2022). Professional certification and earnings of health care workers in low social closure occupations. Social Science & Medicine, 303, 115000.

•Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of personcentered care for individuals with dementia. The Gerontologist, 58(suppl—1), S10-S19.

•Frogner, B. K., & Dill, J. S. (2022, April). Tracking turnover among health care workers during the COVID19 pandemic: a cross-sectional study. In JAMA Health Forum (Vol. 3, No. 4, pp. e220371e220371). American Medical Association.

•Kaskie, B., Xu, L., Taylor, S., Smith, L., Cornell, P., Zhang, W., ... & Thomas, K. (2022). Promoting quality of life and safety in AL: A survey of state monitoring and enforcement agents. Medical Care Research and Review, 79(5), 731-737.

•Kelly, C., Morgan, J.C., Kemp, C. L., & Deichert, J. (2020). A profile of the assisted living direct care workforce in the United States. Journal of Applied Gerontology, 39(1), 16-27.

•Kemp, C. L., Ball, M. M., Morgan, J. C., Doyle, P. J., Burgess, E. O., & Perkins, M. M. (2018). Maneuvering Together, Apart, and at Odds: Residents' Care Convoys in Assisted Living. The Journals of Gerontology: Series B, 73(4), e13-e23. https://doi.org/10.1093/geronb/gbx184.

•Kemp, C. L. (2021). # MoreThanAVisitor: Families as ″essential″ care partners during COVID-19. The Gerontologist, 61(2), 145-151. Kemp, C. L., Bender, A. A., Ciofi, J., Craft Morgan, J., Burgess, E. O., Duong, S., ... & Perkins, M. M. (2021). Meaningful engagement among assisted living residents with dementia: Successful approaches. Journal of Applied Gerontology, 40(12), 1751-1757.

•Morgan, J.C., Dill, J., & Kalleberg, A. L. (2013). The quality of healthcare jobs: can intrinsic rewards compensate for low extrinsic rewards?. Work, employment and society, 27(5), 802-822.

•NCAL (2022) https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AL-SurveyJune2022.pdf.

•Poey, J. L., Hermer, L., Cornelison, L., Kaup, M. L., Drake, P., Stone, R. I., & Doll, G. (2017). Does personcentered care improve residents' satisfaction with nursing home quality?. Journal of the American Medical Directors Association, 18(11), 974-979.

•Scales, K., & Lepore, M. J. (2020). Always essential: Valuing direct care workers in long-term care. Public Policy & Aging Report, 30(4), 173-177.

•Yan, Z., Traynor, V., Alananzeh, I., Drury, P., & Chang, H. C. (2023). The impact of montessori-based programmes on individuals with dementia living in residential aged care: A systematic review. Dementia, 14713012231173817.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS

JANUARY 25, 2024

QUESTIONS FOR THE RECORD

Julie Simpkins

Please see pages 59 through 77 for Questions, Responses, and Exhibits

POLSINELLI.

150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606 • (312) 819-1900

February 16, 2024

Matthew J. Murer
[redacted]

Confidential

The Honorable Robert P. Casey, Jr.
Chairman, Special Committee on Aging
United States Senate
Washington, D.C. 20510

The Honorable Elizabeth Warren
United States Senate
Washington, D.C. 20510

The Honorable John Fetterman
United States Senate
Washington, D.C. 20510

Re: Gardant Management Solutions' Response to January 24, 2024 Inquiry

Dear Chairman Casey, Senators Warren and Fetterman:

I am writing on behalf of my client, Gardant Management Solutions ("Gardant"), in response to your correspondence dated January 24, 2024 (the "Letter"). We appreciate the opportunity to provide information to your offices regarding Gardant's response to your Questions for the Record.

Gardant was founded in 1999 on the foundation of operating communities with dignity, compassion and enriched services and has more nearly 25 years' experience managing licensed assisted living facilities across five states, including Illinois, Indiana, Ohio, Maryland, and West Virginia). Gardant does not provide services under a Medicaid Waiver Program in Maryland or West Virginia. At each community, Gardant only serves as a manager and does not own any of the assisted living facilities it manages. Gardant currently serves as a manager for 82 properties that include independent living memory care, and assisted living facilities serving approximately 6,500 residents. Gardant is committed to applying best practices at all of its managed facilities as it serves one of the most vulnerable populations.

POLSINELLI.

This letter contains Gardant's and its managed facilities' confidential, trade secret, and/or proprietary information. We have marked this letter "Confidential" and request that it not be disclosed beyond your individual offices or the United States Senate Special Committee on Aging ("Committee") or otherwise made public. We ask that you treat this letter and accompanying documents as confidential committee records in accordance with Standing Rule of the Senate XXIX, clause 5, afford them the maximum protection available to information provided to a Senate or House office or committee. We request you inform us of any proposed use of the information contained herein or accompanying documents and provide Gardant with an opportunity to be heard prior to any such proposed use.

The information contained in this response is based on Gardant's best efforts undertaken within the timeframe provided and based on its understanding of the information requested. The representations made in this response are based on information reasonably available to Gardant and may not reflect all existing relevant information. Gardant reserves the opportunity to supplement information in this response and will do so as warranted. In providing information and materials responsive to the request, Gardant does not waive any rights or legal options relating to this inquiry.

For your convenience, we have reproduced below, in bold, each question in your Letter followed by our response. Please note that our response reflects the data as of February 1, 2024.

1) **During the hearing, Sen. Braun asked about the cost of providing care for residents and the sources of funding Gardant Management Solutions uses to pay for those costs. He was especially complementary that Gardant could provide residents with services to address their needs at a rate much lower than what Ms. Vessenmeyer paid and suggested Gardant's model might be a model for the nation. So that we can better understand the cost model for your services, please share with us the following:**

    a. **All sources of Federal funding that Gardant uses to cover assisted living costs, including Federal funding that may be specific to an individual resident such as Medicaid funding and Social Security funding, and HUD funding**.

    Gardant is a third-party manager of these communities. As such, it bills each state's Medicaid program and payments are then sent from the Medicaid agency to the owners of the communities. The only source of Federal funding that the communities receive to cover the cost of providing assisted living services to seniors is Medicaid payments that are paid under Medicaid Waiver Programs.

POLSINELLI.

b. **All sources of state funding Gardant uses to cover assisted living costs, disaggregated by state**.

The only state funding that the communities receive to cover the cost of providing assisted living services is Medicaid payments, which are paid under Medicaid Waiver Programs, to the extent that such payments are considered "state funding."

c. **The total amount of personal funds paid by residents disaggregated by assisted living facility, for the past five years**.

This below chart reflects the total funds paid by residents, including both room and board and service charges. Gardant estimates the average paid per resident is $1,600/month.

	IL – Medicaid Residents/Personal Funds	IN – Medicaid Residents/Personal Funds	OH – Medicaid Residents/Personal Funds
2019	$[redacted]	$[redacted]	
2020	$[redacted]	$[redacted]	
2021	$[redacted]	$[redacted]	
2022	$[redacted]	$[redacted]	
2023	$[redacted][1]	$[redacted]	$[redacted]

d. For residents who sign over their social security cash benefits, the monthly personal allowance for residents in each state.

	Illinois	Indiana	Ohio
Monthly Personal Allowance	$90	$52	$50

[1] The 2023 increase in the total amount of personal funds paid by Illinois residents was the result of the addition of 14 new Supportive Living Facilities and 1 new Assisted Living Facility.

POLSINELLI.

e. The total value of the Low-Income Housing Tax Credits (LIHTC) Gardant currently owns and has owned over the past five years.

Gardant is a third-party operator and does not have an ownership interest in any of the communities it manages. As a result, Gardant, does not presently own any Low Income Housing Tax Credits, nor has it owned any during the prior 5-year period.

2) In your written testimony you mentioned that you only provide assisted living in states that have sufficient or higher Medicaid reimbursement rates? What daily rate is sufficient for Gardant to provide assisted living in a state?

It would be impossible to identify one rate that would be sufficient for providing assisted living as there are a multitude of factors that impact the cost of providing care and services including construction costs, zoning limitations, property taxes, local taxes, food costs, the local labor market (availability and prevailing wages), insurance costs, and facility size/capacity.

Medicaid payments in the states we currently operate in are as follows:

	Assisted Living Medicaid Rate Range	Memory Care Medicaid Rate Range
Illinois	$130.69 - $135.53 / day	$191.59 – $208.35 / day
Indiana	$101.98 – 132.04 / day	$101.98 – 132.04 / day
Ohio	$130 / day	$155 / day
Maryland	N/A	N/A
West Virginia	N/A	N/A

3) Do you support federal requirements to publicly report assisted living facility fees, sources of funding, and incidents of injuries, elopements, and deaths? If you do not support federal regulations for any of these, please provide your rationale.

We support the existing reporting requirements under state law and the Medicaid Waiver Programs. Federal reporting would be largely duplicative of the reporting that is already

POLSINELLI.

mandated through the Medicaid Waiver Programs and existing state law. The information that you suggested be reported at the federal level is already available to the Centers for Medicare and Medicaid Services ("CMS") through the Medicaid Waiver Program reporting. We would also highlight the fact that CMS reviews each Waiver Program on an annual basis.

4) **How many senior living, assisted living, and memory care communities does Gardant operate?**

Gardant currently serves as a manager for 82 properties that include:

- 64 assisted living communities accepting Medicaid payment for services. Five of these communities also provide memory care services.
- 8 independent living communities.
- 10 private pay communities.
  - Two of these communities provide memory care services.
  - Three of these communities provide multiple service levels (independent, assisted, and memory care).
  - Four of these communities provide assisted living services.

a. How many residents live in each of these types of Gardant communities?

Gardant currently serves approximately 6,500 residents.

5) **In what states does Gardant provide services at these facilities under a Medicaid Waiver Program?**

Gardant provides services under a Medicaid Waiver Program in Illinois, Indiana, and Ohio.

a. What kind of services are provided by Gardant under these Medicaid Wavier Programs?

Medicaid Waiver Programs include assistance with activities of daily living (ADLs) (i.e., bathing, dressing, eating), medication assistance and administration, meals, laundry, housekeeping, activities, transportation for shopping and medical visits, and activity programs. Memory care programs also include specialized programming and additional security and monitoring.

POLSINELLI.

b. How many residents receive services under these Medicaid Waiver Programs?

We estimate that we provide approximately 75-80 % of our residents (4,875 – 5,200) receive assisted living services under Medicaid Waiver Programs.

6) How much in total Medicaid reimbursements has Gardant received in each of the last five calendar years?

As discussed earlier, Gardant is a third-party manager of these communities. As such, it bills each state's Medicaid program and payments are then sent from the Medicaid agency to the owners of the communities. Gardant does not retain the Medicaid payments.

Year	Medicaid Payments
2019	$[redacted]
2020	$[redacted]
2021	$[redacted]
2022	$[redacted]
2023	$[redacted]

7) How often are Gardant facilities inspected by state authorities in each state where Gardant operates?

Gardant's communities are inspected annually and, as necessary, when complaints are received by the state.

a. Please provide a copy of the most recent state inspection report for each facility.

Reports are attached as Exhibit 1.

8) Your testimony indicates that Gardant reports ("overreports") all elopements to state authorities. How many reports of elopements have you made to state officials in each of the last five calendar years? Please provide a summary of all such reports.

Gardant has reported 11 elopements in the last 5 calendar years. See Exhibit 2.

POLSINELLI.

9) **How many "critical incidents"[2] have occurred at Gardant facilities in each of the last five years?**

There have been 10 total incidents that have occurred at Gardant facilities in the last 5 years.

a. **Please provide a detailed list of all such incidents.**

Please see Exhibit 3.

10) **Has Gardant been subject to any state enforcement actions related to quality of care provided at its facilities?**

During the past 5 years there have been no instances in which the state took action against any of Gardant's licenses related to quality of care.

a. **Please provide a detailed list of all such actions.**

N/A

11) **Are minimum staffing standards in place at Gardant facilities? If so, please provide a summary of those standards.**

The following sets forth each state's regulatory requirement regarding the number of staff:

Illinois: Shall have staff sufficient in number with qualifications, adequate skills, education ad and experience to meet the 24-hour scheduled and unscheduled needs of residents. There are no staffing ratios.

Indiana: Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the 24-hour scheduled and unscheduled needs of the residents and services provided.

[2] These are "incidents that may cause harm to a beneficiary's health or welfare, such as abuse, neglect, or exploitation." See, GAO, MEDICAID ASSISTED LIVING SERVICES Improved Federal Oversight of Beneficiary Health and Welfare Is Needed, at 7, January 2018, at https://www.gao.gov/assets/gao-18-179.pdf.

POLSINELLI.

Maryland: There will be on-site staff in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the residents. There are no staffing ratios.

Ohio: While there are not staffing ratios, at least one staff member must be on duty at all times and sufficient additional staff members must be present to meet the residents' total care needs.

West Virginia: A sufficient number of qualified employees must be on duty to provide resident with all the care and services they require.

Gardant staffs its communities taking the following factors into account: 1) resident acuity (including acuity limitations imposed by the state); 2) services required under each resident's person centered service plan; and 3) size of the community and number of residents. Based upon these factors, Gardant generally follows the internal minimum staff guidelines below:

Minimum caregiver staffing in AL setting:
Days – 1/20
Afternoons – 1/25
Evenings – 1/40

Minimum nursing/caregiver staffing in MC setting:
Minimum of 1/8 or 1/10

12) **What training requirements are in place for Gardant facilities that provide services under Medicaid waiver programs?**

Illinois
89 Ill. Admin. Code Section 146.235(e)
Illinois staffing requirements provide that a facility provide training within 30 days of beginning employment and semi-annual training, covering resident rights, ; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission

application policy; and non-discrimination policy (these subjects shall be trained as part of staff orientation and at least annually thereafter). There is no specific hour requirement given in the regulation.

89 Ill. Admin. Code Section 146.660(e)
Dementia Care: All staff who work on the unit (e.g., nurses, CNAs, housekeepers, activities staff) shall have four hours of training specific to working with persons with Alzheimer's disease or related dementia within seven days after working on the unit. They shall annually complete at least 12 hours of in-service training regarding Alzheimer's disease and other related dementia.

Indiana
410 IN ADC 16.2-3.1-14 Indiana Administrative Code
For regular care, according to 410 IAC 16.2-3.1-14 and 410 IAC 16.2-5-1.4, staff who have regular contact with residents must have a minimum of six hours of dementia-specific training within six months of initial employment, or within thirty days for personnel assigned to the Alzheimer's and dementia special care unit. They must also have three hours of dementia-specific training annually thereafter.

In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

Ohio
Ohio Administrative Code Chapter 3701-16 Residential Care Facility ("RCF")
Training Requirements: All staff must receive orientation and training in their job responsibilities, facility procedures, securing emergency

POLSINELLI.

assistance, and residents' rights. Staff must receive 8 hours of continuing education annually in personal care techniques, observational skills, and communication skills. Training must be provided by a licensed nurse. All direct care staff must have first-aid training within 60 days of hire. Administrators must receive 9 hours of continuing education annually in gerontology, health care, business administration, and RCF operation.

Staff members employed by a RCF, or part thereof, that admits or retains residents with: (1) late-stage cognitive impairment with significant ongoing daily living assistance needs; (2) cognitive impairments with increased emotional needs or presenting behaviors that cause problems for the resident or other residents, or both; or (3) diagnoses of serious mental illness must have, within 14 days of the first day of work, 2 hours of training in the care of such residents and 4 hours of continuing education in the care of such residents annually. These hours may count towards the general staff training requirements described above.

13) **During your testimony you indicated that Gardant had investors who provided funding for your facilities and operations.**

a. **Who are the company's largest investors?**

As previously stated, Gardant is a third-party manager for the assisted living communities. It does not have an investment interest in any of the communities.

b. **What is the return rate investors receive on their investment? Please share the return rate for each of the past five years.**

Gardant does not have access to this information.

c. **How are returns paid out to investors (i.e., dividends, cash disbursements, or any other method)?**

Gardant does not have access to this information.

POLSINELLI.

14) What fees does Gardant charge residents on top of their basic monthly costs?

a. Please provide a copy of the fee schedule for Gardant facilities.

A fee schedule summary is attached as Exhibit 4.

b. Do you charge fees for medical services?

Medical services are included in the Medicaid Waiver Program payment.

c. Do you charge fees for personal services?

We assume that the question regarding charging for "personal services" is meant to address whether we charge for assistance with ADLs. These services are included in the Medicaid Waiver Program payment.

d. What other types of fees does Gardant charge residents?

The only additional fees that residents are charged are beauty shop services, guest meals, and internet services.

e. Do you use a "point schedule" or similar approach to establish fees for certain services? If so, how does this system work?

We do not use a point system to determine fees. Our fees are based upon the costs of delivering those services, which includes the cost of staffing, overhead, etc. We develop a person-centered individualized service plan for each resident based upon an assessment of each person's condition and needs.

f. What is the average amount paid in fees by residents at Gardant facilities?

Given the diversity among the communities that we operate (e.g., size, urban vs. rural, resident acuity, tax and insurance expenses), we do not believe that an average is particularly helpful. Residents who are supported by Medicaid generally pay between $800 to $1,000 / month from personal funds but often less.

15) Ms. Simpkins: In your testimony, you stated that it would be "unworkable" and "irresponsible" to standardize the regulations that oversee assisted living facilities at

POLSINELLI.

the federal level. Can you tell me specifically how each of the following requirements would harm residents at assisted living facilities?

a. A minimum daily reimbursement rate for assisted living services

b. A minimum staffing ratio for memory care units

c. A minimum standard for dementia training, including content of training and length of training

d. A requirement to have a nurse or other medical professional on site

e. A standard definition for a "memory care unit" or other similarly named units

By way of clarification, Ms. Simpkins never stated that standardized regulations would harm residents. The following is a transcript of Ms. Simpkins' testimony regarding standardizing regulations at the federal level.

> When we talk about assisted living, it is important to note that every State, every community, and every resident is different. Efforts to standardize all assisted living communities would be both unworkable and irresponsible for resident care.
>
> State regulations appropriately recognize the diversity within assisted living by holding our profession accountable, and they are consistently updated to reflect the evolving nature of our sector and our residents.

We believe that existing Medicaid Waiver Program requirements that were initially reviewed and approved by CMS and are reviewed annually by CMS are appropriate and sufficient to address the issues identified including but limited to staffing, training, and reporting, which allows CMS to monitor and review facility performance.

Assisted living provides life-affirming care for nearly one million seniors every day, and residents and families are consistently satisfied with the care they receive. The safety and security of those residents are our number one priority. We continue to collaborate with State regulators

POLSINELLI.

and share best practices with other care providers throughout the United States to continuously improve policies, procedures, education, and training to meet the current and future needs of the people we serve, including those living with dementia and the employees that serve them.

Gardant appreciates the opportunity to provide your offices with information regarding this critical industry. Gardant looks forward to working with your offices to ensure that all residents continue to receive appropriate support and care.

Respectfully submitted,
GARDANT MANAGEMENT SOLUTIONS

By: Matthew J. Murer
One of Its Attorneys

Atts.
Cc: Rod Burkett
Julie Simpkins
Greg Echols

MJM:mr

For Exhibits 1 through 4, please see additional exhibits submitted by Julie Simpkins in the "Statements for the Record" section.

EXHIBIT 1
ANNUAL SURVEY DATA

Community Name	Annual Survey Date
Belvedere Senior Housing	12/04/23
Bowman Estates of Danville	11/20/23
Brookstone Estates Effingham	05/30/23
Brookstone Estates Fairfield	06/12/23
Brookstone Estates Mattoon North	04/25/23
Brookstone Estates Olney	09/26/23
Brookstone Estates Paris	11/16/23
Brookstone Estates Rantoul	09/25/23
Brookstone Estates Robinson	09/25/23
Brookstone Estates of Tuscola	09/05/23
Brookstone Estates Vandalia	05/08/23
Cambridge House of Maryville	07/18/23
Cambridge House of O'Fallon	11/23/23
Cambridge House of Swansea	05/24/23
Carriage Court Grove City	02/01/22
Carriage Court Washington Court	09/14/23
Churchview	11/28/23
Deerpath Of Huntley	08/21/23
Emerald Glen Olney	11/06/23
Evergreen Village at Bloomington	08/16/23
Evergreen Village at Fort Wayne	03/30/23
Glasswater Creek of Lafayette	04/13/23
Glasswater Creek of Plainfield	11/17/21
Grand Prairie of Macomb	04/13/23
Grand Vic Rockford	12/12/23
Grand Victorian Sycamore	08/01/23

Green Oaks River Oaks	*[1]09/30/19
Green Oaks Park Forest	*09/19/19
Gull Creek Senior Living Community	11/20/23
Heritage Woods of Belvedere	12/06/23
Heritage Woods of Freeport	07/02/23
Heritage Woods Manteno	12/08/23
Heritage Woods of Batavia	12/11/23
Heritage Woods of Benton	08/31/23
Heritage Woods of Bolingbrook	06/29/21
Heritage Woods of Centralia	04/28/23
Heritage Woods of Charleston	12/24/23
Heritage Woods of Chicago	07/24/23
Heritage Woods Of DeKalb	1/24/2023
Heritage Woods of Dwight	10/24/22
Heritage Woods of Flora	05/18/23
Heritage Woods of Gurnee	01/15/23
Heritage Woods of McHenry	04/26/23
Heritage Woods of Minooka	02/28/22
Heritage Woods of Moline	12/28/23
Heritage Woods of Mt. Vernon	08/02/23
Heritage Woods of Newburgh	11/21/22
Heritage Woods of Noblesville	08/04/23
Heritage Woods of Ottawa	12/13/23
Heritage Woods of Plainfield	09/26/19
Heritage Woods of Rockford	06/12/23
Heritage Woods of South Elgin	07/11/23
Heritage Woods of Sterling	10/23/23
Heritage Woods of Watseka	04/24/23
Heritage Woods of Yorkville	09/19/23
John Evans SLC	05/02/23

[1] Gardant began managing Green Oaks River Oaks Green Oaks Park Forest on 10/1/22. As the most recent annual survey predates Gardant's management, Gardant is unable to provide a copy.

Lacey Creek Supportive Living	07/24/23
Montclare of Lawndale	04/06/23
Oak Hill Supportive Living	01/31/23
Oasis at 30th	08/30/23
Oasis at 56th	04/20/23
Prairie Winds of Urbana	05/16/23
Reflections Lancaster	12/12/23
St. Anthony of Lansing	07/29/22
Sweet Galilee at the Wigwam	05/12/23
Timberlake Supportive Living	04/04/23
VCJoliet SLF	02/27/19
Vivera Senior Living of Columbus	06/02/23
White Oaks of South Elgin	02/17/23
White Oaks of Spring Street	06/01/23

EXHIBIT 2
ELOPEMENTS

Facility	Date	Elopement Summary
Heritage Woods of Chicago	6/1/2018	[redacted]
Cambridge House of Swansea	9/6/2020	
Heritage Woods of Charleston	1/12/2021	
Heritage Woods of Sterling	2/15/2021	
Heritage Woods of Noblesville	6/1/2021	
Oasis at 30th	8/3/2021	
Heritage Woods of Noblesville	10/6/2021	
Heritage Woods of Benton	2/18/2022	
Heritage Woods of Noblesville	9/16/2022	
Cambridge House of Swansea	10/12/2023	
Heritage Woods of Watseka	1/21/2024	

EXHIBIT 3
CRITICAL INCIDENTS

Facility	Survey Date	Survey Findings
Evergreen Village at Bloomington	12/7/23	[redacted]
Belvedere Senior Housing	4/20/23	
Heritage Wood of Noblesville	6/1/21	
	8/24/21	
Oasis at 30th	10/1/20	
	2/26/21	
	4/22/21	
	8/30/23	
Oasis at 56th	10/24/19	
	2/10/23	

EXHIBIT 4
SCHEDULE OF ADDITIONAL FEES

Late Fee (*per resident lease agreement*)	$3-10
Guest Meals	$5-8
Beauty Salon Services (*price ranges for services provided*)	$5-50
Technology Fees (*Correlating to the setup, monthly service, and maintenance of cable, telephone, and internet for Illinois and Indiana. Ohio does not charge technology fees.*)	Tech. Fee 1 $25 Tech. Fee 2 $22* Tech. Fee 3 $17 **Subject to long distance charges*

U.S. SENATE SPECIAL COMMITTEE ON AGING

"ASSISTED LIVING FACILITIES: UNDERSTANDING LONG-TERM CARE OPTIONS FOR OLDER ADULTS"

JANUARY 25, 2024

QUESTIONS FOR THE RECORD

Richard Mollot

Chairman Robert P. Casey, Jr.

Question:

Can you tell us what standard information about assisted living facilities would be most useful to families and who should be collecting and disseminating that information?

Response:

Seniors and their families would strongly benefit from the following information about assisted living facilities:

1. Staffing, including:

a. the licensure, certification, and training levels of all staff providing resident care or services;

b. whether there is a RN, MD, or other professional (i.e., individual with licensure to provide professional supervision, such as assess residents and manage medications) on staff with a regular presence in the nursing home (full time or part time indicated);

c. the numbers of each type of care staff present in the building by shift and weekday vs. weekend based upon payroll or other auditable records; and

d. Whether there are staff in the building 24/7 (indicating whether or not staff are required to be awake during their shifts).

2. Services offered, including:

a. Care: Whether or not the facility provides specialized dementia care, aging in place, hospice, palliative, and/or Medicaid assisted living (or other reduced cost options), the extent to which these services are available (such as entire facility or one wing), the licensure/certification of individuals providing any special services;

b. Community: Including whether there are resident and/or family councils (with contact information), a recent calendar of activities that the facility provides to residents, and how the facility provides connections to the broader community (i.e., bus to local shopping, religious services, etc.)

3. Costs of residential, care, and other services in a clear and concise manner (including costs of residence, cost of meals, cost of assistance and other services; what is included in base rate vs what will cost extra now or in the future).

4. Resident rights in the facility under state and federal law, including ADA and other non-discrimination rights, rights to access to LTC Ombudsman services, contacts for the LTC Ombudsman, Adult Protective Services, state oversight agency, law enforcement, emergency services and state "No Wrong Door" access point (see https://nwd.acl.gov/index.html).

5. Quality & Safety of facility, including access to complete inspection and citation records that are unredacted (except for the name(s) of residents).

6. Facility policies, including transfer/discharge policies, whether the facility imposes a pre-dispute arbitration clause in its residency agreements, whether residents have rights to have pets, smoking and drinking policies, etc.

7. Ownership of facility, including any individual or entity with 5% or greater ownership interest and the administrator of the facility, in a searchable federal database that provides information on ownership within and across states, with access to inspection and citation records.

To the greatest extent possible, this information should be collected and published by the federal government in an online tool similar to Home Health Compare, Hospice Compare, etc. In addition, facilities should be required to have this information available for inspection by residents, families, and visitors in the facility and on its

website (if it has one). The information provided by the facility should be in English and any other language of the residents that it has accepted into its facility.

Question:

The written testimony of Ms. Julie Simpkins stated that federal regulations would be irresponsible. Based on your research, do you think industry standardizations would be irresponsible for resident care?

Response:

The growing body of news media reports, Government Accountability Office reports, and peer-reviewed studies all indicate that, in fact, it is irresponsible not to have baseline federal assisted living standards to protect residents from physical, emotional, and financial harm. It is important to provide some background here. In order to fight growing calls for baseline federal standards, the industry has fallen back on the argument that such standards would inhibit its ability to provide individualized care and services. This is a false argument. Federal regulations are needed to ensure baseline safety, quality, transparency, and accountability. They would actually foster improvements in resident-centered care, by helping individuals and families understand what they have a right to expect and the extent to which a facility will be able to fulfill their needs, expectations, and goals now and in the future.

Question:

Can you speak to ways in which the industry standards could be improved, while still recognizing the diversity within assisted living?

Response:

Some ways in which industry standards could be improved include:

1. Setting baseline requirements for the individuals providing care and services in assisted living (including the minimum numbers of care staff in a facility and the licensure/certification of those staff;

2. Establishing clear definitions of ″memory care″ and ″aging in place″ and other terminology used by the industry (so that they are more than just hollow marketing terms);

3. Ensuring that facilities fulfill their promises to seniors and families by establishing standards for government oversight including annual inspections carried out by state inspection teams with relevant core competencies (i.e., nurse, dietician, social worker) and meaningful penalties for violations that impact resident safety and dignity.;

4. Fire, emergency planning, safety requirements;

5. Implement federal community characteristic standards - which were recently promulgated for Medicaid assisted living - for all assisted living.

None of these categories of standards would in any way impede an operator's ability to meet the diverse needs of the community it is serving. For more specific information on these and other policies that would improve quality of life and quality of care in assisted living, please see our report, ″Assisted Living: Promising Policies and Practices for Improving Resident Health, Quality of Life, and Safety.″ https://nursinghome411.org/ltccc-report-assisted-living-promising-policies-and-practices/

Question:

Ms. Simpkins also states in her testimony that state regulations are ″consistently updated.″ Is it your experience that state regulations are consistently updated? If not, what are your recommendations for how and when they should be updated?

Response:

To my knowledge, state laws and regulations are not consistently updated. In fact, in my experience, state legislators tend to be disinclined to promulgate new assisted living laws and when changes or updates are implemented, they tend to be in response to pressure from industry lobbyists, resulting in a significant weakening of state rules and their enforcement.

Senator Kirsten Gillibrand

Question:

Assisted living facilities are not required to disclose inspection reports, financial reinvestment in patient care, or staffing requirements for services offered. Residents and families should be aware of safety violations found during inspections, but this information is not always made public. In New York, citations are available, but the full inspection report is not.

How would resident care improve by making information from current assisted living facilities inspections public?

Response:

Better information would enable prospective residents to make informed choices about where they are going. It would enable current residents and families to be aware of what is going on in their assisted living - their home - and hold their facility accountable for addressing the problems.

Question:

Does a lack of information exacerbate the health and financial burdens for residents and their families to house loved ones in assisted living facilities? What information should be available to the aging population to help them prepare for long-term care?

Response:

In short, yes. People tend to think that their base monthly payment will cover most if not all of their costs. However, additional costs often arise unexpectedly, particularly as an individual's needs increase. A resident may not realize when they ask for a helping hand it will come with a price tag.

Seniors and their families need accessible information on what services are available to them, where they can access those services (with meaningful information on the potential strengths and weaknesses of different options), who will be providing the services (nurse, certified nurse aide, or someone with less or no training), how much services will cost, and options for paying for those services. Furthermore, seniors and their families should be informed, in clear language, about the agencies or companies that are providing services and the quality record of those providers.

Question:

Would transparency in the assisted living facility industry help residents during the transition from assisted living to skilled nursing facilities?

Response:

Yes. Due to lax state rules and oversight, too many assisted living retain residents for whom they can no longer provide safe care. Transparency would empower residents and families to make choices appropriate for their needs.

Question:

Private equity firms have capitalized on assisted living facilities as a real estate opportunity to collect higher profit yields than other investments in offices and hotels. Assisted living facilities increasingly house older adults whose the health needs demand care and specialization, but private equity firms have minimal accountability for the services they provide.

When residents suffer harm while living in assisted living facilities, are they able to choose a course of action, such as a jury trial or arbitration, to hold assisted living facilities accountable. Does the current process adequately protect residents and the public from unnecessary harm? Does it facilitate transparency?

Response:

Too often, the answer to this question is no. Many assisted living companies insert pre-dispute arbitration clauses into their residency agreements, which effectively prevents someone from suing, even when their loved one has been severely harmed or dies as a result of neglect or grossly substandard care.

Question:

What consequences do private equity firms face when negligent behavior or harm occurs to residents or workers under their supervision?

Response:

Unfortunately, due to the lack of accountability and transparency, we have no way of knowing specifics about consequences for assisted living operators. However, we do know in the senior care industry generally that the use of complex investment vehicles in which the facility itself is depleted of assets is a common technique for avoiding accountability for negligence or, even, avoidable death.

Question:

How well is private equity delivering on the concept of an assisted living facilities as a social model? Are private equity-operate assisted living facilities performing comparably with the rest of the industry?

Response:

Based on what we have seen in nursing homes (and other areas of health care) quality and safety tend to degrade significantly when private equity investment enters the sector.

Statements for the Record

Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

United States Senate Special Committee on Aging
Hearing on "Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults"

January 25, 2024

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Special Committee on Aging hearing on **"Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults."** The Association and AIM thank the Committee for its continued leadership on issues important to the millions of individuals living with Alzheimer's and other dementia and their caregivers. This statement highlights the importance of policies that will help ensure a quality direct care workforce that can meet the unique needs of our nation's growing number of Americans living with Alzheimer's and other dementia.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

An estimated 6.7 million Americans age 65 and older are living with Alzheimer's dementia in 2023. Total payments for all individuals with Alzheimer's or other dementias are estimated at $345 billion (not including unpaid caregiving) in 2023. Medicare and Medicaid are expected to cover $222 billion or 64 percent of the total health care and long-term care payments for people with Alzheimer's or other dementias, which are projected to increase to more than $1.1 trillion by 2050. These mounting costs threaten to bankrupt families, businesses, and our health care system. Unfortunately, our work is only growing more urgent.

Assisted living is one of the fastest-growing options for residential housing for older Americans. There are approximately 30,600 assisted living communities with nearly 1.2 million licensed beds in the United States today. Assisted living bridges the gap between living independently and living in a nursing home and more assisted living providers are offering services designed specifically for people with dementia.

Use and Costs of Long-Term Care for Individuals with Alzheimer's and Dementia

People living with Alzheimer's and other dementia make up a significant portion of all long-term care residents, comprising 48 percent of residents in nursing homes and 34 percent of all residents in assisted living communities and other residential care facilities. Twenty-four percent of Medicare beneficiaries with Alzheimer's or other dementias reside in a nursing home, compared with one percent of Medicare beneficiaries without these conditions. Approximately 75 percent of individuals with Alzheimer's disease diagnosed at age 70 will reside in a nursing home by age 80, compared with only four percent of the general population surviving to age 80. Given our constituents' intensive use of these services, the quality of this care is of the utmost importance. As a result, we encourage the Committee to consider the following recommendations to improve long-term care and support for the growing number of Americans affected by Alzheimer's and other dementia.

Best Practices in Dementia Care

Given our constituents' intensive use of these services, the quality of this care is of the utmost importance. To this end, the Alzheimer's Association developed the *Alzheimer's Association's Dementia Care Practice Recommendations*. Grounded in the fundamentals of person-centered care and published in a special supplement of *The Gerontologist*, the Dementia Care Practice Recommendations outline recommendations for quality care practices based on a comprehensive review of current evidence, best practice, and expert opinion. The Dementia Care Practice Recommendations were developed to better define quality care across all settings, including assisted living, and throughout the disease course. They are intended for professional care providers who work with individuals living with dementia and their families in long-term and community-based care settings.

Assisted living communities should ensure that the care and services provided have a **Person Centered Focus** which includes: (1) **Knowing the person living with dementia**. The individual living with dementia is more than a diagnosis. It is important to know the unique and complete person including his/her values, beliefs, interests, abilities, likes and dislikes — both past and present. This information should inform every interaction and belief; (2) **Recognize and accept the person's reality.** It is important to see the world from the perspective of the individual living with dementia. Doing so recognizes behavior as a form of communication, thereby promoting effective and empathetic communication that validates feeling and connects with the individual and his/her reality; (3) **Identify and support ongoing opportunities for meaningful engagement.** Every experience and interaction can be seen as an opportunity for engagement. Engagement should be meaningful to, and purposeful for, the individual living with dementia. It should support interests and preferences, allow for choice and success, and recognize that even when the dementia is most severe, the person can experience joy, and comfort, and meaning in life; (4) **Create and maintain a supportive community for individuals, families and staff.** A supportive community allows for comfort and creates opportunities for success. It is a community that values each person and respects individual differences, celebrates

accomplishments and occasions, and provides access to and opportunities for autonomy, engagement, and shared experiences; (5) **Evaluate care practices regularly and make appropriate changes.** It is important to regularly evaluate practices and models, share findings, and make changes to interactions, programs, and practices as needed. A culture of continuous quality improvement is a continuing theme throughout all of the recommendations.

Detection and diagnosis is one of two new areas of focus in the Dementia Care Practice Recommendations. Assisted living communities should: (1) make information about brain health and cognitive aging readily available to older adults and their families; (2) all non-physician care staff should be trained to know the signs and symptoms of cognitive impairment, that signs and symptoms do not constitute a diagnosis of dementia, and that a diagnostic evaluation is essential for diagnosis of dementia; (3) non-physician care staff should listen for concerns about cognition, observe for signs and symptoms of cognitive impairment, and note changes that occurs abruptly or slowly over time; (4) develop and maintain procedures for detection of cognition and referral for diagnostic evaluation; (5) use a brief mental status to detect cognitive impairment only if such testing is with the scope of practice of the non-physician care staff, the non-physician care staff has been trained to use the test, required consent procedures are know and used and there is an established procedure for offering a referral for individuals who score below a preset score on the test to a physician for a diagnostic evaluation; (6) encourage older adults whose physician has recommended a diagnostic evaluation to follow through on the communication; (7) support a better understanding of a dementia diagnosis.

Assessment and care planning is crucial to provide quality dementia care. Assisted living communities should: (1) perform regular, comprehensive person-centered assessments and timely interim assessments; (2) use assessment as on opportunity for information gathering, relationship building, education, and support; (3) approach assessment and care planning with a collaborative team approach; (4) use documentation and communication systems to facilitate the delivery of person-centered information between all care providers; (5) advance care planning is another continuing theme throughout the Recommendations. An early and ongoing discussion of what matters, including values, quality of life and goals of care, are essential for person-centered care. Encourage advance planning to optimize physical, psychosocial, and fiscal well-being and to increase awareness of all care options, including palliative and hospice care.

Medical management is the second new topic area of the Recommendations. Assisted living communities must ensure that: (1) non-physician staff adopt a holistic person-centered approach to care and embrace a positive approach to the support for persons living with dementia and their caregivers that acknowledges the importance of individuals' ongoing medical care to their well-being and quality of life; (2) staff understand the role of medical providers in the care of persons living with dementia and the contributions they make towards a shared vision of care; (3) staff are educated on common comorbidities of aging and dementia and encourage persons living with dementia and their families to talk with the person's physician about how to manage comorbidities in a residential setting; (4) nonpharmacologic interventions

are the first line of treatment in managing behavioral and psychological symptoms of dementia; (5) although nonpharmacological interventions are preferred, there are times when pharmacological treatment may be warranted for behavioral and psychological symptoms; (6) there is an understanding of the general principles for starting and more importantly, ending pharmacological treatments and there must be regular medication reviews to consider the discontinuation of medications when appropriate.

Information, education and support is crucial for persons living with dementia and their care partners. Assisted living communities should: (1) provide education and support early in the disease to prepare for the future; (2) encourage care partners to work together and plan together; (3) build culturally sensitive programs that are easily adaptable to special populations; (4) ensure education, information, and support programs are accessible during times of transition; (5) use technology to reach more families in need of education, information, and support.

A large majority of residents in assisted living need assistance with **Activities of Daily Living (ADLs)**. Assisted living communities should: (1) acknowledge support of ADL function must recognize the activity, the individual's functional ability to perform the activity, and the extent of cognitive impairment; (2) follow person-centered practices when providing support for all ADL needs; (3) when providing support for dressing, attend to dignity, respect and choice; and the dressing environment; (4) when providing support for toileting, attend to dignity and respect the toileting process, the toileting environment, and health and biological considerations; (5) when providing support for eating, attend to dignity, respect and choice the dining environment; health and biological considerations; adaptations and functioning; and food, beverage, and appetite.

Up to 97 percent of persons living with dementia experience at least one **Dementia-Related Behavior**, the most common being apathy, depression, irritability, agitation, and anxiety. Assisted living communities should: (1) identify characteristics of the social and physical environment that trigger or exacerbate behavioral and psychological symptoms for the person living with dementia; (2) implement non-pharmacological practices that are person-centered, evidence-based, and feasible in the care setting; (3) recognize the investment required to implement non-pharmacological practices, including staff training and equipment costs; (4) adhere to protocols of administration to ensure that practices are used when and as needed, and sustained in ongoing care; (5) develop systems for evaluating effectiveness of practices and make changes as needed.

An adequate and well-trained **Workforce** is fundamental to providing quality dementia care. Assisted living communities should: (1) provide a thorough orientation program for new staff, as well as ongoing training; (2) develop systems for collecting and disseminating person-centered information; (3) encourage communication, teamwork, and interdepartmental/interdisciplinary collaboration; (4) establish an involved, care and supportive leadership team; (5) promote and encourage resident, staff, and family relationships; (5) evaluate systems and progress routinely for continuous improvement.

To maintain a strong dementia care workforce assisted living communities should: (1) have staffing levels adequate to allow for proper care at all times — day and night; (2) ensure that all staff be sufficiently trained in all aspects of care, including dementia care; (3) staff should be adequately compensated for their valuable work; (4) staff should work in a supportive atmosphere that appreciates their contributions to overall quality care because improved working environments will result in reduced turnover in all care settings; (5) ensure that staff have the opportunity for career growth. Additionally, we know that consistent assignment is an important component of quality care for staff working with residents with dementia.

A **Supportive and Therapeutic Environment** contributes significantly to the quality of life for persons with dementia. Assisted living communities should: (1) create a sense of community within the care environment; (2) enhance comfort and dignity for everyone; (3) support courtesy, concern, and safety; (4) provide opportunities for choice for all persons; (5) offer opportunities for meaningful engagement to members of the community.

Persons with dementia often have **Transitions** between assisted living and other settings including emergency rooms, hospitals, and nursing homes. Assisted living communities should: (1) prepare and educate persons living with dementia and their care partners about common transitions in care: (2) ensure complete and timely communication of information between, across and within settings; (3) evaluate the preferences and goals of the person with dementia along the continuum of transitions of care; (4) create strong interprofessional collaborative team environments to assist persons living with dementia and their care partners as they make transitions; (5) initiate/use evidence-based models to avoid, delay, or plan transitions of care.

While much of the training for long-term care staff is regulated at the state level, we encourage the Committee to consider proposals that support state health departments in implementing and improving dementia training for direct care workers and their oversight of these activities. Training policies should be competency-based, should target providers in a broad range of settings and not limited to dementia-specific programs or settings, and should enable staff to (1) provide person-centered dementia care based on a thorough knowledge of the care recipient and their needs; (2) advance optimal functioning and high quality of life; and (3) incorporate problem-solving approaches into care practices.

We also urge the Committee to support state dementia efforts in the following ways: (1) any training curriculum should be delivered by knowledgeable staff that has hands-on experience and demonstrated competency in providing dementia care; (2) continuing education should be offered and encouraged; and (3) training should be portable, meaning that these workers should have the opportunity to transfer their skills or education from one setting to another.

Acuity-Based Staffing

Fifty-eight percent of assisted living communities offer programs for residents with Alzheimer's or other dementias, and 19 percent have a dementia care unit. Staffing requirements in long-term care settings providing dementia care vary by the setting and state. Residential care, including assisted living communities, is licensed by the respective state agencies, though most states do not specify minimum staffing levels or ratios in dementia care. Appropriate staffing ratio practices affect the quality of life for those in assisted living communities, especially those living with dementia. However, there is limited research identifying an optimal ratio of staffing.

In residential long-term care settings, staffing is a key driver of quality care. A review of scholarly literature on this subject verifies that there is a clear association between higher levels of licensed staff and higher quality of care. A resident's individual outcomes (including the presence of weight loss, bed sores, and general functional ability), are regularly linked to staffing and there is an association between higher turnover rates and lower quality of care.

Beyond meeting any mandatory staffing numbers required in organizations serving persons with dementia, there is a growing awareness of the need to deploy staff in a manner that aligns with resident routines and needs. A simple staffing ratio, while clear, may not be sufficient to consistently deliver high-quality care. The makeup of the resident population including, for example, the number of people with dementia, should impact the numbers of nursing staff present at any given time. Encouraging the implementation of acuity-based staffing models could improve the quality of care individuals receive in assisted living communities. Acuity-based staffing refers to "the allocation of clinical expertise and caregiver resources necessary to ensure a resident's quality of care/life, based on their medical complexity, ADL dependency, and behavior challenges, as defined by a formal assessment process."

For long-term care communities, developing the appropriate acuity-based nurse staffing levels can be challenging but existing research has provided guidance to inform facilities and policymakers. According to Harrington et. al. (2020), there are five steps to determine sufficient nurse staffing levels: (1) determine the collective resident acuity and care needs; (2) determine the facility's actual per resident per day staffing levels; (3) determine appropriate nurse staffing levels based on resident acuity; (4) identify evidence regarding the adequacy of staffing; (5) analyze the adequacy of facility staffing.

Expanding the Health Care Workforce Serving Older Adults

As highlighted above, while the prevalence of Alzheimer's disease increases, so does the need for well-trained members of the paid dementia care workforce. Shortages in direct care workers in long-term care settings will place an even bigger burden on family and friends who provide unpaid care — already an effort equivalent to nearly $257 billion annually. From 2016 to 2026, the demand for direct care workers is projected to grow by more than 40 percent, while their availability is expected to decline. The United States will have to nearly triple the number of geriatricians to effectively care for the number of people projected to have Alzheimer's in 2050, while efforts to increase recruitment and retention remain slow. In 48 U.S. states, double-digit

percentage increases in home health and personal care aides will be needed by 2028 to meet demand. An estimated 1.2 million additional direct care workers will be needed between 2020 and 2030 — more new workers than in any other single occupation in the United States.

Although more direct care workers will be needed in the years ahead, the long-term care field is already struggling to fill existing direct care positions. Turnover rates are high in this workforce — estimated at 64 percent annually for direct care workers providing home care and 99 percent for nursing assistants in nursing homes — and recruitment and retention are long-standing challenges. In turn, instability in the workforce and understaffing across care settings can lead to stress, injury, and burnout among direct care workers while also compromising care access and quality.

State-Level Actions to Improve Quality Dementia Care

The Committee may find the following state-based efforts instructive, and we would be pleased to provide additional examples at your request.

PENNSYLVANIA
In 2022, skilled nursing facility regulations were updated in Pennsylvania (Regulation No. 10-224 #3343) and require dementia training as part of all staff orientation.

In addition to looking to the states for ways to ensure safe, quality, person-centered care in assisted living facilities, Congress should consider the steps it can take at the federal level, including expanding the necessary workforce and improving dementia training standards and access.

GEORGIA
In Georgia, where there are currently over 150,000 individuals living with Alzheimer's, House Bill 987 (Act 403 of 2020) was enacted, establishing memory care licensure and dementia training for all direct care workers and all other LTC staff in memory care centers. The legislation requires that all Assisted Living Facilities and Personal Care Homes that offer memory care receive a certificate to operate from the Department of Community Health, and it requires the Department of Community Health to establish additional requirements to better serve people with dementia in memory care centers in the areas of (1) admissions, assessment, and care planning; (2) physical settings to accommodate and protect residents; and (3) protocols to prevent elopement.

Further, the legislation requires memory care centers to have at least one dementia-trained direct care staffer for every 12 residents during the daytime and one to 15 overnight (based on a monthly average); that all staff receive four hours of dementia training within their first 30 days of employment including (1) basic education on the process and management of Alzheimer's and other dementias; (2) reducing challenging dementia behaviors; (3) identifying and reducing

safety risks to residents with dementia; and (4) successful communication techniques with individuals with dementia. The legislation also required direct care staff in the memory center to receive at least 16 hours of specialized dementia training within their first 30 days of employment and eight hours of dementia training each year thereafter. The dementia training for direct care staff must incorporate (1) the nature of Alzheimer's and other dementias; (2) the center's philosophy related to the care of residents with dementia; (3) policies and procedures for dementia care; (4) dementia-related behaviors and positive interventions to reduce them; (5) maintaining the safety of the resident; and (6) the role of the family in caring for residents with Alzheimer's and other dementias.

INDIANA

Introduced in 2021, Indiana Senate Bill 169 (Public Law 48 of 2021) requires assisted living facilities that provide memory care services to disclose their dementia-specific care, staffing levels, and transfer/discharge policies. Introduced in 2022, Senate Bill 0353 (Public Law 44 of 2022) establishes dementia training standards for home health aides caring for people with dementia, requiring three hours of annual continuing education on dementia and six hours of initial dementia training for new hires.

Conclusion

The Alzheimer's Association and AIM appreciate the Committee's steadfast support and commitment to advancing issues important to the millions of individuals living with Alzheimer's and other dementia, as well as their caregivers. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance policies that will ensure individuals living with Alzheimer's and other dementia have adequate access to high-quality assisted living and all long-term and community-based care services, especially as the population of Americans living with dementia continues to grow.

ARGENTUM
EXPANDING SENIOR LIVING

January 25, 2024

The Honorable Bob Casey
Chairman
United States Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Braun
Ranking Member
United States Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Casey and Ranking Member Braun:

On behalf of Argentum, the largest national association representing assisted living communities and the older adults and families they serve, thank you for holding this important hearing on long-term care options for older Americans. Approximately 1.4 million seniors reside in assisted living or memory care, and more than 1.6 million individuals work in our communities. Assisted living is critically important to both the residents it serves, and as a solution to the care crisis for our rapidly aging nation.

Assisted living was created to provide seniors with a choice and dignity in care in a residential setting, as opposed to institutional nursing home facilities. Assisted living communities are not nursing homes or institutional care settings. Our communities are individual apartment homes where residents share caregivers who focus on activities of daily living (ADLs), as well as the social determinants of health. Not only is care provided, but our social model promotes restaurant-like nutritious meals, abundant social and educational activities and strong resident engagement. Pets and family involvement are strongly encouraged. Our goal is to assist seniors in living well.

By focusing on the social determinants of health, assisted living provides more of what matters when it comes to helping seniors stay as healthy, happy, and independent as possible. Assisted living consistently receives extremely high customer satisfaction rates from residents and their families, and by helping to lower costs within the health care system, preserves vital resources for public health programs like Medicare and Medicaid and veterans' health.

Caring for an Aging Population

According to the Census Bureau, the U.S. population is aging at the fastest rate in more than a century. Last year, the Bureau reported the highest median age in history, and this trend will only accelerate in the coming years. Today, the average age of an American is 39; by 2100, it will grow to at least 49.[1]

[1] U.S. Census Bureau, *America Is Getting Older*, June 22, 2023 https://www.census.gov/newsroom/press-releases/2023/population-estimates-characteristics.htm

ARGENTUM
EXPANDING SENIOR LIVING

Each day, more than 10,000 Americans turn 65—a trend that will continue as the youngest Baby Boomers reach 65 in the next five years. There are currently 62 million Americans aged 65 and above, accounting for 18% of the population. In just 30 years, 84 million adults 65 and older will make up an estimated 23% of the population. In this same period, the number of centenarians will more than quadruple, from an estimated 101,000 today to roughly 422,000 in 2054. By 2029, there will be more seniors than children for the first time in American history.[2]

The number of Americans needing long-term care will increase as well. Federal data shows that someone turning 65 today has a 70% chance of needing some type of long-term care in their lifetime, 50% will need more extensive care in a skilled nursing facility or assisted living community, and 20% will need it for five years or more. By 2050, the number of Americans requiring paid long-term care will grow to more than 27 million.[3]

According to a study by the National Institutes of Health (NIH), 94% of assisted living residents have at least one chronic condition, while 76% have two or more.[4] A separate study by the Nonpartisan and Objective Research organization (NORC) at the University of Chicago found that the average assisted living resident manages 14 chronic conditions. The most common include Alzheimer's disease and other dementias (42%), heart disease (34%), depression (28%), diabetes (17%) and COPD (15%).[5] By coordinating care and managing these chronic conditions, assisted living communities improve the health and wellbeing of their residents while decreasing the financial strain on the healthcare system.

Assisted Living is the Most Cost Effective Care Model, Saving Families and Health Programs Billions

Compared to other long-term care providers, assisted living offers lower costs, improved quality of life, better health outcomes, and reduced health care costs. The average cost of a private room in a nursing home is $108,405 and $95,000 for a semi-private room. The average cost of a home health aide is $61,776 (based on 40 hours a week) but can reach as much as $235,000 for 24/7 coverage, and does not cover the costs of housing, meals, transportation, or offer socialization, all of which are core components of assisted living. The national average for assisted living is $54,000.[6]

---

[2] Pew Research Center, *U.S. centenarian population is projected to quadruple over the next 30 years*, January 9, 2024 https://www.pewresearch.org/short-reads/2024/01/09/us-centenarian-population-is-projected-to-quadruple-over-the-next-30-years/

[3] U.S. Department of Health and Human Services, *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation*, May 13, 2023 https://aspe.hhs.gov/reports/future-supply-long-term-care-workers-relation-aging-baby-boom-generation

[4] National Institutes of Health, The Impact of Complex Chronic Diseases on Care Utilization Among Assisted Living Residents, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3977595/

[5] NORC at the University of Chicago, Understanding the Health Needs and Spending of Senior Housing Residents https://info.nic.org/hubfs/20220909_NIC%20September%20Conference_FINAL.pd

[6] Genworth Financial, Cost of Care Survey (2021), https://www.genworth.com/aging-and-you/finances/cost-of-care.html

ARGENTUM
EXPANDING SENIOR LIVING

Assisted living preserves vital social safety net programs. Today, Medicaid is the largest payer of long-term care. According to estimates, if assisted living were not an option, as many as 61% of senior residents may be forced into far-costlier skilled nursing facilities at a cost of $43.4 billion. This additional cost would cripple state Medicaid budgets and expedite the potential insolvency of Medicare and Medicaid.

The assisted living care model focuses on the social determinants of health, chronic disease management, social interaction and often facilitates care coordination with other healthcare providers. Though no assisting living facility receives Medicare dollars, this coordinated care, including social and preventative care, keeps seniors healthier and saves Medicare an estimated $15.4 billion through reduced hospitalizations and readmissions, less social isolation, and delay in far costlier skilled nursing care.[7]

The savings are not isolated to just Medicare and Medicaid. In 2021, the Department of Veterans Affairs reported to Congress the critical need for increasing veterans access to different long-term care settings as the high cost and institutional nature care continue to overburden VA budgets. The VA found that veteran placement in a nursing home costs $120,000 annually, compared to only $51,000 in an assisted living community. The report states that providing care at an assistant living community would save almost $70,000 per veteran per year.[8]

The nonprofit Family Caregiver Alliance reports that more than 1 in 6 Americans working full-time or part-time assist with the care of an elderly or disabled family member, relative, or friend, and 70% suffer work-related difficulties due to their dual roles. The survey estimates that 61% of caregivers who work outside the home experience at least one employment change due to their caregiving responsibilities, such as cutting back work hours, taking a leave of absence, or disciplinary actions tied to performance or attendance.[9]

Recent findings estimate that family care giving led to the loss of 656,000 jobs, with an additional 791,000 family caregivers suffering from absenteeism at work. These job losses and absenteeism among family members and informal caregivers have a direct annual economic impact of $43.9 billion, and indirect costs of $221 billion in lost productivity. By easing these burdens, assisted living can improve the financial well-being of families.[10]

Assisted Living Enjoys Consistently High Customer Satisfaction

Assisted living consistently receives very high customer satisfaction ratings. According to the J.D. Power 2023 US Senior Living Satisfaction Survey, senior living communities received a satisfaction score of 837 (on a 1,000-point scale) — higher than industries like travel and

---

[7] Senior Housing News, *Juniper Care Model Could Save Medicare $15 Billion Annually*, https://seniorhousingnews.com/2017/09/24/junipers-care-model-save-medicare-15-billion-annually/
[8] Department of Veterans Affairs, Report to Congress on Long-Term Care Projections, September 2021, https://www.argentum.org/wp-content/uploads/2023/02/VA-Report-To-Congress-FY-2021-CTR-Long-Term-Care-Projections.pdf
[9] Family Caregiver Alliance, *Caregiver Statistics: Work and Caregiving* https://www.caregiver.org/resource/caregiver-statistics-work-and-caregiving/
[10] Blue Cross Blue Shield Association, *The Economic Impact of Caregiving,* November 8, 2021 https://www.bcbs.com/the-health-of-america/reports/the-economic-impact-of-caregiving

ARGENTUM
EXPANDING SENIOR LIVING

hospitality, which received a score of 596.[11] And based on industry surveys, more than 90% of residents report high levels of satisfaction, 85% report high value, 70% report an improved health outlook, and nearly 75% report an improved quality of life. Additionally, 99% feel safe living in their community, and 91% feel safer than living on their own.

Assisted Living Not Immune to Workforce Shortage But Provides Solutions

The United States is currently experiencing a labor shortage, and the senior living industry is no exception. After losing hundreds of thousands of jobs during the pandemic, today, there is a shortage of 400,000 caregivers across all long-term care settings.[12]

While there has been some improvement since the depths of the pandemic, many communities are still facing significant workforce shortages. To recruit and retain staff, more than 90% of assisted living communities are offering higher wages, 70% are offering signing bonuses, and many are having to rely on staffing agencies, which can cost upwards of two, three, or more times as much per hour as full-time employees.[13]

Total employment in the long-term care industry is projected to reach almost 8.3 million by 2040, an increase of some 2.5 million jobs—or 42.1%—from its 2021 employment level of 5.8 million. In addition to the new jobs that will be created, there will be an additional 18 million job openings that result when employees either exit the labor force or transfer to a different occupation. In total, the combined senior care industry will need to fill more than 20.2 million occupational openings by 2040.[14]

The federal government administers successful workforce development programs via the Departments of Labor and Health & Human Services, but there has not been a focus on addressing the care needs of America's seniors. Simply modifying the priorities of these existing workforce programs, such as apprenticeships, to highlight the opportunities and career pathways within senior care would dramatically increase the pipeline of new caregivers.

Argentum has been working with members of Congress on both sides of the aisle to help solve the workforce crisis, and helped pass legislation to help transform existing education and training programs, and to make necessary investments to develop the senior care workforce. The bill provides $285 million to expand workforce opportunities through apprenticeships grants, $65 million for Strengthening Community College Training Grants; and $1.8 billion for Job Corps.

Workforce shortages will not be solved by legislation alone. In 2023, Argentum released a new strategic plan that, in part, seeks to engage, develop, and support 2 million career opportunities in the profession. One way that Argentum is working to address the workforce shortage is to

---

[11] J.D. Power 2023 US Senior Living Satisfaction Survey, November 15, 2023 https://www.jdpower.com/business/press-releases/2023-us-senior-living-satisfaction-study

[12] Argentum, *Workforce Projections for Senior Care Sectors,* March 2023 https://www.argentum.org/argentums-workforce-projections-for-senior-care-report-sees-a-need-to-fill-20-million-job-openings-through-2040/

[13] Leading Age, Workforce Informal Snap Poll: Toplines, https://leadingage.org/wp-content/uploads/2023/03/Workforce-Snap-Poll-Toplines-2023-1.pdf

[14] Argentum, *Workforce Projections for Senior Care Sectors,* March 2023 https://www.argentum.org/argentums-workforce-projections-for-senior-care-report-sees-a-need-to-fill-20-million-job-openings-through-2040/

ARGENTUM
EXPANDING SENIOR LIVING

partner with Job Corps centers to create new senior living programs. There are presently three pilot sites, in Maryland, Kentucky, and Nevada, where students can learn more about the breadth of career opportunities in senior living, covering areas like caregiving and nursing, hospitality and resident service, dining and culinary services, building maintenance and housekeeping, sales, marketing, office support, and management.

This is a unique collaboration that can serve as a blueprint for matching interested Job Corps students to jobs serving senior living communities. There are real career-long pathways for young people in caring for residents in assisted living, memory care, and other senior living settings.

Argentum administers a national Department of Labor apprenticeship program, the Healthcare Apprenticeship Expansion Program that will serve as the framework for including Job Corps students as recipients of the national apprenticeship program. The HAEP collaborative is addressing the skills gap in healthcare and healthcare IT occupations by expanding apprenticeship pathways for positions like CNAs, LPNs, RNs, and rehab technicians, as well as creating new apprenticeship programs for healthcare leadership positions such as nursing directors and executive directors. Argentum and its partners plan to enroll and support over 7,200 apprentices by the end of this year.

It is worth noting that despite recent efforts to set minimum federal staffing standards for long-term care providers, there is no evidence that nationally mandated staffing levels would improve health outcomes. In fact, a 2023 Kaiser Family Foundation report stated that there was "no single staffing level that would guarantee quality care."[15]

Assisted living communities are licensed and regulated in all 50 states. This regulatory framework encourages states to innovate and explore ways to provide cost-effective long-term care at a much more local level than could ever be replicated by one-sized-fits-all federal regulations.

Last year, Argentum, the American Seniors Housing Association (ASHA), LeadingAge, and the National Center for Assisted Living (NCAL), together with the National Association for Regulatory Administration (NARA) formed the Quality in Assisted Living Collaborative to identify, define, and develop model guidance for assisted living. This industrywide initiative is expected to result in greater consistency across states, and the Collaborative's resources will be available to aid and educate providers, regulators, policymakers, and other stakeholders.

Resident Safety

Many Americans prefer to age in place in their own homes, but this is not always the best, or safest option for everyone. Assisted living communities offer dignity and peace of mind to those who can no longer live independently, or that require more assistance than an informal caregiver can provide, which is why surveys find that 91% of residents say they feel safer than living on their own.

---

[15] KFF News, *CMS Study Sabotages Efforts to Bolster Nursing Home Staffing, Advocates Say*, August 29, 2023 https://kffhealthnews.org/news/article/cms-study-nursing-home-staffing-levels/

ARGENTUM
EXPANDING SENIOR LIVING

The Alzheimer's Association estimates that 60% of people living with dementia will wander at least once; many do so repeatedly and without warning.[16] Professionally managed communities have security procedures such as exit/entry logs, wearable tracking devices, and cameras in place to keep residents safe, but assisted living communities are residents' homes and unless an independent physician has deemed them a risk for their own safety, they are free to come and go from their home as they choose.

A recent article by *The Washington Post* examined tragic but isolated incidents of resident elopements. Resident safety is job one, and any fatality is one too many. However, the reporting failed to note just how rare these incidents are. According to the Post's own data, which we have not been able to review or corroborate, 99.97% of assisted living residents never experience a wandering episode like those the article portrays, and fatalities due to wandering represent a small percentage (0.0015%) of the 6.2 million assisted living residents served in the last five years.

The article also failed to note what Argentum told the reporters before publication and in a joint industry letter to the editor with other long-term care providers that the Post declined to publish — nothing is more important than our residents' safety. When protocols and safety procedures are not followed, appropriate disciplinary action should be taken. Argentum strongly supports state regulations already in place to investigate incidents and punish any wrongdoing, up to, and including, community closures, if warranted.

Conclusion

In conclusion, I want to thank you for the opportunity to provide comments for today's hearing. Argentum and its members look forward to working with you and your colleagues to pursue cost-effective solutions to meet the challenges of our rapidly aging population. Please contact Maggie Elehwany, J.D., Argentum Senior Vice President of Government affairs at melehwany@argentum.org with any questions or requests for additional information.

Sincerely,

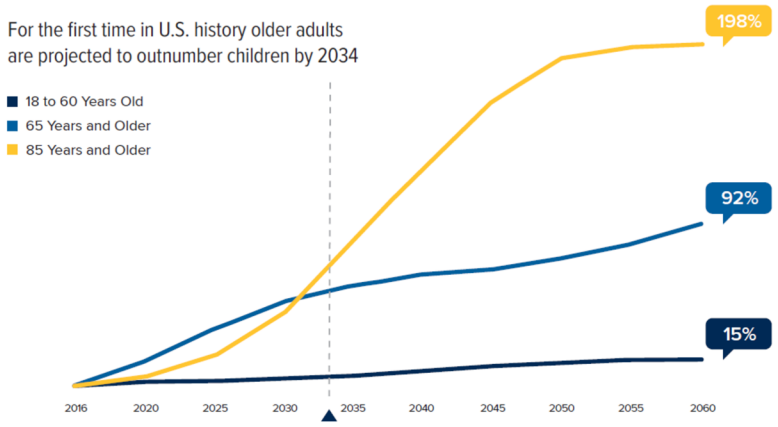
James Balda
President & CEO
Argentum

[16] The Alzheimer's Association, *Wandering*, https://www.alz.org/help-support/caregiving/stages-behaviors/wandering

ARGENTUM
EXPANDING SENIOR LIVING

PROJECTED POPULATION GROWTH BY AGE GROUP, 2016 TO 2060

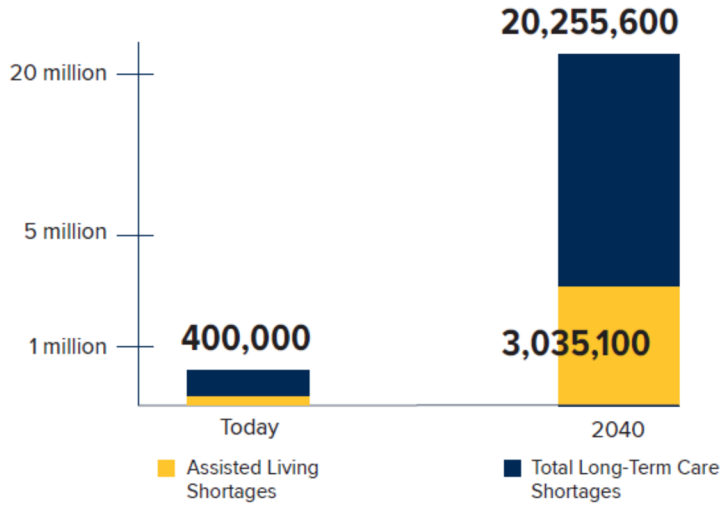
For the first time in U.S. history older adults are projected to outnumber children by 2034



ARGENTUM
EXPANDING SENIOR LIVING

LONG-TERM CARE WORKFORCE CRISIS THROUGH 2040

Severe job shortages will grow exponentially



ARGENTUM
EXPANDING SENIOR LIVING

Senior Living Industry Workforce Projections: 2021 to 2030

State	2021 Jobs	2030 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Alabama	7,400	8,000	600	9,700	10,300
Alaska	1,300	1,500	200	1,800	2,000
Arizona	21,900	26,900	5,000	30,800	35,800
Arkansas	4,300	4,600	300	5,600	5,900
California	93,500	107,900	14,400	127,000	141,400
Colorado	16,900	20,200	3,300	23,400	26,700
Connecticut	10,000	11,300	1,300	13,400	14,700
Delaware	3,300	4,000	700	4,600	5,300
District of Columbia	1,100	1,200	100	1,400	1,500
Florida	62,300	75,100	12,800	86,800	99,400
Georgia	19,400	22,800	3,400	26,600	30,000
Hawaii	2,900	3,300	400	3,900	4,300
Idaho	6,700	8,200	1,500	9,400	10,900
Illinois	34,900	38,400	3,500	46,200	49,700
Indiana	17,600	19,400	1,800	23,300	25,100
Iowa	13,800	15,400	1,600	18,400	20,000
Kansas	14,200	15,900	1,700	19,000	20,700
Kentucky	5,900	6,400	500	7,700	8,200
Louisiana	6,100	6,700	600	8,100	8,700
Maine	5,400	6,000	600	7,200	7,800
Maryland	21,700	24,400	2,700	29,100	31,800
Massachusetts	21,800	25,100	3,300	29,600	32,900
Michigan	31,000	33,800	2,800	40,800	43,600
Minnesota	24,900	28,900	4,000	33,900	37,900
Mississippi	3,700	4,000	300	4,900	5,200
Missouri	13,300	14,500	1,200	17,500	18,700
Montana	3,000	3,400	400	4,000	4,400

State	2021 Jobs	2030 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Nebraska	8,500	9,700	1,200	11,500	12,700
Nevada	4,000	5,000	1,000	5,700	6,700
New Hampshire	4,500	5,100	600	6,000	6,600
New Jersey	21,000	23,900	2,900	28,300	31,200
New Mexico	3,700	4,300	600	5,000	5,600
New York	28,800	32,900	4,100	38,900	43,000
North Carolina	31,300	36,600	5,300	42,800	48,100
North Dakota	2,700	3,000	300	3,600	3,900
Ohio	33,100	35,800	2,700	43,400	46,100
Oklahoma	6,300	6,700	400	8,200	8,600
Oregon	25,000	28,500	3,500	33,700	37,200
Pennsylvania	62,000	68,500	6,500	82,300	88,800
Rhode Island	2,800	3,200	400	3,800	4,200
South Carolina	13,600	16,000	2,400	18,700	21,100
South Dakota	3,300	3,800	500	4,500	5,000
Tennessee	14,100	15,600	1,500	18,700	20,200
Texas	49,700	59,000	9,300	68,500	77,800
Utah	7,800	9,600	1,800	11,000	12,800
Vermont	2,400	2,700	300	3,200	3,500
Virginia	29,200	33,800	4,600	39,700	44,300
Washington	30,400	35,600	5,200	41,600	46,800
West Virginia	3,000	3,200	200	3,900	4,100
Wisconsin	32,100	36,300	4,200	43,100	47,300
Wyoming	900	1,100	200	1,300	1,500

Source: Argentum analysis of data from the Bureau of Labor Statistics

** In addition to the net job growth in the senior living sector, the industry will need to fill job openings that result when employees permanently leave their occupations, either through exiting the labor force or transferring to a different occupation. These are referred to as 'occupational replacement needs.'*

ARGENTUM
EXPANDING SENIOR LIVING

Senior Living Industry Workforce Projections: 2021 to 2040

State	2021 Jobs	2040 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Alabama	7,400	8,800	1,400	21,500	22,900
Alaska	1,300	1,800	500	4,100	4,600
Arizona	21,900	33,700	11,800	73,300	85,100
Arkansas	4,300	5,000	700	12,300	13,000
California	93,500	125,600	32,100	290,700	322,800
Colorado	16,900	24,500	7,600	54,700	62,300
Connecticut	10,000	13,000	3,000	30,400	33,400
Delaware	3,300	4,900	1,600	10,800	12,400
District of Columbia	1,100	1,300	200	3,200	3,400
Florida	62,300	91,600	29,300	203,500	232,800
Georgia	19,400	27,200	7,800	61,700	69,500
Hawaii	2,900	3,800	900	8,900	9,800
Idaho	6,700	10,200	3,500	22,300	25,800
Illinois	34,900	42,700	7,800	103,100	110,900
Indiana	17,600	21,600	4,000	52,000	56,000
Iowa	13,800	17,400	3,600	41,400	45,000
Kansas	14,200	18,000	3,800	42,800	46,600
Kentucky	5,900	7,000	1,100	17,100	18,200
Louisiana	6,100	7,500	1,400	18,100	19,500
Maine	5,400	6,700	1,300	16,100	17,400
Maryland	21,700	27,800	6,100	65,700	71,800
Massachusetts	21,800	29,300	7,500	67,700	75,200
Michigan	31,000	37,100	6,100	90,500	96,600
Minnesota	24,900	34,100	9,200	78,100	87,300
Mississippi	3,700	4,400	700	10,800	11,500
Missouri	13,300	15,900	2,600	38,800	41,400
Montana	3,000	4,000	1,000	9,200	10,200

State	2021 Jobs	2040 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Nebraska	8,500	11,200	2,700	26,200	28,900
Nevada	4,000	6,300	2,300	13,600	15,900
New Hampshire	4,500	5,900	1,400	13,700	15,100
New Jersey	21,000	27,600	6,600	64,400	71,000
New Mexico	3,700	5,100	1,400	11,600	13,000
New York	28,800	38,100	9,300	88,700	98,000
North Carolina	31,300	43,500	12,200	99,000	111,200
North Dakota	2,700	3,400	700	8,100	8,800
Ohio	33,100	39,100	6,000	95,900	101,900
Oklahoma	6,300	7,200	900	17,900	18,800
Oregon	25,000	33,000	8,000	76,800	84,800
Pennsylvania	62,000	76,500	14,500	184,000	198,500
Rhode Island	2,800	3,600	800	8,600	9,400
South Carolina	13,600	19,100	5,500	43,300	48,800
South Dakota	3,300	4,400	1,100	10,200	11,300
Tennessee	14,100	17,500	3,400	41,900	45,300
Texas	49,700	71,200	21,500	159,800	181,300
Utah	7,800	12,000	4,200	26,100	30,300
Vermont	2,400	3,100	700	7,300	8,000
Virginia	29,200	39,700	10,500	91,200	101,700
Washington	30,400	42,400	12,000	96,300	108,300
West Virginia	3,000	3,400	400	8,500	8,900
Wisconsin	32,100	41,500	9,400	97,700	107,100
Wyoming	900	1,300	400	3,000	3,400

Source: Argentum analysis of data from the Bureau of Labor Statistics

** In addition to the net job growth in the senior living sector, the industry will need to fill job openings that result when employees permanently leave their occupations, either through exiting the labor force or transferring to a different occupation. These are referred to as 'occupational replacement needs.'*

ARGENTUM
EXPANDING SENIOR LIVING

Total Senior Care Workforce Projections: 2021 to 2030

State	2021 Jobs	2030 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Alabama	52,300	54,900	2,600	62,700	65,300
Alaska	6,300	7,800	1,500	8,600	10,100
Arizona	92,800	119,300	26,500	128,200	154,700
Arkansas	46,200	48,400	2,200	56,300	58,500
California	964,300	1,209,000	244,700	1,357,600	1,602,300
Colorado	85,700	106,200	20,500	115,600	136,100
Connecticut	80,400	91,900	11,500	103,600	115,100
Delaware	17,300	21,500	4,200	23,300	27,500
District of Columbia	13,200	14,600	1,400	16,500	17,900
Florida	251,500	296,400	44,900	321,200	366,100
Georgia	95,000	111,100	16,100	121,200	137,300
Hawaii	17,200	20,300	3,100	22,500	25,600
Idaho	28,200	35,600	7,400	38,100	45,500
Illinois	204,100	223,300	19,200	254,200	273,400
Indiana	101,100	108,800	7,700	123,300	131,000
Iowa	57,600	62,300	4,700	71,100	75,800
Kansas	57,000	64,100	7,100	73,300	80,400
Kentucky	56,200	59,900	3,700	68,800	72,500
Louisiana	73,100	80,900	7,800	91,500	99,300
Maine	26,200	29,300	3,100	33,700	36,800
Maryland	82,300	92,000	9,700	102,900	112,600
Massachusetts	179,600	215,700	36,100	239,600	275,700
Michigan	127,700	137,900	10,200	157,200	167,400
Minnesota	144,100	171,800	27,700	191,400	219,100
Mississippi	36,800	40,200	3,400	45,600	49,000
Missouri	128,100	140,300	12,200	162,600	174,800
Montana	14,200	16,300	2,100	18,200	20,300

State	2021 Jobs	2030 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Nebraska	31,700	35,100	3,400	39,500	42,900
Nevada	28,700	38,200	9,500	40,500	50,000
New Hampshire	19,900	22,600	2,700	25,400	28,100
New Jersey	137,200	156,700	19,500	173,100	192,600
New Mexico	45,700	56,800	11,100	62,100	73,200
New York	591,500	700,400	108,900	762,500	871,400
North Carolina	132,800	155,500	22,700	170,400	193,100
North Dakota	14,800	15,700	900	17,900	18,800
Ohio	212,900	225,000	12,100	256,100	268,200
Oklahoma	47,400	49,000	1,600	56,300	57,900
Oregon	76,700	91,900	15,200	104,800	120,000
Pennsylvania	320,000	364,200	44,200	416,800	461,000
Rhode Island	19,100	20,900	1,800	23,300	25,100
South Carolina	65,100	78,300	13,200	85,500	98,700
South Dakota	12,600	13,700	1,100	15,400	16,500
Tennessee	85,500	93,900	8,400	106,100	114,500
Texas	498,400	608,200	109,800	644,700	754,500
Utah	33,600	42,100	8,500	45,300	53,800
Vermont	14,400	16,800	2,400	19,100	21,500
Virginia	124,300	147,100	22,800	162,600	185,400
Washington	136,600	173,200	36,600	193,900	230,500
West Virginia	29,300	30,700	1,400	36,000	37,400
Wisconsin	116,100	134,500	18,400	153,800	172,200
Wyoming	6,700	8,300	1,600	9,200	10,800

Source: Argentum analysis of data from the Bureau of Labor Statistics

** In addition to the net job growth in the senior living sector, the industry will need to fill job openings that result when employees permanently leave their occupations, either through exiting the labor force or transferring to a different occupation. These are referred to as 'occupational replacement needs.'*

ARGENTUM
EXPANDING SENIOR LIVING

Total Senior Care Workforce Projections: 2021 to 2040

State	2021 Jobs	2040 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Alabama	52,300	58,600	6,300	136,800	143,100
Alaska	6,300	9,900	3,600	20,700	24,300
Arizona	92,800	160,800	68,000	317,400	385,400
Arkansas	46,200	51,600	5,400	122,800	128,200
California	964,300	1,558,400	594,100	3,285,900	3,880,000
Colorado	85,700	136,100	50,400	278,700	329,100
Connecticut	80,400	108,100	27,700	238,100	265,800
Delaware	17,300	27,900	10,600	56,400	67,000
District of Columbia	13,200	16,400	3,200	37,000	40,200
Florida	251,500	360,200	108,700	750,900	859,600
Georgia	95,000	133,500	38,500	281,800	320,300
Hawaii	17,200	24,700	7,500	52,700	60,200
Idaho	28,200	46,800	18,600	93,000	111,600
Illinois	204,100	249,000	44,900	567,600	612,500
Indiana	101,100	119,200	18,100	272,600	290,700
Iowa	57,600	68,900	11,300	157,900	169,200
Kansas	57,000	73,700	16,700	166,600	183,300
Kentucky	56,200	65,000	8,800	151,500	160,300
Louisiana	73,100	91,400	18,300	205,700	224,000
Maine	26,200	33,400	7,200	76,000	83,200
Maryland	82,300	105,000	22,700	232,600	255,300
Massachusetts	179,600	266,100	86,500	566,000	652,500
Michigan	127,700	151,100	23,400	347,700	371,100
Minnesota	144,100	212,100	68,000	451,500	519,500
Mississippi	36,800	44,400	7,600	101,500	109,100
Missouri	128,100	156,700	28,600	363,700	392,300
Montana	14,200	19,300	5,100	42,000	47,100

State	2021 Jobs	2040 Jobs	Net Job Growth	Occupational Replacement Needs*	Total Employees Needed
Nebraska	31,700	39,600	7,900	89,000	96,900
Nevada	28,700	53,200	24,500	102,500	127,000
New Hampshire	19,900	26,500	6,600	58,200	64,800
New Jersey	137,200	183,300	46,100	396,700	442,800
New Mexico	45,700	73,100	27,400	150,000	177,400
New York	591,500	849,700	258,200	1,783,300	2,041,500
North Carolina	132,800	187,500	54,700	396,700	451,400
North Dakota	14,800	17,000	2,200	39,400	41,600
Ohio	212,900	241,300	28,400	560,100	588,500
Oklahoma	47,400	51,200	3,800	121,500	125,300
Oregon	76,700	113,000	36,300	246,900	283,200
Pennsylvania	320,000	422,000	102,000	951,000	1,053,000
Rhode Island	19,100	23,400	4,300	52,200	56,500
South Carolina	65,100	97,000	31,900	202,200	234,100
South Dakota	12,600	15,100	2,500	34,100	36,600
Tennessee	85,500	105,300	19,800	237,600	257,400
Texas	498,400	766,000	267,600	1,537,700	1,805,300
Utah	33,600	55,100	21,500	110,400	131,900
Vermont	14,400	20,100	5,700	44,300	50,000
Virginia	124,300	179,100	54,800	380,700	435,500
Washington	136,600	226,500	89,900	473,100	563,000
West Virginia	29,300	32,500	3,200	78,200	81,400
Wisconsin	116,100	160,000	43,900	355,800	399,700
Wyoming	6,700	10,500	3,800	22,100	25,900

Source: Argentum analysis of data from the Bureau of Labor Statistics

** In addition to the net job growth in the senior living sector, the industry will need to fill job openings that result when employees permanently leave their occupations, either through exiting the labor force or transferring to a different occupation. These are referred to as 'occupational replacement needs.'*

OHCA
OREGON HEALTH
CARE ASSOCIATION

Oregon's Voice for Long Term Care & Senior Housing

11740 SW 68th Parkway Ste. 250
Portland, OR 97223
Office: (503) 726-5260
www.ohca.com

The Honorable Bob Casey
Chairman
United States Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Braun
Ranking Member
United States Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Casey and Ranking Member Braun:

Oregon Health Care Association (OHCA) is a nonprofit trade association that represents 518 assisted living and residential care providers in Oregon. OHCA has improved the lives of older adults and persons with disabilities in Oregon by advocating for quality care since 1950, and our team of qualified staff works each day to ensure that Oregon remains a leader in providing excellent long term care. Our top priority has always been, and continues to be, a commitment to helping members provide quality care while supporting the staff who provide that care.

Assisted living is highly regulated in Oregon, with regulations governing all aspects of care from pre-admission disclosures to staffing levels and staff training and much more. The regulations reflect Oregon's values and philosophies on providing quality, person-centered care. These regulations are "designed to enhance the dignity, independence, individuality, and decision making ability of the resident in a safe and secure environment while addressing the needs of the resident in a manner that supports and enables the individual to maximize abilities to function at the highest level possible."

Required Disclosure to Promote Transparency

During the recent Senate hearing, testimony was shared that residents and families need to have information to make informed decisions. To promote transparency and informed decision making, Oregon regulations require assisted living facilities to provide potential residents and their family members with different types of disclosure documents prior to move-in. The first is a "Consumer Summary Statement" that is specific to the facility and must address the following components:

- A summary of the services provided by the facility.
- A summary of the services and types of care the facility *does not* provide.
- A statement that, if the facility is not capable of meeting the resident's needs for care and services, the facility may require the resident to move to another facility or care setting, in accordance with applicable regulations.

- A statement explaining that, if a resident leaves the facility to receive acute medical, psychiatric, nursing or other specialized care, the facility will evaluate the facility's ability to meet the resident's care needs before the resident is permitted to return to the facility, in accordance with applicable regulations.

Of equal importance, the Consumer Summary Statement *must be signed* by the resident or the person acting on behalf of the resident to confirm they received the disclosure statement and understand the content and implications of the information shared. The Consumer Summary Statement is also made available to the public through the state licensing agency's website: Oregon Dept of Human Service Consumer Summary webpage.

The second disclosure form is the "Uniform Disclosure Statement," which again is specific to the facility. The "Uniform Disclosure Statement" is concise, but thorough and must address the services offered, whether the cost of those services is included in the base rate or are available at an additional cost, and common questions that residents and/or families may have about operations (e.g., medication administration, typical staffing patterns, staff training, and discharges/move-outs). You can access a copy of this form here: ODHS Uniform Disclosure Statement APD Form 9098A

The third disclosure document is the Residency Agreement, which must be reviewed by the state licensing agency before it can be used with residents and their families. Under Oregon regulations, the Residency Agreement must address:

- Terms of occupancy.
- Payment provisions including the basic rental rate and what it includes, cost of additional services, billing method, payment system and due dates, deposits, and non-refundable fees, if applicable.
- The method for evaluating a resident's service needs and assessing the costs for the services provided.
- Policy for increases, additions, or changes to the rate structure, including but not limited to the minimum requirement that residents be provided 30 days prior written notice of any facility-wide changes to the rates.
- Refund and proration conditions.
- A description of the scope of resident services available.
- A description of the service planning process.
- Additional available services.
- The philosophy of how health care and activity of daily living services are provided to the resident.
- Resident rights and responsibilities.
- The facility's system for packaging medications including the option for residents to choose a pharmacy.
- Criteria, actions, circumstances, or conditions that may result in a move-out notification or intra-facility move consistent with applicable regulations.
- Resident rights pertaining to notification of involuntary move-out.
- Notice that the state licensing agency has the authority to examine resident records as part of the evaluation of the facility.
- The facility's staffing plan.

Staffing to Meet Residents' Needs

Unlike skilled nursing facilities, which provide 24-hour skilled services and medical assistance, assisted living providers provide a wide range of support with activities of daily living in a non-medical, home-like environment. Assisted living residents can be independent with only a need for medication assistance or they can require cueing and direction with personal hygiene as well as assistance with ambulation and transfers. **The population of residents at each assisted living facility is unique and assisted living providers therefore need to assess staffing levels based on the overall needs of its specific resident population at any given time.**

Oregon recognizes that staffing an assisted living facility is an art, not a science because the needs of each resident are unique.

Oregon has an overarching requirement that assisted living facilities must have sufficient staff to "meet the 24-hour scheduled and unscheduled needs of each resident." Assisted living facilities are also required to adopt and implement a technology-based Acuity-Based Staffing Tool (ABST) to help them account for each resident's scheduled needs in determining staffing levels. Based on the resident acuity captured in an ABST and other factors, including but not limited to the facility's physical design, fire safety evacuation standards, and residents who require the assistance of two direct care staff, the facility develops and implements an appropriate staffing plan.

To promote transparency, the facility's staffing plan must be posted in the facility in a public area. Information on a facility's staffing levels is therefore readily accessible and available to potential residents and their families as well as current residents and their families.

Required Dementia Care Training

As previously noted, assisted living providers serve a broad range of residents including some with cognitive impairments or dementia. To invest in our frontline staff and better serve residents in assisted living, **Oregon requires specific dementia care training for all direct care staff.** The training must occur *before* the direct care staff starts providing services to residents and required topics include:

- Education on the dementia disease process, including the progression of the disease, memory loss, and psychiatric and behavioral symptoms.
- Techniques for understanding, communicating, and responding to distressful behavioral symptoms, including, but not limited to, reducing the use of antipsychotic medications for non-standard uses.
- Strategies for addressing social needs of persons with dementia and engaging them with meaningful activities.
- Information concerning specific aspects of dementia care and ensuring the safety of residents with dementia, including, but not limited to, how to:
    - Identify and address pain.
    - Provide food and fluids.
    - Prevent wandering and elopement.
    - Use a person-centered approach.
- Environmental factors that are important to residents' well-being (e.g. noise, staff interactions, lighting, room temperature, etc.).

- Family support and the role the family may have in the care of the resident.
- How to recognize behaviors that indicate a change in the resident's condition and report behaviors that require on-going assessment.

For assisted living providers that are also endorsed memory care communities, *all staff* working in the facility, including those who are not involved with direct care, must complete the pre-service dementia training outlined above. In addition, all of the direct care staff must complete a minimum of sixteen (16) hours of annual training with six (6) of those hours specifically focused on dementia care.

Publicly Available Information on Facilities

As previously noted, every assisted living provider must have a "Consumer Summary Statement" that summarizes the scope of services offered and not offered by that facility, and every facility's "Consumer Summary Statement" is made publicly available through the state licensing agency's website. To further help prospective residents and their families make informed decisions about their care, Oregon's state licensing agency manages a consumer facing website (https://ltclicensing.oregon.gov/) that shares detailed information on each facility, including their licensing status, survey history, regulatory violations as well as the severity of those violations, and any state action that has been taken against the license. This added layer of transparency allows consumers to research the performance history of a facility and make informed decisions prior to moving in.

In conclusion, OHCA thanks you for the opportunity to provide comments. OHCA and our provider members remain committed to pursuing solutions to meet the challenges of our rapidly aging population and to providing the highest level of quality care.

Sincerely,

Phil Bentley
President and CEO
Oregon Health Care Association

To: Senate Aging Committee
From: Health Care Association of Michigan
Date: January 31, 2024

Subject: Testimony in Response to the Senate Aging Committee hearing, "Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults."

The Health Care Association of Michigan represents more than 240 assisted living communities across the state. The association and its members are dedicated to ensuring quality services are provided to seniors and adults residing in our state's assisted living communities.

On January 25, 2024, U.S. Senator Bob Casey (D-PA), Chairman of the U.S. Senate Special Committee on Aging, made several statements during the "Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults" hearing where he questioned whether residents and their families have the information they need to make informed decisions when it comes to assisted living.

In Michigan, assisted living operates under two separate licenses: Adult Foster Care (AFC) and Homes for the Aged (HFA).

In general, a home for the aged (HFA) provides care to persons who are aged 55 or older while an adult foster care (AFC) home can provide care to any adult in need of adult foster care services. Both licenses have disclosure requirements mandating specific information that must be shared with residents and their families.

Both are required to adopt and provide to each resident at admission, and publicly post in the facility, a policy describing the rights and responsibilities of residents. Residents must be treated in accordance with the policy.

HCAM fully supports transparency and ensuring residents can make informed decisions.

LeadingAge Testimony for the Record
U.S. Senate Special Committee on Aging Hearing:
"Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults"
January 25, 2024

Chairman Casey, Ranking Member Braun, and distinguished members of the Senate Special Committee on Aging (the Committee), we appreciate the opportunity to submit written testimony from LeadingAge on your hearing titled, "Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults".

LeadingAge represents more than 5,000 nonprofit aging services providers, and other mission-minded aging services organizations. Alongside our members and 36 state partners, representing 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including serving older adults with complex care needs in assisted living settings.

Most of LeadingAge's members who provide assisted living services do so as one component of multi-service settings. Almost all are nonprofit organizations. In 2020, approximately 17.1% of the nation's assisted living organizations were classified as nonprofit providers.[1] Similar to other long-term care settings, that percentage is trending down.

The Committee's focus today on critical issues in long-term services and supports, and assisted living specifically -- access, quality, staffing, and financing issues – are top concerns of LeadingAge and our members. Quality care in every care setting, including assisted living, is our top priority. In addition, we embrace state efforts to balance the need to protect the safety of residents while maximizing autonomy and providing the highest quality care. This is the goal of assisted living.

We Have No Tolerance for Bad Care

LeadingAge and our nonprofit, mission-driven members are committed to improving quality of care and quality of life for older adults. We make no apology or excuses for poor quality of care; bad performers must improve and there must be accountability for wrongdoing. Every assisted living community should be striving for excellence every day.

We support state systems that provide complete transparency about complaints, their resolution, and quality ratings so that consumers have all the knowledge they need before they move into a residential setting. We do not believe it would be effective to attempt imposing a federal regulation or reporting structure on a set of services that evolved to respond to state and local consumer interest in supportive care – but not nursing care – and a distaste for nursing homes.[2] Multiple models can be successful.

In addition to being an unsuitable fit and the prohibitive costs of a misaligned regulatory overlay, a federal standards and enforcement system for a service that is primarily purchased privately by consumers using their own funds, however limited, will not improve quality. Rather, a federal regulatory system would dramatically halt innovation and drive the best providers out of the field, limiting consumer options just as our aging population needs more, not fewer good providers of care.

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

We would like to use this opportunity to make several key points:

- There is no federal definition of assisted living and minimal federal funding.
- Equity in access is a significant concern and lack of options severely limits the ability of older adults and their families to find the right care for their situations. The vast majority of assisted living spending is by consumers, out of pocket. Only 17.5% of spending is generated from public sources, primarily the state-federal Medicaid program.[3] In addition to inadequate funding, structural barriers in Medicaid hinder access to Medicaid-funded assisted living care.
- Assisted living providers must, above all, provide high-quality, person-centered care and transparent reporting. Providers who consistently offer poor care should not be in business. States should take swift enforcement action to ensure these providers are not allowed to harm seniors.
- Federal investment in the caregiving workforce is needed immediately. This should include training resources, including a focus on dementia care, pipeline programs, and expedited immigration for those willing to move to the U.S. to work in long-term care. The impact of the Biden Administration's nursing home staffing mandate, if implemented as proposed, will reverberate throughout the healthcare system; assisted living providers will compete with others to recruit and retain the limited number of available workers.
- As the population of the country continues to age, there will be fewer family caregivers and increasing older individuals seeking quality residential care they can trust. Families seeking assisted living services and their family members need resources to better understand the options and the costs.
- Assisted living – all long-term care – has costs attached to it. Most older people and their families cannot afford care today and, as time goes on, even more will not have the funds to pay for the help they need. Comprehensive long-term care financing is urgently needed.

We offer recommendations for the Committee's consideration:

- Establish and fund a clearinghouse and technical assistance center to expand knowledge about the wide variety of state approaches to regulating assisted living, evaluate their impact on quality, including consumer satisfaction, and support adoption of the most effective models by states.
- Take steps immediately to expand domestic and international pipelines to increase the pool of committed, qualified people available to deliver care to residents.
- Establish and fund a national resource center for assisted living staff training, including training in dementia care.
- Provide more federal funding through the Department of Health and Human Services' (HHS) Administration on Community Living to support the development of federal and state consumer materials to help people seeking care in assisted living settings that cover: the service offering; complaints reported, resident quality ratings, and the cost of care.
- Take steps to establish a national system to finance long-term care services to ensure that the 50% of people over age 65 who will need paid long-term care before they die have options and financing to cover their care.

The remaining sections of this testimony describe these key points and recommendations in more detail.

States Define and Regulate Assisted Living

Assisted living emerged from a community need for residential places where older people could live safely and relatively independently, with access to care and services if they need them. It had its roots in the belief that a non-medical, non-nursing home setting was missing – with the goal of providing options for people who needed some support they could not easily get in their home in the community, but less than the more intensive care provided by nursing homes.

Absent common agreement on the definition of assisted living, multiple models have continued to evolve based on what developers and providers have offered and states have regulated.[4] The HHS/Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) spent years creating a very basic definition for the purpose of conducting what is now known as the residential living component of the National Post-Acute and Long-Term Care Survey (NPALS), the only federal source of national data on assisted living.

That definition includes "a care setting regulated by states to provide room and board to 4 or more residents, at least 2 meals a day, around the clock supervision, and help with personal care to a predominantly adult population." Using those parameters, NCHS identified 28,900 communities across the U.S. in 2020, serving just under 1 million people. However, there is enormous variation across models that are offered and regulated, with extensive inconsistency in the balance of medical and social models.

While that diversity promotes innovation and consumer-responsive models, it also makes it challenging to agree on minimum components and regulatory requirements. Over the past three decades, as assisted living has become more widely offered across the country, there have been calls for federal regulations similar to the approach used in nursing homes.

With more than 50 different definitions and regulatory approaches and very little federal (or even public) funding, it is unclear how the federal government would define assisted living.

One particular concern is that attempts to impose federally mandated staffing ratios could force closures of many assisted living communities. The wide diversity of models in the cluster of communities under the rubric of assisted living means that there will never be one "right" staffing ratio.

A federal regulatory system aimed at the minority of "bad actors" will be ineffective and inefficient. Targeting punitive policy interventions to the lowest common denominator has not achieved its intended goal of quality improvement; there's little reason to believe similar efforts in assisted living would be successful. Most LeadingAge members say that providers who routinely do not protect the safety of residents should not be offering assisted living (or any) services to older people.

Finally, the CMS-state nursing home survey enterprise – that must reach the country's 15,000 nursing homes - is suffering terribly from both the same staffing challenges faced in long-term care settings, with long delays, and inadequate state-federal funding.

LeadingAge partners with the National Association for Regulatory Administration (NARA) and three other associations to create the Quality in Assisted Living Collaborative (QALC), to identify, define, and develop model guidance for assisted living. The Collaborative's resources will be available to aid and educate providers, regulators, policymakers, and other stakeholders.

Recommendations:

- ***Congress should establish and fund a clearinghouse and technical assistance center to expand knowledge about the wide variety of state approaches to regulating assisted living, evaluate their impact on quality, including consumer satisfaction, and support adoption of the most effective models by states.***
- ***Members of the Committee might want to review the work of the Quality in Assisted Living Collaborative (the NARA collaborative work). Provider organizations are working together to identify a set of recommended guidelines for states to consider adopting. They are beginning with guidelines related to infection prevention and control.***

Consumers Do Not Consistently Have the Information They Need About Services Offered, Costs, Quality Reporting and Transparency

Individuals looking for an assisted living community for themselves or a loved one are already in a stressful position. They should have access to all the information they need, including the total cost of housing, care, and services. If there are going to be additional costs, consumers should know this up front. Recent articles in the media have highlighted stories of consumers caught unaware by unanticipated added costs.

The information available to consumers in some states includes complaints that have been made and how they have been resolved. To help consumers make good decisions, transparency about staffing, ownership and complaints is essential. LeadingAge supports efforts in a number of states to maintain online reporting of complaints and some consumer ratings of quality.

Recommendation:

- ***Provide more federal funding through the HHS Administration on Community Living to support the development of federal and state consumer materials to help people seeking care to understand what they are being offered, complaints reported, resident quality ratings, and the cost of care before they move in.***

Staff are Paramount to Quality: The Workforce Shortage Limits Access to Good Care

Successful aging services organizations employ enough staff to meet their commitment to provide high quality care. Like the entire field of aging services and most other industries in the nation, assisted living providers face near-paralyzing shortages of staff, particularly frontline, direct service staff (e.g., personal care aides), dining, and activities. In organizations (and states) that require nurses, the nursing shortage is clearly felt across assisted living communities.

Members of LeadingAge report that as many as 20% of vacant positions go unfilled, with no applicants. Because they are mostly nonprofit, mission focused providers, they limit admissions if they do not have staff to serve people.

In an environment with unemployment rates consistently below 3%, aging services providers compete with retail, restaurant, and entertainment venues, where entry level employees can earn as much or more per hour for work that is typically less taxing and less complex.

It is gratifying that many workers in LeadingAge organizations argue that aging services jobs are more rewarding than other similarly paid positions. However, it is essential to understand that the skills, abilities, knowledge, and commitment required to work in assisted living settings should also be more highly valued. LeadingAge member communities report holding frequent conversations and town meetings with residents to connect monthly costs to staff wages.

An article in the January 21 Washington Post reported that teenage workforce participation has reached a 14 year high.[5] Many LeadingAge provider members have joined with local high schools and community colleges to invite young workers, early in their careers to check into jobs available in long-term care. Many seasoned leaders in long-term care tell stories of starting in aging services in their teen years. These provider school partnerships require dedication, but they also require the formal attention of policymakers and funding. The Health Resources Services Administration's training programs are limited in scope and reach. We need more as well as dedicated funding for the aging services workforce, including for assisted living staff.

Many aging services providers, again, like other industries, faced with an economy that typically has 1.5 jobs for every available job seeker, turn to other countries to recruit and hire staff. For a few select professional categories (including nurses), the U.S. immigration system offers some legal pathways to employment. However, these visa programs are difficult and expensive to navigate, require the coordination of at least three federal departments, and LeadingAge members report delays of anywhere from two to ten years.

There are no such opportunities for frontline workers in jobs that do not require at least a bachelor's degree. Yet, one in four direct care workers in the U.S. were born in other countries.[6] These individuals have mostly come to the United States as part of a family ("chain migration"). LeadingAge members report that they are some of the most dedicated staff members, and, in fact, the best recruiters, often bringing relatives and friends into the organization too.

The U.S. immigration system is broken at a time when we cannot fill jobs with native born workers. There are not enough people to fill the jobs, much less qualified, committed people. Policymakers frequently fall into the false assumption that issues with illegal border crossing and legal immigration are two separate issues. Expert observers note that to fix illegal border crossing issues we must fix the root cause, our outdated legal immigration system.

Recommendations

- ***Take steps immediately to expand domestic and international pipelines so there are more committed, qualified people available to deliver care to residents.***
- ***Modify current immigration authorities to expedite processing of applications for workers in aging and long-term care settings.***
- ***Establish new immigration channels for frontline workers.***
- ***Promote refugee resettlement program partnerships with aging services provider organizations.***

Ongoing Evidence Based Training is Inconsistent

Just as service definitions, staffing requirements, and regulations differ from state to state and across provider organizations, training and minimum qualifications vary as well. As they serve more and more people with increasingly higher levels of need, assisted living communities require more highly skilled professionals—with a range of skill sets, from clinical care to "soft skills" needed for delivery of

activities of daily living. The latter are developed over time and are more difficult to measure based on a universal standard.

As noted earlier in this testimony, individuals entering positions in assisted living must be well trained, using evidence-based methods, in a wide array of essential skills. They must receive continuous, ongoing in-service training to expand their skills and keep up with rapidly changing demands, needs, and knowledge.

Extensive training materials are available for frontline staff but many providers, especially smaller, single site organizations, are confused by the offerings. There are no tried and true ways to evaluate which work and in what settings. Which are evidence based? Marketers may stretch the underlying science to sell a training product. There is no neutral party to help providers select the best training.

In addition, training programs can be costly and out of reach for many smaller providers, particularly those who depend more heavily on Medicaid dollars and serve residents with lower incomes.

Further, onerous and outdated requirements for certified nurse aide programs make it exceedingly difficult to launch and sustain direct care training programs.

At the same time training enables staff members to increase their value to the organization – and their ability to provide even better care and services to residents – wages and job opportunities must keep pace or individuals will leave to seek better positions where they can keep growing.

Competitive wages are critical to recruiting and retaining direct care staff who work in long term care, including assisted living. Our Making Care Work Pay research, using publicly available data and standard economic simulation techniques, demonstrates that higher wages would bring myriad benefits to direct care workers, the direct care field, care recipients, and local communities—for a relatively modest cost.

Increased wages are one of several changes needed to recruit and retain a stable direct care workforce in long-term care, including assisted living.

Recommendations

- ***Establish and fund a national resource center for assisted living staff training, including training in dementia care.***
- ***Review the LeadingAge LTSS Center @UMass Boston publication "Feeling Valued" Vision for Professionalizing the Direct Care Workforce, which offers strategies for reimagining the professional direct care workforce across long-term care settings.***
- ***Create a national training curriculum and testing program for direct care workers.***

Most Americans Cannot Access Care Because They Cannot Afford It

Assisted living is one of the few care settings in which government reimbursement through either Medicare or Medicaid is not the most common payer. Assisted living is almost exclusively out-of-pocket, private pay. Medicare does not cover long-term care, including assisted living services. Medicaid can cover the services offered in an assisted living but cannot pay for the room and board components of meals or shelter. But fewer than half of assisted living providers accept any Medicaid funds because the rates simply do not cover the cost of care.

It is not surprising that 90% of residents in assisted living identify as white, non-Hispanic, while the Census bureau reports that two-thirds of Americans identify with this racial group. Access to all long-term care depends on the ability to pay. The inequities in assisted living are especially stark.

By 2033 there will be more people in the United States over the age of 65 than under the age of 18. While lower income people are losing years of expected high quality life, wealthier Americans are gaining in life expectancy, further increasing disparities.

Half of Americans turning 65 will need some amount of paid long-term care before they die, typically 18 months to 2.5 years. The average cost of care in assisted living is $4,500 per month, or $54,000 annually.[7] Few Americans plan for a healthy retirement let alone for the possibility or likelihood that they will need to also pay for long-term care.

When Medicare was created in 1965, most individuals did not live much past the age of 65. If they did and they required help, many more family members were available to provide that help, along with a place to live. Churches and other nonprofit community organizations filled in for those without caregivers.

Today, people are living much longer, they have fewer caregivers, and many more organizations exist to serve them. But few people can afford the care they need -- only the very wealthy, with sufficient out of pocket resources and those with incomes and resources low enough to qualify for Medicaid. This situation exacerbates equity concerns.

Aging services – long-term care – is an essential part of health care and, like the rest of health care, it has a price tag. Long-term care financing reform is essential – to ensure that all Americans are able to have choices about how and where they get the help that many of them will need in their later years. As a nation we committed in 1965 to not allowing older people to impoverish themselves and lose years of life because they cannot pay for the health care they need. It is long past time for bold policymakers to finish making good on the commitment.

Recommendation

- ***Take steps to establish a national system to finance long-term care services to ensure that the 50% of people over age 65 who will need paid long-term care before they die have options and financing to cover their care. The various public and public-private options have been identified and discussed for decades. Bold policymakers must step up and take action.***

Medicaid Barriers Impede Equitable Access to Care

For the 17.5% of assisted living care that is covered by Medicaid, there are additional, unique challenges. In 48 states, assisted living is provided as a Medicaid service, typically under a waiver, but it is considered a home and community-based service.[8] Unlike nursing home care, it does not cover room and board, which must come out of Social Security/SSI. Reimbursement for Medicaid funded assisted living makes it a challenging service to offer – this financial challenge combined with regulatory barrier contributes to the dearth of options available.

As a home and community-based service, assisted living services must be delivered in a manner that is person centered, optimizes community integration, and protects residents according to requirements outlined in the “HCBS Settings” or “Olmstead” rule. They include, for example, restrictions about locked doors and outings into the community. The requirements of the settings rule

have been open to interpretation by state agencies and, in many cases, make it nearly impossible to provide assisted living under Medicaid, leading to even more concerns about equity in access and quality -- some members have reported a chilling effect on their state's willingness to offer Medicaid funded assisted living or expand the availability.

Recommendation

- ***Congress should authorize and appropriate funds to study policy barriers to states offering Medicaid assisted living including funding and the settings rule and other existing regulations. The report should offer policy options to expand the availability and viability of Medicaid funded assisted living.***

CONCLUSION

Chairman Casey, Ranking Member Braun, and members of the Committee, LeadingAge appreciates this opportunity to provide written testimony for the January 25 hearing on assisted living and we stand ready to introduce you to our nonprofit, mission driven provider members across the country. If you would like to meet or discuss issues raised in this written testimony or any other long-term care or aging services related issues, please contact Ruth Katz, Senior Vice President for Policy and Advocacy (rkatz@leadingage.org).

[1] Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics' National Post-acute and Long-term Care Study (NPALS) Table 1, as accessed at https://www.cdc.gov/nchs/npals/webtables/overview.htm on January 23, 2024.
[2] Sheryl Zimmerman, Philip D. Sloane, Definition and Classification of Assisted Living, *The Gerontologist*, Volume 47, Issue suppl_1, December 2007, Pages 33–39, as accessed at https://doi.org/10.1093/geront/47.Supplement_1.33 as accessed on January 23, 2024.
[3] Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics' National Post-acute and Long-term Care Study (NPALS) Table 1, as accessed at https://www.cdc.gov/nchs/npals/webtables/overview.htm on January 23, 2024.
[4] Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics' National Post-acute and Long-term Care Study (NPALS) Table 1, as accessed at https://www.cdc.gov/nchs/npals/webtables/overview.htm on January 23, 2024.
[5] Bhattarai, Abha, and Lauren Kaori Gurley, "Gen Z is Bringing Back the Part-time Job," *The Washington Post*, January 21, 2024, as accessed at https://www.washingtonpost.com/business/2024/01/21/teen-jobs-pandemic-wages/?utm_campaign=mb&utm_medium=newsletter&utm_source=morning_brew on January 23, 2024.
[6] Espinoza, Robert. "Immigrants and the Direct Care Workforce", PHI, June 2017, as accessed at www.phinational.org/wp-content/uploads/2017/06/immigrants_and_the_direct_care_workforce_-_phi_-_june_2017.pdf on January 23, 2024.
[7] Genworth, Cost of Care Survey, as accessed at https://www.genworth.com/aging-and-you/finances/cost-of-care.html on January 23, 2024.
[8] Government Accountability Office. (2018). *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed.* (GAO Publication No. 18-179). Accessed at www.gao.gov/assets/690/689467.pdf on January 23, 2024.

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

SPECIAL REPORT

An Illusion of Protection: Meaningless Federal "Quality Measures" Endanger Assisted Living Residents

FEBRUARY 2024

Eric Carlson, Director, Long-Term Services and Supports Advocacy

How can older Americans have confidence in the quality of Medicaid-funded assisted living? Federal policy points to assisted living performance measures, but, as demonstrated in this report, those measures are of little use to consumers or anyone else.

Through a public records request and subsequent lawsuit, Justice in Aging obtained California's "performance measure" data from the state's Medicaid assisted living program. The data demonstrate deep problems in both federal and state Medicaid policies. Under government policy, assisted living quality measures don't measure assisted living or quality.

Specifically, California administers 18 assisted living performance measures, but none provide useful information about the care received by assisted living residents. Many of the measures are trivial — for example, a finding of perfect performance based on the one participating home health agency maintaining its licensure each year. Also, because all of the data are aggregate, none of the measures distinguish between individual facilities.

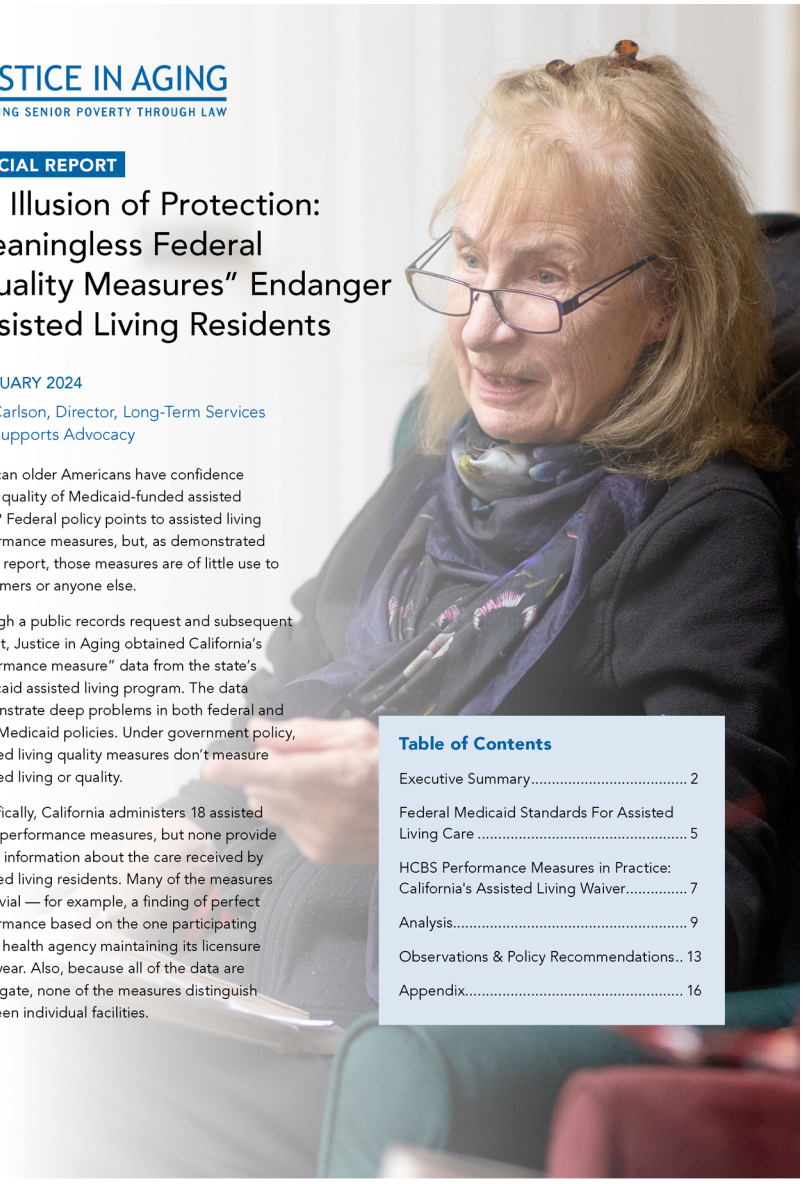


Table of Contents

EXECUTIVE SUMMARY

As demonstrated by California's Assisted Living Waiver (ALW), federal assisted living quality measures are largely ineffectual.

Under federal law, a state Medicaid program can use a home and community-based services (HCBS) waiver to cover at-home personal care and certain facility-based care, including assisted living. HCBS coverage is open only to those persons with significant care needs — specifically, persons who need the equivalent of nursing facility care.

Federal HCBS protocols require the state to monitor HCBS waiver program quality through performance measures. These performance measures focus primarily on the actions of agencies administering the waiver, and are not designed to measure quality of care or identify the better service providers.

Under the federal protocols, performance scores are expressed through percentages; a score of 85% or less requires a state to conduct appropriate remediation activities. States choose their own performance measures and may see easy-to-meet performance measures as the path of least resistance.

Using the HCBS waiver authority, California operates an Assisted Living Waiver (ALW) that covers care provided in assisted living facilities and, less commonly, certain other settings. The ALW currently funds assisted living services for roughly 12,000 participants, with another 3,000 persons (approx.) on a waitlist.

As detailed in this report, California's ALW provides a striking example of the inherent flaws in the federal performance measures system. In general, the performance measures provide little value to anyone — not federal or state governments, not assisted living facilities and other service providers, not facility residents, and not the general public.

ALW performance measures are kept from the public.

Across the country, assisted living waiver performance measures generally are not available to the public. In California, the California Department of Health Care Services (DHCS) does not post its ALW performance measure information on its website, or otherwise make the information available to the public. Accordingly, in December 2021, Justice in Aging submitted a public records act request to DHCS for information related to ALW performance measures. DHCS failed to comply with the request for over a year, finally turning over documents only after Justice in Aging filed a lawsuit in December 2022.

ALW performance measures are virtually worthless.

The information eventually turned over by DHCS covers the three-year period from March 2019 through February 2022. The information indicates that DHCS administers 18 performance measures within the ALW. These 18 measures are comprised of:

- **Seven** easy-to-satisfy measures with purported 100% compliance;
- **Six** case-file-review measures with suspiciously identical results;
- **Two** measures based on facilities meeting basic licensure and in-service training requirements;
- **One** faulty measure; and

- **Two** potentially useful measures relating to payment processes.

Overall, the measures provide little to no value. Consistent with federal protocols, as discussed above, the measures focus heavily on agency performance rather than provider quality. Five of the measures supposedly evaluate quality in some fashion: three of those look only at qualifications, i.e., licensure, while another merely records whether the provider offered in-service training. The fifth measure purportedly documents whether services were delivered in accordance with the service plan, but the results from that measure are drawn from a dubious case review process discussed below.

In general, few of the measures seem to offer any insight as to how DHCS might improve the ALW. Many of the measures are designed to be easy, with perfect or near-perfect performance virtually guaranteed. For example, one measure records whether participating home health agencies retained provider qualifications, i.e., licensure, during the year. Because only one home health agency participates in the ALW, and that agency was licensed for all three years, this measure yielded a 100% score for each year.

Similarly, a related measure considers whether facilities held licenses when they were accepted for participation during the year. Again, not surprisingly, the measure recorded a 100% score for each year, since licensure is a minimal threshold requirement for provider enrollment.

Six measures involve case review, and for each of these six measures the case review produced the exact same result: compliance in 26 of 27 reviewed files in the first year, compliance in all 75 reviewed files in the second year, and compliance in 478 of 483 reviewed files in the third year. Such lockstep results suggest strongly that review was cursory, compliance was virtually automatic, and noncompliance was found only when a file was unavailable or compromised in some way.

Finally, none of the performance measures are useful in distinguishing between providers. For many other types of health care providers, Medicare's Care Compare website provides data that allow for comparison of one provider to others. Such provider-specific information can be extremely useful — for example, for a consumer choosing a provider, or an inspector looking for potential quality of care problems. The ALW's performance measures, however — like all HCBS performance measures, under federal protocols — aggregate data across the entire state.

Federal and state governments should reorient HCBS performance measures towards usefulness and transparency.

Current federal procedures prescribe HCBS performance measures largely as a means of tracking a state's performance, rather than the performance of individual providers. As described in this report, California's ALW performance measures fall short in their current state-procedure-focused objective. Also, of course, they provide no information whatsoever regarding individual providers.

California is not an outlier. Many performance measure problems stem from federal procedures, and many states' performance measures have problems similar to California's.

The federal government should reorient HCBS performance measures to focus on quality of care rather than administrative processes. When possible, measures should distinguish between individual providers; this is particularly true for assisted living facilities and other residential facilities, since they are more likely to be larger. Similarly, measures as appropriate should be stratified based on participant characteristics including care needs, race, and

gender, in order to facilitate identification and reduction of care disparities.

Also, federal standards should require true transparency. All performance measure information must be made available in a timely fashion on the internet, in a format reasonably accessible to consumers.

Most importantly, the federal government should reset the approach to performance measures to focus on real-world usefulness. Mediocre performance measures represent both a poor use of resources and a lost opportunity to improve care.

California should make similar changes, i.e, evaluate performance of individual providers (including assisted living facilities), make information public and accessible, and reorient performance measures towards real-world usefulness. California has stated its intent to reevaluate the entire ALW in the near future, making this a particularly favorable time in which to consider performance measure revisions.

FEDERAL MEDICAID STANDARDS FOR ASSISTED LIVING CARE

Medicaid can pay for assisted living care through Home and Community-Based Services waivers.

Federal Medicaid law does not provide an "assisted living" benefit comparable to Medicaid's coverage of (for example) hospital care or nursing facility care. Instead, if a state Medicaid program wishes to cover assisted living care, the state in most cases proceeds through a federal waiver – most commonly, a Home and Community-Based Services (HCBS) waiver. HCBS waivers are frequently used to cover personal care assistance provided in a participant's house or apartment, but they also can be used to cover care in certain residential facilities, including assisted living. The waiver pays for care services while the participant retains financial responsibility for room and board expenses. Provision of the Medicaid-funded services is guided by a service plan developed with the participant's involvement.[1]

An HCBS waiver is intended to provide an alternative to nursing facility care; accordingly, each participant must have care needs significant enough to qualify them for nursing facility care. On the financial side, a state HCBS program at a minimum must demonstrate cost neutrality, i.e., that the cost of waiver services does not exceed the cost that would have been incurred had the participant received nursing facility care rather than HCBS. Notably, HCBS waivers allow a state to limit the number of participants and, when a program is at full capacity, place applicants on waitlists for potentially months or years.[2]

A state applies for an HCBS waiver through a form application developed by the Centers for Medicare & Medicaid Services (CMS). Original approval is granted for up to three years, while renewals may extend for five years.[3]

States must report "performance measure" percentage data to support assurances made to federal government.

As a condition of an HCBS waiver, a state Medicaid program must provide CMS with formal assurances that "necessary safeguards" (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services."[4] In implementing this requirement, CMS requires specific assurances of state compliance in six specified areas. In addition, for each of these six assurances, CMS requires one or more specific subassurances to better flesh out compliance realities, with a total of 16 subassurances:

1. Administrative authority (1 subassurance);
2. Level of care determinations (2 subassurances);
3. Provider qualifications (3 subassurances);
4. Waiver service plans (4 subassurances);
5. Health and welfare (4 subassurances); and
6. Financial accountability (2 subassurances).[5]

To document compliance with subassurances, the state devises and administers "performance measures" (subject to CMS approval) to measure

whether the waiver program is meeting assurances. The performance measures are expressed in a percentage, with a percentage score of 86% or above considered satisfactory. If a performance measure yields a score below 86%, the state must implement a remediation plan to address the situation.[6] For this reason, a state has an incentive to use performance measures that will produce scores above 85%, in order to avoid the additional work of developing, implementing, and documenting a remediation plan.

As an example of the HCBS performance measure system, consider the Level of Care assurance, in which the state assures the federal government that the state implements waiver-designated processes and instruments for evaluating whether participants' care needs would qualify them for nursing facility services. In the two associated subassurances, a state must assure CMS that 1) all applicants receive a level of care evaluation; and 2) waiver-designated processes and instruments are appropriate to determine participant level of care needs. In California's assisted living waiver (as discussed below), these subassurances are monitored through two corresponding performance measures: 1) the percent of new participants whose initial level-of-care determination was performed by a registered nurse from a care coordination agency; and 2) the percent of determinations in which specified processes and instruments were used appropriately in determining participants' level of care needs.

As demonstrated in these examples, current performance measures focus primarily on the actions of agencies administering the waiver, and are not designed to distinguish between individual providers or identify disparities in care. The measures do little or nothing to help a consumer choose a provider, direct inspectors to potential instances of substandard care, or support quality improvement projects by individual providers.

CMS IS PROPOSING FUTURE CHANGES TO HCBS PERFORMANCE MEASURES

In July 2022, CMS released a new HCBS Quality Measure Set. Although use of the Quality Measure Set (QMS) is voluntary at this time, CMS stated its intention to incorporate the QMS into HCBS reporting requirements.[7]

The QMS includes 97 separate performance measures. Almost half of these measures relate to current HCBS waiver assurances, either Waiver Service Plans (29 measures), or Health and Welfare (14 measures). The remaining measures address access (15 measures), rebalancing state programs away from institutional care (6 measures), and community integration (including compliance with the recently-implemented federal regulations to promote non-institutional practices and environments) (33 measures).[8]

HCBS PERFORMANCE MEASURES IN PRACTICE: CALIFORNIA'S ASSISTED LIVING WAIVER

California utilizes HCBS waiver authority to cover assisted living care.

California offers coverage of assisted living care through a Medicaid HCBS waiver called the Assisted Living Waiver (ALW).[9] The vast majority of ALW participants live in Residential Care Facilities for the Elderly (RCFEs), which is California's licensing term for assisted living facilities. Many fewer ALW participants live in Adult Residential Facilities (ARFs), which are licensed to care for persons under age 65. ALW participants may also reside in publicly subsidized housing, with services provided by home health agencies, but this slice of the ALW participant population is extremely small: ALW approval has been extended only to eight publicly subsidized housing sites and one home health agency.[10]

The ALW operates in only 15 counties, mostly in urban areas.[11] Within these counties, 686 individual facilities are approved for ALW participation, with an aggregate capacity of approximately 27,000.[12] The ALW, however, due largely to the state-set enrollment cap, had an August 2023 enrollment of only 11,657, with a waitlist of 3,032 applicants.[13]

California monitors Assisted Living Waiver with eighteen performance measures.

As discussed above, federal performance measure protocols focus on waiver program operations, rather than care quality. CMS requires state Medicaid programs to issue assurances and subassurances, and then to use corresponding performance measures to document compliance. California's Department of Health Care Services (DHCS) monitors the ALW with eighteen separate performance measures. Most of the performance measures relate to service plans (five measures), provider qualifications (four), or health and welfare (four). Two measures relate to level of care determinations, and another two measures relate to financial accountability. A final measure relates to administrative authority.

Not surprisingly, the ALW's subassurances and 18 performance measures track the 16 subassurances required by CMS. The "extra" two performance measures are attributable to DHCS using three separate performance measures for the providers-are-qualified subassurance (+two) and two separate performance measures for the service-plan-revision subassurance (+one), while not using a performance measure for an unlicensed provider subassurance (-one) (because the ALW does not utilize unlicensed providers).[14]

Details about the ALW performance measures, including three years of data, are set forth in a table in the Appendix. The table includes assurances, subassurances, performance measures, and the data related to those measures. The data were obtained from DHCS pursuant to a public records act request.

CALIFORNIA'S PERFORMANCE MEASURES FOR ASSISTED LIVING WAIVER

1. Percent of applications from care coordination agencies that resulted in agency being enrolled into program.
2. Percent of level-of-care determinations performed by registered nurse.
3. Percent of level-of-care determinations conducted appropriately.
4. Percent of enrolled home health agencies that maintained provider qualifications.
5. Percent of enrolled facilities qualified to provide waiver services.
6. Percent of enrolled facilities that did not allow licensure or certification to lapse.
7. Percent of enrolled providers that held mandatory in-service training for staff.
8. Percent of waiver service plans that reflect participant's needs.
9. Percent of waiver service plans submitted within ten days of assessment's completion.
10. Percent of participants with reassessments whose services plans were revised to address changed needs.
11. Percent of participants with services delivered in accordance with waiver service plan.
12. Percent of participants offered choice between waiver services and nursing facility care.
13. Percent of Serious Incident Reports involving abuse, neglect or exploitation.
14. Percent of resolved cases among reported cases of abuse, neglect or exploitation.
15. Percent of waiver service plans that do not call for restraints or seclusion.
16. Percent of reviewed cases indicating that state monitored overall health care standards.
17. Percent of participants enrolled prior to claim submission.
18. Percent of claims coded and paid in accordance with reimbursement methodology.

California currently is applying to renew Assisted Living Waiver.

The ALW's current five-year term expires on February 29, 2024, and DHCS currently is preparing an application for another five-year renewal. DHCS circulated a draft waiver application for public comment; the comment period ended on October 5, 2023.

The draft waiver application proposes to retain 12 of the 18 performance measures, but does not mention the other six measures — ## 3, 10, 12, 14, 15 & 16. It is unclear if these omissions are meant to be permanent or, on the other hand, the omissions just reflect the application's draft status.[15]

Most likely, DHCS does not at this point intend to delete the six measures, many of which may be needed to meet CMS-required subassurances. In a bullet-point "Major Changes" introductory section to the draft application, DHCS simply lists "Updated Performance Measures." In accord, a DHCS e-mail to stakeholders stated that it intended only minor changes in this draft application.[16]

ANALYSIS

Performance measures do not measure provider quality.

Few of the 18 performance measures actually relate to the quality of Medicaid-certified providers. And for those few that do relate at least somewhat to quality, the data from the performance measures are generally unimportant or unrevealing.

Specifically, only five of the performance measures purport to evaluate provider quality in some way:

- #4. Percent of enrolled home health agencies that maintained provider qualifications.
- #5. Percent of enrolled facilities that were qualified to provide waiver services.
- #6. Percent of enrolled facilities that did not allow licensure or certification to lapse.
- #7. Percent of enrolled providers that held mandatory in-service training for staff.
- #11. Percent of participants with services delivered in accordance with waiver service plan.

> “Few ALW performance measures relate to quality, and data from those few measures are generally unimportant or unrevealing.

The first three of these are trivial: in each case, the measure is simply whether the provider met basic prerequisites for participating in the ALW. The data reflect the measure's triviality. For measures #4 and #5, DHCS reports a measure of 100% for each of the three reported waiver years, while measure #6 yields similarly high results: 98.95%, 96.67% and 98.45% for waiver years 1 through 3, respectively.

Performance measure #7 — the percent of providers that conducted mandatory in-service trainings — also has little relationship to care actually provided. Again, DHCS reports high percentages — 99.48%, 96.67% and 98.45% for waiver years 1 through 3 — but those high percentages say more about the measure's triviality than quality of care.

Performance measure #11 theoretically could relate to quality, based on the measure's description, but data and other contextual information indicate that the measure actually has little value. The measure is comprised of the percent of participants with services delivered in accordance with the waiver service plan — notably, results are based solely on facility case file reviews. DHCS reports the following results:

- **Year #1**: 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year #2**: 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year #3**: 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Although at first glance these high percentages are attractive, further examination reveals these data to be hollow. Review simply was not designed to truly determine whether participants received needed services. Data were drawn merely from reviewing facility case files, and not from any independent inquiry or interview with program participants. Also, review only included a small percentage of participant case files.

Most significantly, the reported data indicate that case review was extremely cursory. The three bullets above list the ***EXACT*** three-year results not only for measure #11, but also for measures ## 8, 9, 12,

15, and 16.* For each of those six measures, in a review of a total of 585 files, reviewers evidently found perfect compliance in Year #2, and one and five instances of noncompliance, respectively, in Years ## 1 and 3. This suspicious data pattern indicates that 1) reviewers accepted almost any level of documentation as proof of compliance for the six performance measures at issue; and 2) six files were either missing or severely compromised, leading to the limited findings of noncompliance in Years ## 1 and 3.

Thus, measure #11 has little to say about whether participants actually received adequate services. Compliance evidently was virtually guaranteed by measure #11's design and implementation, except in the rare instances when a file was unavailable or compromised.

Case review is not meaningful.

As discussed immediately above, the data indicate that ALW case review is perfunctory. A full six measures — measures ## 8, 9, 11, 12, 15, and 16 — produced ***EXACTLY*** the same results: compliance in 26 of 27 reviewed files reviewed in Year #1, in all 75 reviewed files in Year #2, and in 478 of 483 reviewed files in Year #3.

Under CMS procedures, these high percentages — 96.30% to 100% compliance — supposedly indicate strong performance, e.g., that service plans reflected a participant's needs (measure #8), participants were given a choice between waiver services and nursing facility services (#12), and the state monitored overall health care standards (#16). The lockstep nature of the results, however, indicates that neither the case review process nor the data are meaningful. As a practical matter, the data suggest that reviewers found compliance whenever a case file was available and intact. Then, in the rare instances in which a file was unavailable or compromised for some reason, the reviewer found noncompliance for each of the six relevant performance measures, leading to identical percentages for each of the measures.

> “The six measures based on case review had identical results, suggesting that review was cursory, finding compliance whenever a case file was intact.

This conclusion — that purported "case review" is not meaningful — is reinforced by consideration of measure #15, which is the percentage of waiver service plans not calling for restraints or seclusion. In fact, the ALW prohibits restraints or seclusion, making it even more likely that a finding of non-compliance is due to the lack of an intact case file, rather than a service plan calling for an explicitly prohibited intervention.[17] Also, this measure is trivial like many of the "perfect compliance" measures discussed immediately below, since a perfect or near-perfect score is virtually guaranteed.

"Perfect" compliance indicates that measures are not meaningful.

For obvious reasons, trivial performance measures lead to "perfect" or near-perfect scores. DHCS reported three-year 100% compliance for 7 of the 18 performance measures (## 1, 2, 3, 4, 5, 10 & 14). This report already has discussed measures ## 4 (qualified home health agencies) and 5 (qualified

* Measures ## 8, 9, 12, 15 & 16 are, respectively: "waiver service plans that reflect participant's needs," "waiver service plans submitted within ten days of assessment's completion," "participants offered choice between waiver services and nursing facility care," "waiver service plans not calling for restraints or seclusion," and "reviewed cases indicating that state monitored overall health care standards."

> “Supposed "perfect" compliance for over 20,000 level of care determinations and over 1,000 service plans suggests that "in compliance" findings were virtually automatic.

facilities). Here are the other five instances in which DHCS reported 100 percent compliance over the three relevant years:

- **Measure #1**: 15 of 15 applying care coordination agencies enrolled in ALW during relevant years.
- **Measure #2**: 7,541 of 7,541 level-of-care determinations performed by a registered nurse, as required by program standards.
- **Measure #3**: 20,236 of 20,236 level-of-care determinations in which processes and instruments were used appropriately.
- **Measure #10**: 1,020 of 1,020 waiver service plans in which service plans were revised to address changed needs.
- **Measure #14**: 0 of 0 cases in which reports of abuse, neglect or exploitation were resolved.

Measure #1 is trivial, merely reflecting the fact that applications from care coordination agencies were processed. Measure #2 also is relatively trivial, since the ALW requires that all level-of-determinations be performed by a registered nurse. As a measure of performance, this measure makes little more sense than evaluating surgical performance by considering whether the surgeon graduated from medical school.

Measures ## 3 and 10 also are not meaningful. A careful evaluation of level-of-care determinations (measure #3) or service plans (#10) would require time and professional judgment. But clearly, as a practical matter, no such judgment was applied to 20,236 level-of-care determinations and 1,020 waiver service plans. Instead, all evidence suggests that the relevant computer programs generated “in compliance” findings as a matter of course.

The final instance of “perfect” compliance, measure #14, is an odd situation in which DHCS reached 100% compliance by dividing zero by zero. The genesis of the zero was the absence of any substantiated reports of abuse, neglect and/or exploitation in Serious Incident Reports. Measure #14 is described by DHCS in a confusing way (see Appendix), but the desired “performance” seems to be the percentage of relevant cases resolved. The absence of incidents of abuse, neglect and/or exploitation resulted in a numerator and denominator of zero for all three years, which DHCS logged as 100% compliance.

(Also troubling is the absence of any substantiated instances of abuse, neglect or exploitation from over 5,000 Serious Incident Reports during the relevant three-year period.)

The only potentially meaningful performance measures relate to payment processes.

This report thus far has discussed all measures but three: measures ## 13, 17 & 18. Measure #13, relating to Serious Incident Reports, had a faulty design; as a result, DHCS could not collect relevant data.

Measures ## 17 and 18 each relate to payment: the percent of participants who were enrolled prior to submission of claims (#17), and the percent of claims coded and paid for in accordance with reimbursement methodology (#18). Performance

over the three years ranged from 93.7% to 99.7% for each of the measures. It may be that these two measures are of some use to DHCS in evaluating current payment procedures. Notably, however, these two measures have almost nothing to say about quality of care and waiver participants' lives.

SUMMARY OF PERFORMANCE MEASURES

18 Performance Measures:

- **Seven** easy-to-satisfy measures with purported 100% compliance (## 1, 2, 3, 4, 5, 10 & 14)
- **Six** case-file-review measures with suspiciously identical results (## 8, 9, 11, 12, 15 & 16)
- **Two** measures based on facilities meeting basic licensure and in-service training requirements (## 6 & 7).
- **One** faulty measure (#13)
- **Two** potentially useful measures relating to payment processes (## 17-18)

Performance measures are aggregate across California, and do nothing to identify strong or weak providers or disparities in care.

In many health care settings, performance measure data are stratified by provider. Provider-specific data can be used by state agencies to identify problems, and by consumers to choose a provider. Most prominently, Medicare's Care Compare website includes provider-specific data for eight categories of providers, including physicians, hospitals, nursing facilities, and hospice care agencies.[18]

Additionally, health care data often are stratified by patient populations — for example, to distinguish between care needs, gender, race, age, sexual orientation, primary language, and other characteristics. Analysis of these data can identify disparities in care and aid both policymakers and providers in addressing those disparities.

HCBS waiver performance measures, however, are aggregated across an entire state and, as discussed above, focus primarily on waiver program operations themselves. Accordingly, the ALW performance measures do not distinguish between individual providers even though, in some cases, the performance measures themselves are based on actions of RCFEs (performance measures ## 5-7), home health agencies (#4), and care coordination agencies (## 2 & 3). Because of the data's aggregate nature, the measures provide none of the utility that Care Compare offers to policymakers, providers and consumers, and do not allow for comparison of urban and rural settings, large and small facilities, or other provider classifications.

Likewise, aggregate ALW performance measures have little value in identifying participant-to-participant care disparities. Even assuming useful data, aggregation prevents DHCS and CMS from making distinctions between (for example) men and women, and participants of various ethnicities, or with differing care needs. And, of course, the inability to identify disparities makes it impossible to diagnose and then rectify the problems.

Performance measures are kept secret within federal and state government.

DHCS keeps ALW performance measure information entirely private, aside from mandatory reports to CMS. This privacy sharply limits performance measures' potential usefulness. Even if, for example, performance measures included comparative information about individual providers, that information provides little benefit

if participants and other members of the public are kept in the dark.

The current no-disclosure status quo is not accidental, as demonstrated by DHCS's refusal to comply with a relevant public records act request. Through the California Public Records Act, Justice in Aging requested the ALW performance measure information from DHCS on December 14, 2021.[19] In response, over the following year, DHCS did not provide a single document, despite numerous communications from Justice in Aging including, in June 2022, a draft of a public records act complaint that could be filed against DHCS. Never during this period did DHCS claim that the information was exempt from production; instead, aside from sporadic communications, the state simply refused to comply.

Ultimately Justice in Aging filed a public records act case against DHCS on December 8, 2022.[20] Shortly thereafter, on January 3, 2023, DHCS began providing the requested information.

> “
> California did not provide requested information until being sued under the state public records act.

OBSERVATIONS & POLICY RECOMMENDATIONS

If not the first, this report represents one of the few investigations into HCBS performance measures as actually implemented by states. For a variety of reasons, HCBS performance measures have flown largely under the radar, outside a small group of government officials and academics.

This lack of attention has not been healthy for public policy, as demonstrated by the performance measures discussed in this report. Simply put, California's ALW performance measures appear to provide little value to anyone. This state of affairs has been allowed to develop and continue in California and across the country because the performance measure mechanism is entirely invisible to anyone outside government.

The status quo represents a tremendous wasted opportunity. DHCS has many strong reasons to monitor ALW performance; also, information about the ALW and its service providers could be useful to consumers and other stakeholders, and stratification by participant population would assist DHCS in identifying and addressing care disparities. But the current ALW performance measure system does not appear to meet the needs of government, consumers or anyone else. Instead, performance measures are calculated solely to fulfill bureaucratic requirements, with negligible interest in using performance measures as they are intended — to identify problems and improve public policy.

Notably, this critique applies not only to California, but also to CMS and to the other states operating assisted living waivers and other HCBS waivers. Across the country, the reality of performance measures falls far short of their potential.

Federal Policy Recommendations

In fairness to DHCS, it should be noted that the overall approach to HCBS performance measures is largely set by the federal government. As described above, federal guidance requires that performance measures focus on six specific areas: administrative authority, level of care determinations, provider qualifications, waiver service plans, health and welfare, and financial accountability. Overall, the federal guidance calls for a system that monitors

waiver programs themselves, rather than (for example) waiver service providers.

As a result, many of the shortcomings in ALW performance measures are largely attributable to federal policy. This report criticizes the ALW for not measuring provider quality and, by using only aggregate data, not distinguishing between individual providers. Each of these criticisms is best laid at the feet of CMS: the federal HCBS performance measure system is not designed to evaluate individual providers and, by focusing on aggregate agency-level measures within ALW operations, DHCS has merely implemented federal policy.

As discussed above (see page 5), CMS recently announced a new Quality Measure Set that includes 97 separate performance measures.[21] Critique of those 97 measures is beyond the scope of this report, but review of the CMS-related guidance indicates that it largely does not address the issues identified in this report.

Five overarching recommendations address many issues raised in this report:

1. Monitor individual provider performance.

First, CMS should consider how to monitor performance of individual HCBS providers, including assisted living facilities. Such monitoring, accompanied by extensive data sharing on the Care Compare website, is an accepted and prominent part of CMS policy towards hospitals, physicians, nursing facilities, and other federally-certified providers. Implementation of this recommendation should take into account the relatively small size of many HCBS providers.

2. Improve quality monitoring of residential facilities.

Second, and relatedly, CMS should consider how to best monitor HCBS-funded residential facilities (e.g. assisted living facilities). Overall, most HCBS waiver participants receive services in their own houses and apartments; the residential facility waivers are relative outliers. Many performance measures may be relevant for at-home care but not for facility-based care, or vice versa.

CMS review of this issue also should consider strategies beyond performance measures. Currently, both CMS and state Medicaid agencies have little control over assisted living standards and quality. CMS routinely accepts a state Medicaid agency's assurances that residents' health and welfare is safeguarded, and then treats the matter as settled. Furthermore, the state Medicaid agency likewise may have little control over assisted living, since state assisted living licensing standards generally will be developed and enforced by a different state agency. Particularly given the recent federal regulations to promote non-institutional practices and environments in HCBS-funded settings (see p. 6), CMS can no longer maintain what has largely been a hands-off posture towards monitoring and maintaining quality in federally-certified assisted living facilities. CMS should take a more proactive approach, which will require CMS to both set and enforce standards, and to build up the policy infrastructure to make those efforts possible.

3. Use performance measures to address health care disparities.

Third, CMS should expand the scope of performance measures as appropriate to capture resident-specific information including care needs, gender, race, age, sexual orientation, primary language, and other characteristics. CMS and states can use these data to identify disparities in care and then develop strategies to address those disparities.

4. Make performance measure information available to public.

Fourth, states must be required to make up-to-date performance measure information readily available

to the general public, in an accessible format. CMS generally touts transparency as an essential piece in data-driven improvement strategies.[22] Particularly compared to the extensive public-facing data available on Care Compare, current HCBS performance measures are strikingly non-transparent, to the extent in this case that litigation was necessary to extricate performance measure information from the state.

5. Reorient performance measures towards actual policy improvements.

Fifth, CMS should change the orientation of HCBS performance measures to focus more on actual policy improvements. CMS purportedly utilizes a continuous quality improvement cycle in which discovery leads to remediation, which leads to improvement, which leads to design, which leads again to discovery, whereupon the process continues.[23] Needless to say, data from the California ALW give little indication of any such a quality improvement orientation, and CMS complacency is suggested both by the ALW performance measures themselves, and by the process-over-content nature of the relevant DHCS-CMS communications.[24]

California Policy Recommendations

As noted, the current five-year ALW approval will end on February 29, 2024, and DHCS currently is preparing an application for another five-year renewal. In an e-mail to stakeholders, DHCS announced a two-phased approach: an initial renewal application with only minor changes, followed by "a subsequent amendment that will comprehensively address the suggestions raised by stakeholders."[25]

All of the federal recommendations above apply also to California: use performance measures to distinguish between individual providers including assisted living facilities, monitor assisted living quality, use performance measures to address disparities, make performance measure information easily accessible, and change the orientation of performance measure programs to focus on actual policy improvements.

The most needed change is an organizational attitude adjustment towards the performance measure process. The current performance measures seem to be of little use to anyone, and the public measure information is unavailable to the public.

Now is the time for a reset on ALW performance measures, given both the new federal Quality Measure Set and DHCS's stated intention to "comprehensively address" stakeholder suggestions in the ALW Renewal's second phrase. As an initial, necessary step in that reset, CMS should convene a stakeholder session for an honest discussion of the current system and the possibilities for reform.

APPENDIX

The performance measure data from the table below are taken largely from the DHCS report entitled "California State Medicaid Agency Oversight of the Assisted Living Waiver," which is part of a document that DCHS in the footer identifies as CA-0431.R06. The "Oversight" report begins on page 5 of the larger document, which begins on the first page with the California Home and Community-Based Assisted Living Waiver: Waiver Fact Sheet. Citations within the table refer to this report as the "Oversight Report."

In the case of performance measures ## 1, 5, 6, 7, 14, 17 & 18, data from the Oversight report subsequently were modified by CMS's Final Report, Home and Community-Based Services Review, California Assisted Living Waiver, Control #CA-0431.R06, dated February 28, 2023. Citations within the table refer to this report as the "Final Report."

The Final Report includes redacted material on pages 23, 24 and 27. DHCS made those redactions prior to turning over the Final Report, on the grounds that the redacted information pertains to technical details of the State's computer systems, and disclosure of that information could jeopardize system security.

Performance Measures for California's Assisted Living Waiver

March 2019 through February 2022

- **Year 1:** March 2019 – February 2020
- **Year 2:** March 2020 – February 2021
- **Year 3:** March 2221 – February 2022

ADMINISTRATIVE AUTHORITY

ASSURANCE
State retains ultimate administrative authority over waiver program, and administration of waiver program is consistent with waiver application.

▶ **SUBASSURANCE**
Medicaid agency retains ultimate administrative authority by exercising oversight of other governmental and contracted agencies.

PERFORMANCE MEASURE #1	PERFORMANCE MEASURE #1 RESULT: 100%
Percent of complete applications from care coordination agencies that resulted in DHCS enrolling the agency in the waiver program within the waiver year.	» **Year 1:** 5 of 5 applying agencies enrolled. » **Year 2:** 9 of 9 applying agencies enrolled. » **Year 3:** 1 of 1 applying agencies enrolled. Data from Final Report, p. 7.

LEVEL OF CARE DETERMINATIONS

ASSURANCE
State implements waiver-designated processes and instruments for evaluating whether participants' care needs would qualify them for nursing facility services.

SUBASSURANCE
All applicants receive level of care evaluation, if there is reasonable indication that applicant may need waiver services in the future.

PERFORMANCE MEASURE #2

Percent of new participants whose initial level-of-care determination was performed by a registered nurse from a care coordination agency. (The waiver requires that these initial determinations be performed by registered nurses.)

PERFORMANCE MEASURE #2 RESULT: 100%

- **Year 1:** 2,078 of 2,078 participants.
- **Year 2:** 2,475 of 2,475 participants.
- **Year 3:** 2,988 of 2,988 participants.

Data from Oversight Report, p. 11.

SUBASSURANCE
Waiver-designated processes and instruments are appropriate to determine participant level of care needs.

PERFORMANCE MEASURE #3

In determining participant's level-of-care needs, percent of determinations in which specified processes and instruments were used appropriately.

PERFORMANCE MEASURE #3 RESULT: 100%

- **Year 1:** 5,643 of 5,643 participants.
- **Year 2:** 6,782 of 6,782 participants.
- **Year 3:** 7,811 of 7,811 participants.

Data from Oversight Report, p. 14.

PROVIDER QUALIFICATIONS

ASSURANCE
State has designed and implemented an adequate system to ensure that waiver service providers are qualified.

SUBASSURANCE
Providers initially and continually meet licensure/certification standards and other state standards.

PERFORMANCE MEASURE #4

Percent of enrolled home health agencies that maintained provider qualifications.

PERFORMANCE MEASURE #4 RESULT: 100%

- **Year 1:** 1 of 1 home health agencies.
- **Year 2:** 1 of 1 home health agencies.
- **Year 3:** 1 of 1 home health agencies.

Data from Oversight Report, p. 16.

PROVIDER QUALIFICATIONS—CONTINUED

PERFORMANCE MEASURE #5

Percent of facility providers qualified to provide waiver services, of providers enrolled during the waiver year.

PERFORMANCE MEASURE #5 RESULT: 100%

- **Year 1:** 74 of 74 enrolled facility providers.
- **Year 2:** 110 of 110 enrolled facility providers.
- **Year 3:** 176 of 176 enrolled facility providers.

Data from Final Report, p. 14.

PERFORMANCE MEASURE #6

Percent of enrolled facility providers that did not allow licensure and/or certification to lapse, of providers that received onsite monitoring reviews during the year.

PERFORMANCE MEASURE #6 RESULT: 96.67% TO 98.95%

- **Year 1:** 98.95%; 189 of 191 facilities with onsite reviews.
- **Year 2:** 96.67%; 29 of 30 facilities with onsite reviews.
- **Year 3:** 98.45%; 190 of 193 monitoring reviews.

Data from Final Report, p. 15.

▸ SUBASSURANCE

Provider training is conducted in accordance with waiver requirements.

PERFORMANCE MEASURE #7

Percent of enrolled providers that held mandatory in-service training for staff.

While reporting data, DHCS announced its intention going forward to modify the performance measure to the following: Percent of enrolled facility providers that held mandatory in-service training for staff, of providers that received onsite monitoring reviews during the year.

PERFORMANCE MEASURE #7 RESULT: 96.67% TO 99.48%

- **Year 1:** 99.48%; 190 of 191 providers.
- **Year 2:** 96.67%; 29 of 30 providers.
- **Year 3:** 98.45%; 190 of 193 providers.

Data from Oversight Report, p. 22, as modified by Final Report, p. 16.

WAIVER SERVICE PLANS

ASSURANCE

State has adequate system for viewing service plan adequacy.

▸ SUBASSURANCE

Service plans address all participants' assessed needs and personal goals.

PERFORMANCE MEASURE #8

Percent of participants with a waiver service plan that reflected the participant's needs, based on the assessment, clinical records, and participant's personal preferences, as determined through review of a subset of participant case files.

PERFORMANCE MEASURE #8 RESULT: 96.30% TO 100%

- **Year 1**: 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2**: 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3**: 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, pp. 25-26.

WAIVER SERVICE PLANS—CONTINUED

▶ SUBASSURANCE
Service plans are revised at least annually and when warranted by changes in participant's needs.

PERFORMANCE MEASURE #9
Percent of waiver service plans submitted within ten days of completing participant's assessment.

PERFORMANCE MEASURE #9 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, p. 29.

PERFORMANCE MEASURE #10
Percent of participants with reassessments whose waiver service plans were revised to address changed needs.

PERFORMANCE MEASURE #10 RESULT: 100%
- **Year 1:** 116 of 116 participants with reassessments.
- **Year 2:** 322 of 322 participants with reassessments.
- **Year 3:** 582 of 582 participants with reassessments.

Data from Oversight Report, p. 31.

▶ SUBASSURANCE
Services are delivered in accordance with service plan.

PERFORMANCE MEASURE #11
Percent of participants with services delivered in accordance with waiver service plan.

PERFORMANCE MEASURE #11 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, pp. 33-34.

▶ SUBASSURANCE
"Participants are afforded choice between/among waiver services and providers."

PERFORMANCE MEASURE #12
Percent of participants offered choice between waiver services and nursing facility care.

PERFORMANCE MEASURE #12 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, pp. 35-36.

HEALTH AND WELFARE

ASSURANCE
State has an effective system for ensuring participant health and welfare.

▶ SUBASSURANCE
State "identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death."

PERFORMANCE MEASURE #13

Percent of Serious Incident Reports involving abuse, neglect or exploitation.

(While reporting data, DHCS announced its intention going forward to modify the performance measure so that it would measure the percent of Serious Incident Reports resolved during a waiver year.)

PERFORMANCE MEASURE #13 RESULT: 0%

DHCS did not have the necessary data to calculate this performance measure.

Data from Oversight Report, pp. 37-38.

▶ SUBASSURANCE
Incident management system effectively resolves incidents of abuse, neglect and exploitation, and prevents further similar incidents to the extent possible.

PERFORMANCE MEASURE #14

"Percent of cases [from Serious Incident Reports] reviewed with documentation [care coordination agency] has recognizing instances of abuse, neglect or exploitation with the participant/other responsible person reflecting resolution."

This performance measure evidently documents the percentage of resolved cases among cases of abuse, neglect or exploitation.

(While reporting data, DHCS announced its intention to develop a statewide system that allows for inter-departmental information sharing on critical incidents.)

PERFORMANCE MEASURE #14 RESULT: 100%

100% reported, but based on no relevant incidents. A state data report states: "For Waiver Years 1 & 2, there were about 3,000 incident reports submitted to DHCS. However, none of the reported incidents yielded substantiated claims for abuse, neglect, and/or exploitation."

- **Year 1**: 100% reported; 0 of 0 cases (1671 cases overall).
- **Year 2**: 100% reported; 0 of 0 cases (1,336 cases overall).
- **Year 3**: 100% reported; 0 of 0 cases (2,108 cases overall).

Data from Oversight Report, pp. 39-40, as modified by Final Report, pp. 22-23, 26-27.

HEALTH AND WELFARE—CONTINUED

▸ SUBASSURANCE
State policies and procedures for use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

PERFORMANCE MEASURE #15
Percent of waiver service plans that do not call for restraints or seclusion.

PERFORMANCE MEASURE #15 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, p. 42.

▸ SUBASSURANCE
State establishes overall health care standards and monitors those standards based on service providers' responsibility under waiver.

PERFORMANCE MEASURE #16
Percent of reviewed cases indicating that state monitored overall health care standards.

PERFORMANCE MEASURE #16 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, p. 44.

FINANCIAL ACCOUNTABILITY

ASSURANCE
State has designed and implemented adequate system for insuring financial accountability.

▸ SUBASSURANCE
Claims are paid for services rendered in accordance with waiver's reimbursement methodology.

PERFORMANCE MEASURE #17
Percent of participants who were enrolled prior to submission of claims.

PERFORMANCE MEASURE #17 RESULT: 91.9% TO 99.7%
- **Year 1**: 93.7%; 5,239 of 5,594 participants.
- **Year 2**: 91.9%; 6,151 of 6,686 participants.
- **Year 3**: 99.7%; 7,727 of 7,749 participants.

Data from Final Report, p. 31.

FINANCIAL ACCOUNTABILITY—CONTINUED

▶ SUBASSURANCE
Payment rates follow approved rate methodology.

PERFORMANCE MEASURE #18	PERFORMANCE MEASURE #18 RESULT: 93.7% TO 99.7%
Percent of claims coded and paid for in accordance with reimbursement methodology.	» **Year 1:** 93.7%; 138,892 of 139,342 claims. » **Year 2:** 93.7%; 159,337 of 159,878 claims. » **Year 3:** 99.7%; 210,807 of 211,446 claims. Data from Final Report, p. 31.

ENDNOTES

1 *See 42 U.S.C.* § 1396n(c) (federal statutory authority for HCBS waivers); 42 C.F.R. § 441.301(c)(2) (person-centered service plans).

2 *See 42 U.S.C.* § 1396n(c).

3 42 C.F.R. § 441.304(a), (b); CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria (Version 3.6, January 2019).

4 42 U.S.C. § 1396n(c)(2)(A).

5 CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria, at 10-11 (Version 3.6, January 2019).

6 CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria (Version 3.6, January 2019); CMS, Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers (March 12, 2014).

7 CMS, Home and Community-Based Services Quality Measure Set, SMD #22-003 (July 21, 2022).

8 42 C.F.R. § 441.301(c)(4) (non-institutional practices and environments); CMS, Home and Community-Based Services Quality Measure Set, SMD #22-003 (July 21, 2022).

9 Approved Application for Assisted Living Waiver (effective March 1, 2019 through Feb. 29, 2024).

10 Cal. Health & Safety Code §§ 1569- 1569.889 (RCFEs); Cal. Welf. & Inst. Code § 14132.36 (ALW); 22 Cal. Code Regs. §§ 85000- 85187 (ARFs), 87100- 87795 (RCFEs); DHCS, Assisted Living Waiver Program Public Subsidized Housing Facilities (accessed Oct. 16, 2023).

11 Department of Health Care Services, Assisted Living Waiver (accessed Oct. 8, 2023).

12 DHCS, Assisted Living Waiver (ALW) Program Participating Facilities (aggregate numbers calculated by Justice in Aging based on DHCS information current as of March 10, 2023).

13 California Dep't of Health Care Services, Integrated Systems of Care Division, Assisted Living Waiver (ALW) Year to Date Enrollment and Waitlist January 2019 through August 2023.

14 CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria, at 10-11 (Version 3.6, January 2019); *see also Appendix.*

15 The draft waiver was available on the DHCS website while the comment period was open. A copy is on file with Justice in Aging.

16 DHCS e-mail to stakeholders, Home and Community Based Services Waiver Update (Sept. 22, 2023) (on file with Justice in Aging).

17 Approved Application for Assisted Living Waiver, at Appendix G-2.

18 Care Compare, https://www.medicare.gov/care-compare/.

19 *See Cal. Public Records Act, Cal. Gov't Code,* §§ 7920.000- 7931.000.

20 *Justice in Aging v. California Department of Health Care Services*, 22STCV38340 (Superior Ct., Los Angeles County).

21 CMS, Home and Community-Based Services Quality Measure Set, SMD #22-003 (July 21, 2022).

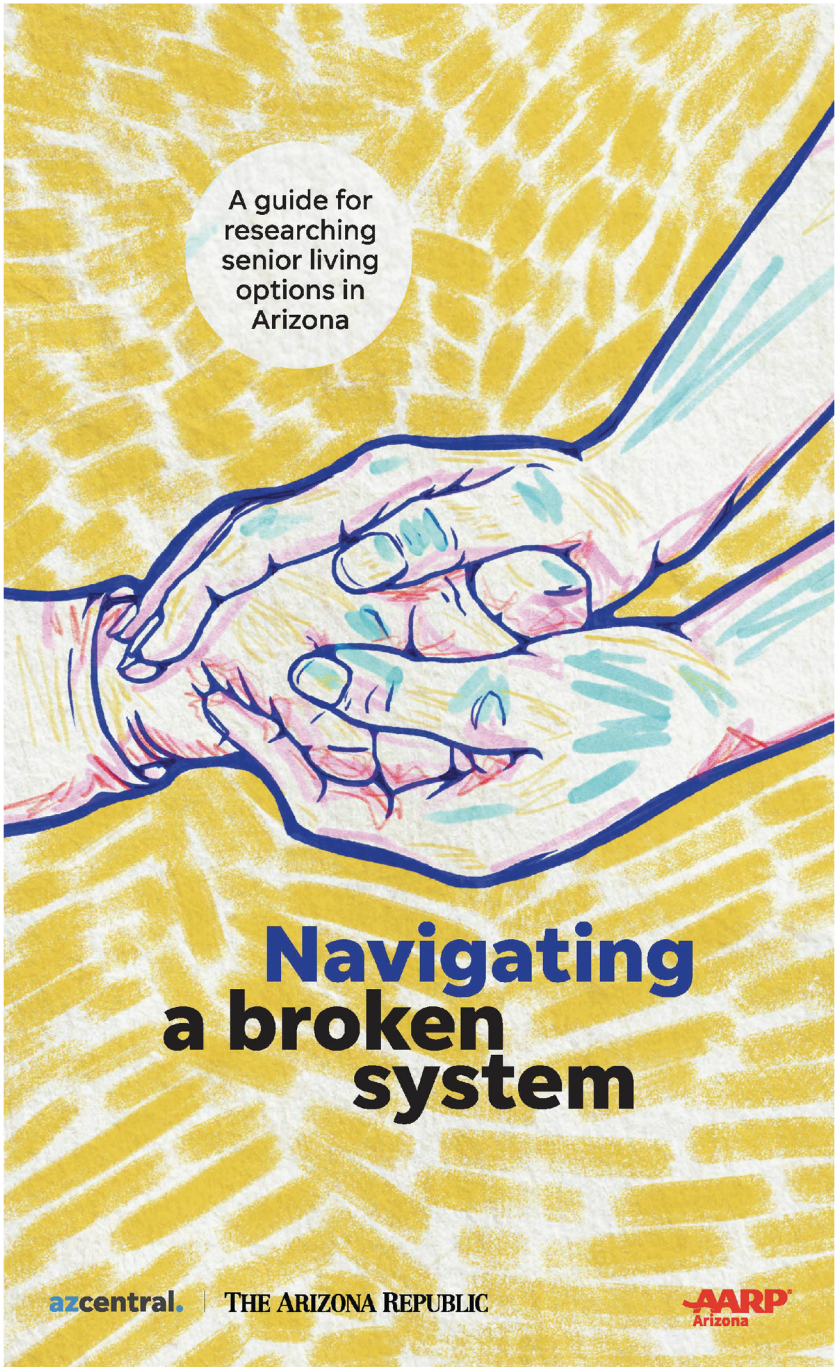
22 *See, e.g., CMS Newsroom website,* Data (accessed October 9, 2023).

23 *See, e.g., CMS,* Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers, at 2 (March 12, 2014).

24 *See CMS, Final Report, Home and Community-Based Services Review, California Assisted Living Waiver, Control* #CA-0431.R06, dated February 28, 2023.

25 DHCS e-mail to stakeholders, Home and Community Based Services Waiver Update (Sept. 22, 2023) (on file with Justice in Aging).

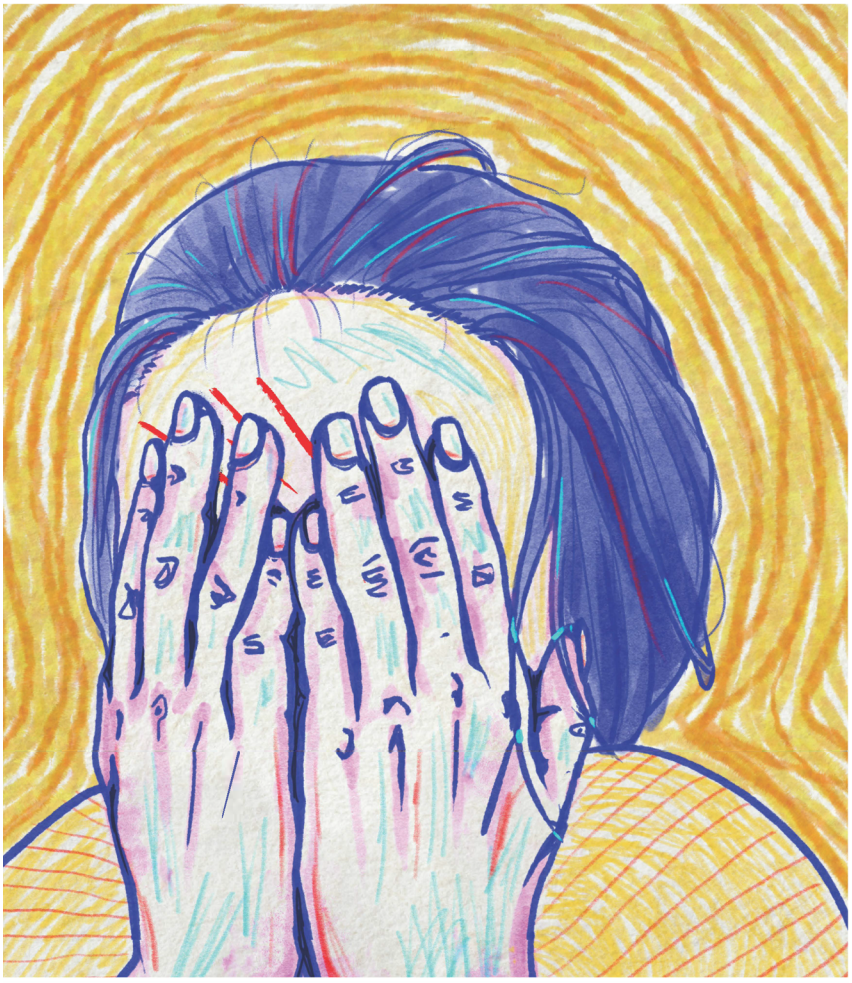
Navigating a Broken System



Arizona's long-term care system is fragmented, expensive, and inequitable. Over the last several years, countless news stories have exposed horrific instances of abuse, neglect, and exploitation of vulnerable adults due to systemic failures. Families have repeatedly conveyed that they need help navigating the complex system and ensuring that their loved ones receive proper care.

In response, AARP Arizona and the Arizona Republic partnered to create the following resource guide to help families better understand Arizona's long-term care system and to protect their loved ones from harm. The guide delves into such topics as comparing types of facilities, signs that someone may need additional support, and questions to ask when choosing a facility. It also exposes where the system has failed and provides some recommendations for improvement.

Critical improvements to Arizona's long-term care system are imperative to ensure that everyone has access to high-quality, affordable care that protects them from abuse, neglect, and exploitation. In the 2024 legislative session, AARP Arizona aims to reform the state's long-term care system through measures that strengthen licensing and enforcement policies, improve quality of care standards, and enhance reporting processes. To learn more about our efforts, please contact Brendon Blake at bblake@aarp.org or 602-245-8801.



CONTENTS

Arizona's long-term care and residential facilities system is broken. Throughout 2023, The Arizona Republic published a series of investigative reports looking at the problems, and Arizonans responded to the journalism with shock.

They felt overwhelmed and unsure how to protect people they love.

Arizona's only tool for backgrounding assisted living facilities doesn't provide the full picture, is not intuitive and isn't designed for comparison of options.

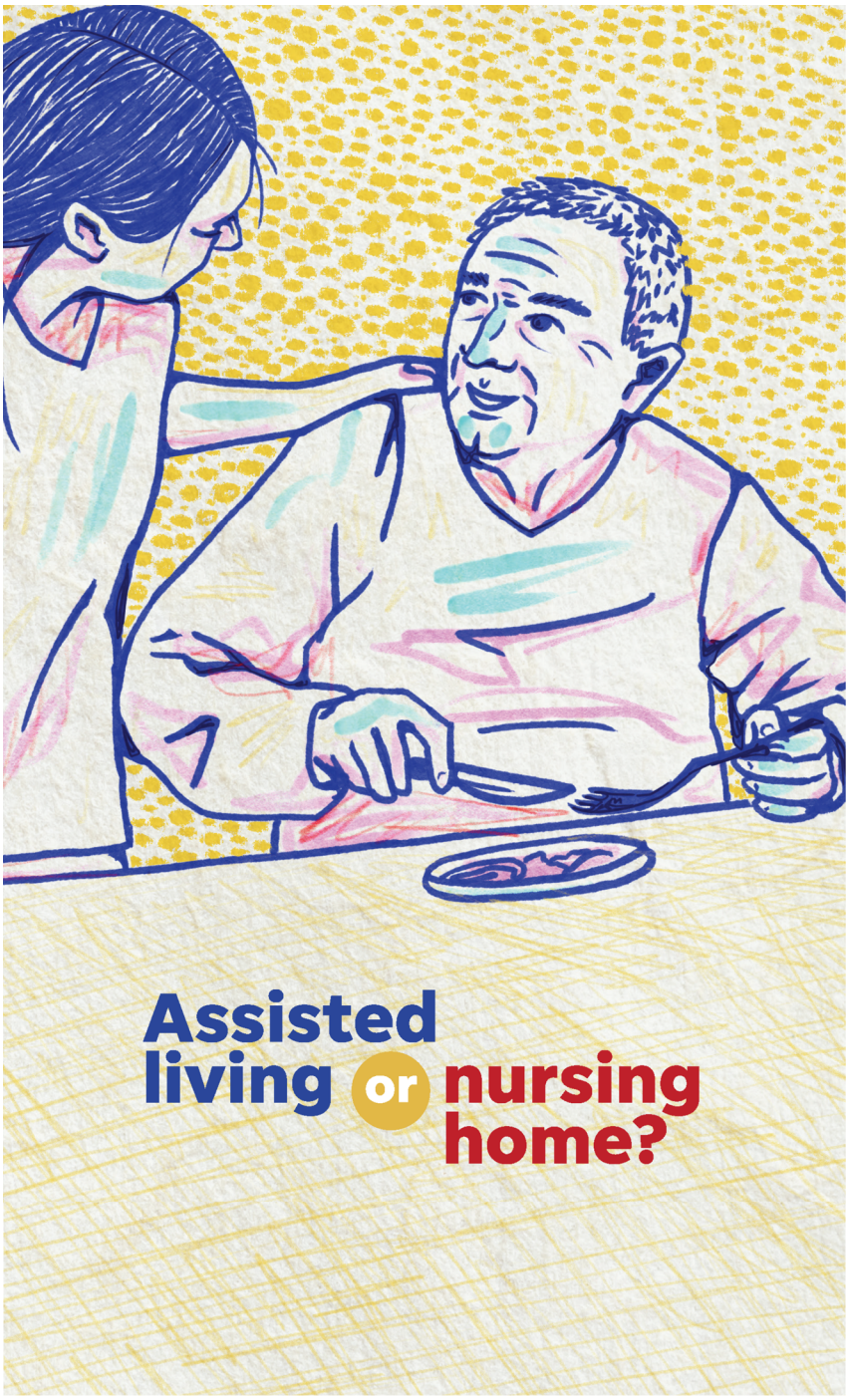
One woman, whose mother suffered from poor care at a Mesa facility, asked a Republic reporter: "Why is it so hard for someone like me to find out everything you know? It shouldn't be that hard for someone like me to research these facilities."

We agree.

So, in partnership with AARP Arizona, we created this pamphlet to help families better understand the system and to help them find the best senior living care option for their loved ones.

Most of this pamphlet focuses on assisted living facilities, as they tend to provide more permanent living arrangements but are less regulated than nursing homes and more difficult to research.

Reporting and analysis: Caitlin McGlade, Sahana Jayaraman | **Editing:** Greg Burton, Wyatt Buchanan, Becca Dyer | **Illustrations:** Emily Nizzi | **Design:** Andrea Brunty


Assisted
living or nursing
home?

How to navigate 2 different care models with different rules

Some Arizonans are surprised to learn that assisted living facilities don't have to follow the same rules as nursing homes. Here's how they are different.

ASSISTED LIVING

What is assisted living?
Arizona has about 1,900 licensed assisted living homes and centers. These facilities offer long-term housing to people who need varying levels of help. "Homes" serve 10 or fewer residents, while "centers" serve 11 or more.

They are licensed in the tiers listed below. While most facilities are licensed to provide the highest level of care, many serve a range of care levels.

Supervisory care: General supervision and the ability to intervene in a crisis. This is the lowest level of care.
Personal care: Assistance with daily tasks such as getting dressed, mobility or basic hygiene, the coordination of intermittent nursing services or medication administration.
Directed care: This designation, which is the highest level of care, includes programs and services for residents who are incapable of recognizing danger, asking for help, expressing need or making basic decisions.

Who works there?
Most employees working with assisted living residents are either certified caregivers who are 18 or older and have taken a course approved by the Health Department or the board that licenses facility managers; or, they are assistant caregivers who require supervision. The rules that govern assisted living operation stipulate that assistants must be at least 16 years old and have "qualifications, skills and knowledge" to do their job.

These facilities are not required to have medical professionals on staff, though some do. You might hear caregivers referred to as "med techs," but this is simply an industry term and does not indicate any additional or specialized training.

Assisted living facilities do not have to report how many employees work each shift to any government body, but they can get cited for inadequate staffing if a state surveyor finds an issue during a visit, such as failing to schedule a certified caregiver during any particular shift.

How often are assisted living centers inspected?
The Arizona Department of Health Services is charged with inspecting assisted living facilities once a year, with one big caveat: If a facility comes out of an annual inspection with no citations, state law prohibits inspectors from returning for two years unless they receive a complaint.

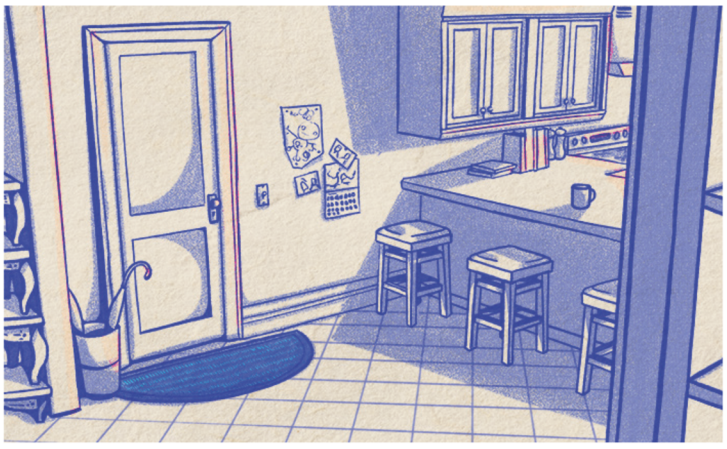
When an employee suspects abuse, neglect or exploitation of a resident, they need to report it to either Adult Protective Services or police. The facility is also required to conduct an internal investigation and keep it on file for a year, but they generally do not have to share the results with anyone unless a state inspector asks for it.

NURSING HOMES

What are nursing homes?
Nursing homes, most of which are federally regulated and receive Medicare and Medicaid funding, are designed to provide around-the-clock medical care, 24-hour supervision, three meals a day, assistance with daily living and rehabilitation services. They serve long-term residents with chronic, disabling conditions or people who need short-term rehabilitation after acute illnesses or injuries. There are about 140 skilled nursing homes in Arizona.

Who works there?
Nursing homes have a director of nursing who oversees registered nurses, licensed practical nurses and certified nursing assistants. They may also have occupational and physical therapists. These employees have medical training. Nursing homes must report daily staffing levels, and that information is tracked by the Centers for Medicaid and Medicare Services.

How often are they inspected?
State law requires that nursing homes be inspected annually, and the Centers for Medicare and Medicaid Services stipulate that they be inspected once every 15 months. The state also receives and investigates complaints about them. They must report any suspected abuse, neglect or exploitation to the Arizona Department of Health Services.




AARP
Join
Renew
Asking for assistance

What are some signs someone needs more help at home?

One thing that AARP Arizona has repeatedly heard from older adults is that they want to stay in their homes for as long as possible. Home- and community-based services (HCBS) play a substantial role in helping people to remain in their homes.

If someone needs additional care at home due to difficulty completing basic activities of daily living (ADLs), such as feeding, bathing, toileting, and medication management, home- and community-based services help provide necessary care.

Broadly, HCBS can provide services such as home-delivered meals, paid in-home caregivers, adult day centers, adult day health centers, transportation, housekeeping, visiting nurses, personal care, respite care and more. These services also provide support to family caregivers.

Here is a list of some statewide resources for home- and community-based services:

- Area Agencies on Aging (Region-Based; Region 1 for Maricopa, www.aaaphx.org).
- Arizona Caregiver Coalition, azcaregiver.org.
- Arizona Long Term Care System (ALTCS) through AHCCCS.
- Many cities and towns provide transportation and meals and recreation programs to reduce social isolation.

While many resources require private pay, there may be some opportunities for reduced or covered care based on your insurance.

What if home- and community-based services are not enough?
Deciding to move a loved one into a long-term care facility is a tremendously difficult decision.

If home- or community-based services aren't an option, consider these questions:

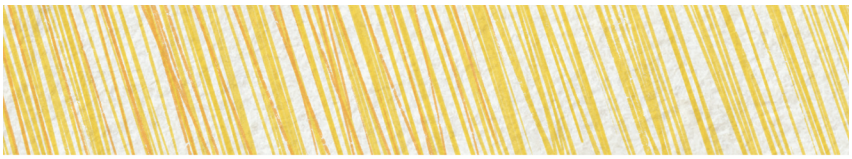
- Does the individual live alone?
- If not,
  - How often do they receive assistance and with what types of activities?
  - Does the person giving care also work?
  - Is the person giving care in good health?
- How many activities of daily living can the individual perform alone?
- Can they manage their finances by themselves?
- Are they able and know how to get help if needed?
- Are they able to manage their medication?
- Are they falling a lot?


Finding the
right facility

Ask these questions when choosing an assisted living facility

Well-manicured grounds, sparkling lobbies and friendly tour guides can easily woo prospective residents and their families. But you should come prepared with questions when shopping for facilities. Find a printable checklist from AARP at https://shorturl.at/nsAPV to take with you on tours. We've also interviewed families of residents, assisted living employees, attorneys and industry experts and created this list of questions that are most helpful:

- **What is the facility's certified-caregiver-to-resident ratio during peak hours, overnight and on weekends?** Compare these ratios when evaluating options. There isn't a nationwide standard, though some states require minimums. For example, Nevada requires one employee for every six residents during waking hours for facilities licensed to serve people with dementia. South Carolina requires one employee per eight residents during peak hours. Generally, the more certified caregivers per resident means more attentive care. But the key word is "certified," as only those caregivers can work solo with residents and – in a pinch – facilities sometimes put assistant caregivers on tasks they're not trained to do.
- **Does the facility have an on-site nurse or a medical team?** Keep in mind that the state doesn't require assisted living to have medical professionals on staff.
- **What does the facility do to ensure that employees know the residents?** A key factor in quality care is tailoring activities and engagement to each resident's specific personality, preferences and needs.



- **Does the facility use any technology to alert staff when a resident has fallen?**
- **What sort of technology do residents in this facility receive to alert a caregiver when they need help?** Are there call buttons, or a lanyard that residents can wear that will ping staff?
- **How does the facility document incidents like falls, or if a resident claims that someone hurt them?** Do employees investigate those incidents and keep the documentation on file? The facility won't have to give these documents to you, but managers should be able to explain their process.
- **Who owns this facility?** Who operates it — does it belong to a chain?
- **Ask for a copy of the facility's most recent state inspector survey.** Facilities are required to help you find their most recent inspection. If they don't, it's not only a violation of the rules, but also a red flag for transparency issues.
- **What training – in addition to state requirements – do managers and caregivers receive to work with people with dementia?** The state requires assisted living managers to take eight hours of training on developing systems for managing residents with dementia, Alzheimer's disease or difficult behaviors. Caregivers have to take four hours of instruction on the care of cognitively impaired residents, such as those with dementia.
- **If a facility claims to have a behavioral unit, ask to see their behavioral license.** Just because a facility bills itself as specializing in "behavioral" or "memory" care, don't assume that it's licensed any differently than other assisted living facilities, or is staffed with workers trained any differently than certified caregivers.


Research like
a reporter

How to background check an assisted living facility

A range of resources exists to help you dig into a facility's record. Depending on how much time and energy you have, try the following steps that reporters and editors at The Arizona Republic use when doing an investigation.

TIME AND EFFORT LEVEL: LOW

Finding actions from Arizona Department of Health Services
ADHS posts all citation reports and enforcement actions against assisted living facilities to Azcarecheck.com. To find them, start by clicking "Residential Facilities" on the homepage. This will launch a search page.

Note that the "Status" defaults to "ACTIVE." You should set it to "ALL." Some facilities get new licenses, which means any citation or enforcement action they received under their old license won't appear within "active" license searches. If you see multiple entries for the facility you are searching, check each one to capture their full record.

When you click on an entry, you'll find one or more surveys you can download. These will spell out each citation the facility received, if there were any.

You can also see if the state fined a facility from this page, under "enforcement actions."

This information is updated daily and contains files dating back to exactly three years from the date you are searching.

The Arizona Republic and azcentral.com also have created a secondary search tool that captures the past three years of citation data for assisted living centers licensed to serve people who need the most help.

The tool allows you to find any citation, links to the reports and – unlike the state's website – also plainly summarizes what the facility was cited for. You also can see how common each particular citation is, which will help you more easily compare facilities.

Find the tool at seniorcare.azcentral.com.

Check out our resident-on-resident harm database
In 2022, The Republic requested police reports about resident injuries at hundreds of facilities from about 40 different police jurisdictions.

We built a database documenting each incident we found of residents hurting each other or staff. The state doesn't track this information, so our site is the only place you'll find it.

You can find that here at https://shorturl.at/fqsFR.

A couple caveats: We didn't get everything we asked for. So don't assume that a facility's absence from the database means they've got a clean record.

Also, some facilities may call the police for incidents that others wouldn't, so don't assume that a facility is more troubled than others based on the incident count.

If you find an incident that happened at a facility you're considering, we recommend asking the management about how they handled it and what they do to prevent similar issues from happening again.

If you're interested in seeing the entire police report, ask us!

Manager license actions
You can find out if your facility's manager has a record by checking https://elicense.az.gov/ARDC_LicenseSearch.

You may have to call a facility to find out who its manager is, but once you have the name you can search the license history. The state's license search tool links to any disciplinary actions taken against the manager.

Facility ownership and affiliation
Knowing what company, or who, owns your facility is important information to understand their motives and their track record around the state or across the country.

Sometimes it is unclear what parent company owns or operates a given assisted living facility. You might find out by asking the staff, but if that doesn't work, check the Arizona Corporation Commission.

Visit https://ecorp.azcc.gov/EntitySearch/Index.

The "principal information" you find here will tell you what other entities are associated with the facility. You may need to put those names into the search tool again to go a layer deeper about who the entities actually are.

TIME AND EFFORT LEVEL: MEDIUM

Court records
Search your facility's name, and the company or individuals associated with it, in your county's court records. Most courthouses have online search engines that show if cases against a particular entity exist. Once you identify a case, you'll likely need to physically go to the courthouse to understand the nature of the case. Complaint documents filed in a case will spell out what the allegations are.

Other state records
If your facility is owned, operated or affiliated with a company that operates in another state, you might find more complete data about its other properties. Colorado, for example, has a robust assisted living search tool. You

can find that here: https://cdphe.colorado.gov/find-and-compare-facilities.

Complaints
The Arizona Department of Health Services received more than 3,000 complaints against assisted living centers from 2017 to late 2023.

When the state substantiates complaints – meaning investigators determined rules were broken – it posts its findings to azcarecheck.com, but the allegations from the rest are never publicized. You may want to read up on these unpublicized allegations. The state's investigations have not always been thorough and – at least for abuse, neglect or exploitation claims – the Health Department depends on Adult Protective Services and law enforcement to determine whether the harm occurred. A 2023 audit slammed protective services for inadequate investigations.

You can find out if a facility had complaints filed against it by searching The Arizona Republic's complaint tool. This source will tell you the Intake ID, the date the complaint was filed and the state's finding.

From there, you'll need to file a public records request for the documents that explain the complaint. (The Republic's tool provides template language and a link to the state's public records request form.)

TIME AND EFFORT LEVEL: HIGH

Police reports
Assisted living facilities are required by law to report suspected abuse, neglect or exploitation to either Adult Protective Services or the police. Adult Protective Services won't tell you anything – but police reports are a public record. Police reports may tell you about dangerous or traumatizing incidents that a facility was never cited for.

If you have time and energy to go this route, we recommend requesting from the relevant police jurisdiction a list of calls for service stemming from the address of the facility you are interested in. Most police departments will turn around calls for service fairly quickly.

Once you get the list, we recommend selecting incident reports having to do with fights, assaults, sex assaults, abuse or neglect of an elder and other keywords similar to these. Request the incident reports using their incident report ID numbers. Depending on the agency, this could take weeks to months. If you're requesting from Phoenix police or the Maricopa County Sheriff's Office, it could take more than a year.


Regulating
senior
living
18

Learn about these state agencies and how you can file complaints

The Arizona Department of Health Services (ADHS)

This state agency is responsible for licensing both nursing homes and assisted living centers, inspecting them regularly and investigating complaints about the facilities. ADHS cites and fines facilities when they break rules designed to ensure quality care, though penalties are capped at $500 per day per violation. The department does not investigate managers who run the facility.

You can file a complaint about a facility online at azcarecheck.com by selecting "Online Complaint Forms" in the side rail. If you need assistance, call 602-364-2639 for help filing assisted living complaints and 602-364-2690 for nursing home complaints.

A complaint will result in one of three outcomes:

- **The state will be unable to substantiate your allegations,** meaning its investigators couldn't find evidence a rule was broken.
- **The state will find your allegations unsubstantiated,** meaning that there was definitive evidence that a rule was not broken.
- **The state will substantiate your allegations,** issue citations, require a corrective action plan and potentially fine the facility.

If the state substantiates your allegations, findings are posted online in reports the department calls "statements of deficiencies," and the department will send you a letter telling you what report to look for. The letter won't tell you how to find the report. Refer to Chapter 4 of this booklet for instructions on how to do that.

Board of Nursing Care Institution Administrators and Assisted Living Facility Managers (AZNCIA)

This board licenses nursing home administrators and assisted living managers, investigates complaints filed against them and licenses training programs for both managers and caregivers. (The board does not, however, license caregivers nor does any regulatory body. They get certificates from the companies the board approves for training.)

The board receives cases in one of two ways: ADHS sends citation reports that resulted in an enforcement action to the board or individuals file complaints. (Most come from ADHS.)

If you want to file a complaint specifically about the manager of a facility, go to https://elicense.az.gov/ARDC_FileComplaint. You also can mail a complaint to 1740 W. Adams St., Suite 2490, Phoenix, AZ 85007.

To reach the Investigations Department, call 602-364-2374, Option #2.

Complaints should be filed within one year of the alleged problem.

The board tries to notify complainants before their allegation goes before the board, but complainants do not always need to be present for the board's discussion or hearing.

The board may dismiss the case, revoke or suspend manager licenses, require additional training or issue letters of concern.

Adult Protective Services (APS)

Adult Protective Services is a program within the state's Department of Economic Security. It's responsible for taking and investigating reports of the abuse, neglect and exploitation of vulnerable adults across Arizona, including those living in nursing homes and assisted living facilities.

You can file a report — which APS refers to as an "allegation" — with the agency online 24/7 at https://des.az.gov/services/basic-needs/adult-protective-services by clicking "File an APS report online," or over the phone at 877-767-2385. Phone lines are staffed between 7 a.m.-7 p.m. Monday-Friday, and from 10 a.m. to 6 p.m. on weekends and state service holidays.

To substantiate an allegation, APS must find that more than 50% of the evidence points to abuse, neglect or exploitation having occurred and been perpetrated by an identified individual. Reports filed with APS that meet its criteria for investigation will have one of three outcomes:

- **The agency will not substantiate your allegation,** meaning they couldn't find enough evidence to prove abuse, neglect or exploitation occurred and was perpetrated by an identified person or persons.
- **The agency will verify your allegation,** meaning they found enough evidence to prove that abuse, neglect or exploitation occurred but could not identify a perpetrator, the allegation was of self-neglect, the perpetrator died or the perpetrator was another vulnerable adult.
- **The agency will substantiate your allegation,** putting a perpetrator on its registry, where their name, date of birth and a description of what happened will remain for 25 years. It's important to note that facilities can still hire people on this registry; that's up to an employer's discretion.

Substantiation is a complex process: APS has the Arizona Attorney General's Office review evidence for any allegation it plans to substantiate. Alleged perpetrators have the chance to appeal to an administrative law judge; if they choose to request a hearing, the Department of Economic Security director has to review the judge's findings before making the ultimate decision about whether a perpetrator will go on the registry.

If you are the alleged victim in a case reported to Protective Services, you can expect that they will contact you at the end of their investigation if your allegation was unsubstantiated or verified. If your allegation is proposed for substantiation, they'll tell you whether the alleged perpetrator has requested a hearing in the allotted time frame, and they'll let you know whether they have decided to substantiate your allegation.

If you're the person who filed a report about abuse, neglect or exploitation with Protective Services — but not an alleged victim — you'll get a letter telling you the outcome of the case. You may also be interviewed if Protective Services needs additional information or if you were party to the case (a family member or witness, etc.).

How do we improve the state's system?

AARP Arizona has advocated for family caregivers for over a decade. Here are some of the key areas for improvement:

Give the Arizona Department of Health Services more tools:

- Allow the department to hold facilities accountable with penalties greater than $500.
- Improve transparency of facility ownership.

Require more from facilities:

- Necessitate improved training standards.
- Require facilities to review the Adult Protective Services' registry before hiring new staff.
- Define memory care standards, specifically:
  - Staffing ratios.
  - Minimum training standards for all staff, such as dementia-specific training.
  - Strong therapy and activity programming.
  - Comprehensive design that lowers resident confusion and agitation.
  - Cognitive and behavioral screening.
- Require facilities to report every injury to the Arizona Department of Health Services.

Consumer improvements:

- A "No Wrong Door" Policy, which would mean that, regardless of which agency is contacted to report abuse or neglect, each department will cross-report to the correct agency.
- Improve the Arizona Department of Health Services' website. Currently, the website is very difficult to navigate and hard for regular consumers to get an accurate picture of the facility and the care that they provide.
- As is allowed in group homes for those with developmental disabilities, if families agree, they should be allowed to have a camera in the room of their loved ones for their safety.

To the families and individuals who trusted The Arizona Republic with your grief, your trauma and your anger: Thank you. We know it's difficult to relive some of your most painful moments and we know you did it with the hope to bring change to the system for others.

We want to acknowledge people we wrote about who passed away after shocking senior living incidents or dementia complications: Estalyn Bouchard, Joyce Dinet, Anita Ferretti, Jennie Fischer, Kevin Rodrigues, Joann Thompson, Bernadine Wick. We did this work for you, and for future residents in hopes that they will not suffer similar problems.

Thank you to the researchers who spent hours on the phone with us and provided valuable context so we could tell these stories in the most sensitive way possible. Eilon Caspi from the University of Connecticut, Charlene Harrington from the University of California-San Francisco, Lori Reynolds, who has a doctorate in gerontology and worked with Northern Arizona University — you were all instrumental to the impact of our reporting in the series, The Bitter End, at azcentral.com.

We also want to thank our colleagues, both current and former, at The Arizona Republic and USA TODAY, who worked tirelessly to produce the series that exposed Arizona's broken assisted living system.

THE BITTER END

Explore The Arizona Republic series on resident-on-resident harm in senior living facilities and how the system enables violence at seniorcare.azcentral.com.

Scan the QR code by opening your phone's camera app and pointing your device at the code. Tap the notification

NCAL®
NATIONAL CENTER FOR ASSISTED LIVING

Submitted Statement of
LaShuan Bethea J.D., M.Ed., BSN, RN
Executive Director, National Center for Assisted Living

For the U.S. Senate Special Committee on Aging Hearing,
Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults

February 1, 2024

Chairman Casey, Ranking Member Braun, and members of the committee:

Thank you for holding the recent hearing, *Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults*. Assisted living is a critical part of the long term care continuum, providing life-affirming care for nearly one million seniors every day. The National Center for Assisted Living appreciates the opportunity to share our perspective on how policymakers and providers can work together to improve accessibility to assisted living and ensure residents and families have the information they need to make informed decisions.

The people who work in this profession do it because they love it. They have a passion for serving seniors and are dedicated to providing a safe, secure, home-like environment while honoring every resident as an individual. This is one of the contributing factors of why the vast majority of assisted living residents love their communities. Surveys find that 99 percent of residents feel safe in their communities, and 91 percent say they feel safer than living on their own.

Every assisted living community is unique and has the ability to adapt to the needs and wants of residents and local communities. Regulation at the state level allows for a dynamic, localized model that allows for individualized, person-centered care and promotes innovation. State-based regulation of assisted living is strong, as reported in the National Center for Assisted Living's "Assisted Living State Regulatory Review." The report found that two-thirds of states reported changes between 2020-2022 and another 31 percent between 2022-2023.

Because every community is different, the best way for someone to determine if an assisted living community is the right place for them is to visit. Many people who seek this type of care are searching locally, close to family and what they know and love. This is a very personal decision. It is important to find the right fit in a community where they are comfortable with how things operate, including resident rights, physical safety, staff training, and other central factors that are available through state survey data. A national database cannot match this personal experience in ensuring residents find the right care.

Regarding the cost of assisted living care, we fully support transparency in pricing. Residents and their family members should fully understand the true cost of care. Assisted living

providers are committed to transparency, and that is why it is common practice for these communities to provide prospective residents with written information regarding services, costs, fees, conditions for residency, and policies/procedures. Further, over 90 percent of states require consumer disclosure agreements and/or resident bill of rights to ensure residents and their families get the information they need to make informed decisions.

Most residents pay for assisted living through personal finances (or private pay), according to an October 2023 report by the Congressional Research Service, and consumer demand for private pay assisted living remains strong. However, the fact remains that **affording long term care out-of-pocket is really challenging for many, especially since assisted living is a combination of housing and some health-related services.** Meanwhile, few Americans are planning for the cost of long term care. While many assisted living providers will continue to meet ongoing demand by private pay consumers, many other providers recognize the potential to serve a growing elderly population who may not have the means. Yet, challenges such as absence of a state Medicaid waiver program, low Medicaid waiver rates, limited public funding make it difficult for some assisted living providers to develop more affordable models that are viable. We need a public-private partnership to identify opportunities to increase affordable assisted living options for low to moderate income older adults who can no longer live at home. It is also vital to look at expanding and properly funding Medicaid assisted living services to allow more providers to participate in the program. NCAL outlined these recommendations and more in the white paper, *The Importance of Expanding Affordable Assisted Living Options and Proposed Solutions*.

Thank you for the opportunity to provide written testimony. We look forward to continuing this discussion and demonstrating that assisted living provides high quality care at a high value to our nation's seniors.

February 1, 2024

Dear Sens. Casey, Braun, and members of the Senate Special Committee on Aging,

On behalf of the nearly 200 senior living communities — including personal care homes and assisted living residences — that fall within the membership of the Pennsylvania Health Care Association, I am writing to you in response to the recent hearing held by your committee to understand long-term care options for older adults — specifically, assisted living residences.

My name is Zach Shamberg, and I serve as the president and CEO of the Pennsylvania Health Care Association (PHCA). We are an advocacy organization for long-term care providers and the residents they care for — a statement proven by our record of advancing the long-term care continuum and improving care outcomes. Our membership includes 184 senior living communities — 166 personal care homes and 18 assisted living residences — that account for more than 15,000 licensed beds. We also serve more than 240 nursing home providers across the state.

From a national standpoint, I am also proud to serve on the Board of Representatives for the National Center for Assisted Living (NCAL).

We write to you today in response to your hearing, as we aim to meet your goal of providing further education about senior living in Pennsylvania and across the country. We appreciate the opportunity to provide additional insight and feedback in this letter, and we welcome any opportunity to participate in future meetings or hearings.

First and foremost, it's important to recognize that like anything relative to meeting health care needs, there is no one-size-fits-all model that works. We are all different and our care should be handled as such. This is why we have various levels of long-term care.

Pennsylvania is unique when it comes to senior living. In our commonwealth, there are two separate licenses for these levels of care: assisted living residences and personal care homes.

These senior living options are designed to allow a resident to age in place within a community — while respecting the resident's independence and rights — without having to move the

resident to a licensed nursing facility until their care needs increase. Both personal care homes and assisted living residences design programs to meet individual needs — for short-term stays when support services are required and for permanent residency when chronic conditions exist.

The differences between our two types of senior living options include construction, amenities, and levels of care offered. A person who needs the level of care of a nursing facility is not permitted to reside in a personal care home and must transfer to a higher care setting when their needs become too great. That same person, however, will be able to remain in an assisted living residence where they will be provided with the services they need to age in place.

Regardless of the type of provider, state regulations and safeguards are in place, and it is the state's responsibility to uphold those regulations. Any concerns addressed during the hearing should be directed to the regulatory agency in the state where the resident was receiving care. Federal intervention would simply add new layers of bureaucracy and result in slower processes and more expensive care for our elderly.

In Pennsylvania, transparency already exists. License Inspection Summaries (LIS) are available on our state's Department of Human Services website. The most recent LIS must be posted in a public place and available to review at all times in each senior living community.

Providers are also required to disclose specific information prior to resident admissions, such as contracts, services available, cost of living, community rules, a resident handbook, inspection results, and any agency-approved waivers.

Residents also have rights, that are clearly outlined in the regulations. Providers must manage and balance what legislators and regulators think is best versus what families and loved ones deem is best — all while factoring in the actual rights of the resident, who still has autonomy in their living and care.

As part of the established regulations, providers are required to appropriately train their staff based on resident care needs, including required training for elopement risk and dementia units. Such training includes that of specialized physical plants, design, modeling, and program development as the need increases. Policies and procedures are in place to balance resident needs, family wants, and various regulatory requirements, including reporting adverse incidents.

In Pennsylvania, our Department of Human Services will investigate to ensure adequate care and staff education are in place while maintaining resident independence and safety. If this is not the approach in other states, Pennsylvania can certainly serve as a model.

It's also important to note that Pennsylvania senior living communities do not receive Medicaid or Medicare funding to support the care of residents. Assisted living and personal care rely almost exclusively on private pay.

That is an emerging challenge in Pennsylvania, as we must recognize the growing demand for senior care and the lack of financial resources seniors will have in the years to come. Roughly one in three adults aged 65 and older are economically insecure. In Pennsylvania, if a resident can't afford senior living and that resident doesn't qualify for Medicaid to receive care in a

nursing home, the resident has no option but to stay home. This is why PHCA continues to advocate for state legislation that would bring a Medicaid waiver to assisted living, just as dozens of states across the country have already done.

PHCA has also supported state legislation that would implement a state retirement savings program to help our population save for their future. Retirement is not just about taking the trips and vacations we always wanted — we need to consider care and living situations in the later years of our lives. This program would ensure Pennsylvanians are better prepared.

The cost of care only continues to grow with the evolving scarcity of workers needed within long-term care. Providers are trying to remain competitive with wages to recruit and retain staff, but that is difficult to do when revenue comes from seniors on fixed incomes.

Where can federal leaders be helpful to the long-term care continuum? We believe you have an important role to play in establishing a workforce pipeline that can match the rapidly increasing demand for senior care — that includes comprehensive immigration reform, regulating staffing agencies, and a number of other initiatives.

The committee's hearing, in some ways, felt like a search for a problem. With the regulations and oversight we have outlined above, perhaps the problem is with the regulators in other states. If there are ever growing concerns over the inability of a provider to deliver care, the state's regulatory body should address it — we know it would be addressed here in Pennsylvania.

The committee should recognize that senior living providers have already been advancing care without the involvement of the federal government, including the evolution of memory and dementia care. With an increased need to care for residents living with dementia, senior living providers are working to evolve communities into secure dementia communities to increase the safety and security of the residents they serve.

Ultimately, we believe assisted living residences and personal care homes are critical to our health care continuum. Providers aren't just supporting our elderly population, they are serving communities by providing care and housing to adults living with mental and physical disabilities. While we appreciate the interest in long-term care and its importance to all of our communities, we believe this latest hearing was a search for damaging issues and negative stories that failed to provide a complete picture of the work our providers do, every single day. This is counterproductive to serving a population in need of care, and we ask for your support in collaborating on ways to strengthen our continuum — in Pennsylvania and beyond.

Once again, due to the unique entities throughout the long-term care continuum and the differences in regulations from state to state, federal government involvement — albeit well-intentioned — will only create issues for residents and providers, just as it has for nursing homes.

We would appreciate the opportunity to continue this conversation and connect with any member of the committee to answer your questions or provide additional information.

I can be reached at zshamberg@phca.org or 717-221-7925.

Thank you.

Zach Shamberg
President & CEO

COUNTRY MEADOWS
RETIREMENT COMMUNITIES

January 22, 2024

The Honorable Robert P Casey Jr.
Chair, Senate Special Committee on Aging
200 N. 3rd Street, Suite 14A
Harrisburg, PA 17101

Dear Senator Casey:

We are writing to ask you to help to open the US to greater numbers of immigrant workers to help tackle the workforce shortage across the healthcare industry. We believe that the quality and affordability concerns you are investigating are fundamentally caused by a shortage of workers willing to do the hands-on care that is needed in the long-term care field. We do not believe the solution to this worker shortage is greater regulation.

As you know our family owns and operates two assisted living organizations, Country Meadows Retirement Communities and Providence Place Senior Living. Together these two firms serve nearly 3,200 Pennsylvania seniors and employ more than 3,000 team members at 26 licensed personal care and assisted living communities across the Commonwealth.

Like others in long-term care, we have been stressed in the past two years by challenges in recruiting and hiring good staff members. Those problems have sometimes necessitated us to use temporary agency staff and have caused us to increase our salaries and wages to attract applicants. Those increased wages have helped to reward team members for the important work they do, but they have also significantly increased costs, which must eventually be passed on to customers.

The current unusually low level of unemployment in the Commonwealth has created a serious scarcity of candidates for front-line caregiver positions. Despite state-wide efforts made to offer training and to publicize these job opportunities, we believe that the solution will require increasing our access to immigrant workers willing and able to do this type of work. Whether through increasing targets for legal immigration or by creating easier access to work visas or guestworker programs, the healthcare industry (and other service areas) needs more immigrant workers. There simply aren't enough people currently interested in doing this type of hands-on work.

It is probably true that this crisis in staffing has caused a few providers to dip below PA regulatory standards for required hours of care and has created some situations in which the quality of care has suffered. Nevertheless, we believe that most providers have maintained an acceptable standard of quality. Those few who have repeatedly demonstrated lapses in quality and have received frequent complaints about care should be, and in PA frequently are, given technical support, provisional licenses, and if quality is not quickly improved, they are fined or lose their license to operate.

It is tempting at times like this-- when challenges with staffing and caregiver turnover have created quality concerns-- to believe that the fix is more regulation, or even federal regulation following the nursing home model. We think that would be a mistake.

Country Meadows Home Office
830 Cherry Drive | Hershey, PA 17033

PHONE: 717.533.2474 | FAX: 717.533.6202
www.countrymeadows.com

As you know, our family started in long-term-care in the skilled nursing business. In the 1970s and 1980s Leader Nursing Centers was the largest provider of skilled nursing in the Commonwealth. Nevertheless, we decided to back away from owning and operating skilled nursing facilities primarily because the federal regulation, though well-intentioned, was excessively burdensome to the point of being counterproductive.

In our opinion skilled nursing regulation has created the institutional environment that is so often criticized by patients and their families. More importantly, we believe overly prescriptive regulation has negatively impacted quality of life for patients in skilled facilities.

Some examples of long-term care regulations negatively affecting patient quality of life include:

- The huge range of special diets that must be offered complicates cooking to such a degree that the focus is on compliance. As a result, the overall quality of meals is notoriously poor in most nursing homes.

- Fall prevention is such a high priority in the regulations that nursing homes are incented to discourage ambulation and many use measures that act as passive restraints to walking.

- Professional nurses spend the bulk of their time on paperwork, MDS documentation and other regulatory reviews, rather than with patients.

The federal regulations of skilled nursing are often so prescriptive that they leave little or no flexibility to adjust to a patient's wishes.

The strength of the assisted living profession is that we are driven by the need to satisfy the wishes of our residents and their families. Our PA regulations establish solid boundaries and give direction to our policies & procedures. Nevertheless, our current regulations normally permit us to adapt our clinical and personal care to meet the needs and wishes of our residents.

We fear that, despite the best of intentions, federal regulation would institute requirements that would take our nurses away from patients and hamper our ability to adapt to resident's individual needs--which would ultimately reduce the quality of life of our residents.

The driving force of assisted living is the need to please our customers. We would hate to see that ever change.

Sincerely yours,

Michael Leader	David Leader	Meredith Mills
Executive Chairman	President & CEO	President & CEO
Country Meadows	Providence Place	Country Meadows

U.S. Senate Special Committee on Aging

Re: Assisted Living Facilities – a personal and professional experience

Date: February 1, 2024

I appreciate your interest in the Assisted Living setting. This is an area where there has already been intense discussion, legislative, and regulatory action in Delaware.

Our Assisted Living environments are licensed, surveyed, and overseen by the State Division of Health Care Quality, the same group that provides the same very precise and documented survey inspections of Skilled Nursing Facilities in our small state. The facilities are extremely varied in size and capabilities. With a few exceptions, the residents pay privately for care. Delaware has not embraced Assisted Living as a Home and Community-Based Option. There are only two out of thirty-four buildings in Delaware that have a sizable number of residents who receive care through the Medicaid program. One of those is for individuals with Traumatic Brain Injury who can live more independently in an Assisted Living Facility and help avoid moving to a Skilled Nursing Facility.

The legislation that provides residents and/or their representatives with disclosure requirements and more information about Assisted Living, is located in the Delaware Code, Title 16, Chapter 11. [1] Specific regulatory details for Assisted Living Facilities can be found in Delaware's Administrative Code, Title 16, Department of Health and Social Services: Division of Health Care Quality 3225: Assisted Living Facilities. [2]

Within the Administrative code are details and definitions for: Assisted Living, Contract, Resident Assessment, Service Agreements, Shared Responsibility, and Uniform Assessment Instruments to name a few terms that could help to eliminate communication and misunderstanding between parties. As someone who found it necessary to find an Assisted Living placement for my mother, I am aware of how important the transparency and communication outlined in the process in Delaware statute and administrative code was to her and our family.

It is also important for families and caregivers to tour buildings and get to know the staff and fellow residents to ensure that they are making an appropriate choice. We did that with my mother and I highly recommend that approach to others. It would be helpful if your group could help educate the public - especially families and individuals who are considering Assisted Living - about what each of the various long-term settings can and cannot provide, how their services are covered (or not) by

---

[1] https://delcode.delaware.gov/title16/c011/index.html

[2] https://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Health%20Care%20Quality/3225.shtml

the government or insurance, and the variability between providers. Another service your group could provide would be to encourage insurers to re-engage in long-term care insurance – which is difficult to purchase for today's consumers as they plan for future needs.

As Executive Director for the state association, I participated with state legislators, advocates, industry representatives, and others in a long study of Delaware's Long-Term Care and Memory Care environment on a state-appointed task force. The group looked carefully at our changing demographics. It developed a lengthy list of recommendations that included support for additional funding, workforce development initiatives, memory care enhancements, and improvements to communication methods shared at admission and assessment. We wholeheartedly support transparency and informed decision-making because it will improve resident care and hopefully lessen misunderstandings between parties.

Most individuals in the Assisted Living environment are happy with the arrangement. But it can be expensive because building appropriate buildings, retrofitting other buildings, adding amenities, making them safe, adding commercial kitchens, recreational areas, and most of all finding the staff is a very expensive proposition. My mother preferred to supplement care in her assisted living with one of her caregivers whom she met living independently. She had the luxury of going back and forth between her home, our home, and the assisted living as circumstances allowed. Her caregiver helped her, in each of those environments and added to the services she received while in the congruent setting.

Please feel free to reach out to me if you have any questions. My experience as a caregiver for my mother, long before I became affiliated with the industry, gives me a unique perspective on these concerns. Thank you again for caring about these watershed issues for our citizens.

Sincerely,

Cheryl Heiks

Cheryl Heiks

Executive Director
Delaware Health Care Facilities Association
302-235-6895 (office)
302-563-3273 (cell)
cheiks@dhcfa.org

nebraska
health care association
advocate. educate. support.

January 31, 2024

U.S. Senator Bob Casey, Chair
U.S. Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 20510-6050

Re: Testimony in response to hearing on assisted living

Dear Members of the U.S. Senate Special Committee on Aging:

Thank you for the opportunity to submit this testimony in response to the committee's January 25, 2024, hearing on assisted living (AL).

Our organization represents 230 nonprofit, governmental, and proprietary AL communities through their membership with Nebraska Assisted Living Association. We also administer the only known private, accredited post-secondary college operated by a long-term care association. Our college is one of three entities approved by the State of Nebraska to train AL administrators.

Nebraska-licensed AL administrators are required to ensure their facilities are compliant with the following laws and regulations:

- In Nebraska, AL is designed to promote the goals of individualized decision-making and personal autonomy. [Neb. Rev. Stat. 71-5902]
- Each AL facility is required to provide written information about the practices of the facility to each applicant for admission to the facility or his or her authorized representative, including a description of the services provided by the facility, the staff available to provide the services, and the charges for services provided by the facility. [Neb. Rev. Stat. 71-5905(3)]
- Any AL facility which offers to provide or provides care for persons with Alzheimer's disease, dementia, or a related disorder by means of an Alzheimer's special care unit is required to disclose the form of care or treatment provided to the department and to any person seeking placement within an Alzheimer's special care unit. The information is required to include the Alzheimer's special care unit's written statement of its overall philosophy and mission; the process and criteria for placement in, transfer to, or discharge from the unit; the process used for assessment and establishment of the plan of care and its implementation; four hours of annual education for direct care staff; the physical environment to support the functioning of cognitively impaired adult residents; the frequency and types of resident activities; the involvement of families and the availability of family support programs; and the costs of care and any additional fees. [Neb. Rev. Stat. 71-516.04(1-2)]
- The AL facility is required to provide residents their rights in writing upon admission and for the duration of their stay, including their right to:
    1. Be treated with dignity and provided care by competent staff;
    2. Be an equal partner in the development of the resident service agreement while retaining final decision making authority;
    3. Be informed in advance about care and treatment and of any changes in care and treatment that may affect the resident's well-being;
    4. Be informed in writing of the pricing structure and/or rates of all facility services;

5. Self-direct activities, participate in decisions which incorporate independence, individuality, privacy and dignity and make decisions regarding care and treatment;
6. Choose a personal attending physician;
7. Voice complaints and grievances without discrimination or reprisal and have those complaints/grievances addressed;
8. Examine the results of the most recent survey of the facility conducted by representatives of the Department;
9. Refuse to perform services for the facility;
10. Refuse to participate in activities;
11. Privacy in written communication including sending and receiving mail;
12. Receive visitors as long as this does not infringe on the rights and safety of other residents;
13. Have access to the use of a telephone with auxiliary aides where calls can be made without being overheard;
14. Have the right to have a telephone in his/her room at the resident's expense;
15. Retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights and safety of other residents;
16. Share a room with a person of his or her choice upon consent of that person;
17. Self-administer medications if it is safe to do so;
18. Be free of chemical and physical restraints;
19. Exercise his or her rights as a resident of the facility and as a U.S. citizen or resident;
20. Form and participate in an organized resident group that functions to address facility issues;
21. Review and receive a copy within two working days of their permanent record;
22. Be free from abuse, neglect, and misappropriation of their money and personal property; and
23. Be free from involuntary transfer or discharge without 30 days advance written notice except in situations where the transfer or discharge is necessary to protect the health and safety of the resident, other residents or staff. [175 Neb. Admin. Code 4]

- The AL facility is required to evaluate each resident and have a written service agreement negotiated with the resident and authorized representative, if applicable, to delineate the services to be provided and the costs for those services. [175 Neb. Admin. Code 4]
- Each AL facility must provide residents care and services in accordance with their established resident service agreements which maximize the residents' dignity, autonomy, privacy and independence [175 Neb, Admin. Code 4]

In addition to the above, Nebraska statute requires that AL direct care staff annually receive four hours of training on topics pertaining to Alzheimer's and dementia care and treatment.

Each state has developed AL services and regulatory oversight to meet the needs of its population. Nebraska regulations are already successfully designed to protect AL residents' needs and rights, including those related to health, safety, privacy, dignity, and disclosure of information. Nebraska is taking care of our assisted living residents.

Sincerely,

Jalene Carpenter
President and CEO

Florida Health Care Association 70 YEARS
REPRESENTING FLORIDA'S LONG TERM CARE COMMUNITY SINCE 1954

February 1, 2024

Scott Bickel
The United States Senate Special Committee on Aging
G16 Dirksen Senate Office Building
Washington, DC 205-6050

Subject: Hearing on Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults

Dear Mr. Bickel:

This letter is in response to the recent hearing on assisted living facilities, specifically focused on understanding long-term care options for older adults. As CEO of the Florida Health Care Association which represents assisted living providers in the state of Florida, I believe it is crucial to address the challenges faced by our aging population and find ways to make assisted living a more affordable option.

One key aspect that was emphasized during the hearing is the need for assisted living communities to have disclosure requirements on costs. Florida has regulations that require transparency and disclosure of costs, services included in the cost and other necessary information for the resident and families to make informed decisions.

It is imperative to recognize that the elderly population is growing rapidly, and their needs are evolving. As a result, it is essential to explore innovative solutions to ensure that assisted living remains an accessible and affordable option.

In conclusion, I urge the Senate Aging Committee to prioritize funding options for assisted living facilities. By focusing on the costs and finding ways to make assisted living more affordable, we can empower older adults and their families to make informed decisions about their long-term care.

Thank you for your attention to this matter. I look forward to the outcomes of the hearing and the positive impact it will have on the lives of older adults.

Sincerely,

J. Emmett Reed

J. Emmett Reed
Chief Executive Officer

T: (850) 224-3907
F: (850) 681-2075
www.fhca.org

Street Address:
307 West Park Avenue
Tallahassee, FL 32301

Mail To:
P.O. Box 1459
Tallahassee, FL 32302

STATEMENT FOR THE RECORD

SUBMITTED TO THE

Special Committee on Aging

United States Senate

Hearing: *Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults*

January 25, 2024

American Seniors Housing Association (ASHA)
5225 Wisconsin Avenue, N.W.
Suite 500
Washington, D.C. 20005

For further Info, contact:
David Schless, President & CEO, david@ashaliving.org
Jeanne McGlynn Delgado, VP, Government Affairs, jeanne@ashaliving.org

The American Seniors Housing Association (ASHA) appreciates the opportunity to submit this statement for the record regarding the Senate Aging Committee hearing, *Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults*.

ASHA is a national organization of over 500 senior living companies who own, operate, or provide services to approximately 7,000 senior living communities across the U.S., including active adult, independent living, assisted living, memory care and life plan/continuing care retirement communities. Our members' communities serve a wide range of seniors, from those who require very little assistance with activities of daily living such as eating, bathing and dressing to those with significant needs associated with Alzheimer's disease and related forms of dementia. The Association's programs are focused on promoting quality and innovation, advancing research, exchanging strategic business information, and educating seniors and their families about the merits of senior living.

As such, we have a keen interest in the policy agenda of the Senate Aging Committee and encourage the committee to look to ASHA as a resource for timely and relevant research on issues that impact seniors relative to their housing options and long-term care needs.

As the Committee seeks to understand the many facets of assisted living as a long-term care option for older adults, we think it is important to address what we believe to be unfair and inaccurate characterization of the assisted living industry as reported in late 2023 by the *Washington Post* series "Memory, Inc." and the *New York Times*, "Dying Broke." Given that these series of articles have partly prompted this hearing, we felt it important to address some of these issues as well as call attention to our nation's aging population's growing demand for long term care.

The *Washington Post* series reported on isolated but tragic incidents of elopement from assisted living and memory care communities over a five-year time frame. Any incident of injury or death due to human error or neglect is devastating to all who are impacted, including the resident, their family, and to the senior living community itself – other residents and staff members alike. Needless to say, poor quality of care in senior living should never be tolerated.

Notwithstanding, we believe this reporting is one sided, lacks context, and misrepresents the vast majority of assisted living communities across the country. It is a disservice to the senior living owners and operators who provide quality assisted living and demeans the work of the dedicated assisted living caregiving workforce. It also fails to recognize the hundreds of thousands of highly satisfied residents and families who choose assisted living and benefit greatly from this option of care.

Elopement is a Not a Routine Event in America's Growing Senior Assisted Living Industry

The five-year *Washington Post* investigation identified almost 100 cases of elopements from assisted living communities that tragically resulted in death. However, over that same time period, the industry provided full-time housing and care for approximately six million seniors, making this a highly rare occurrence.

According to the Alzheimer's Association, approximately 60% of people with dementia will wander at some point. They will wander in assisted living communities, nursing homes and certainly while living in a private home with a spouse, child, or paid caregiver. Communities that serve these residents thoughtfully include design features to prevent elopements and incorporate safety devices, technology, and alerts to quickly identify potential "exit seekers" and respond. Trained caregivers and nurses in assisted living and memory care communities face these odds every day and work creatively and passionately to avoid the outcomes reported by the *Washington Post*. In this regard they overwhelmingly succeed.

The Federal Government Does Not Regulate Assisted Living …States Do

It is true that the federal government does not regulate assisted living like nursing homes. However, the industry is highly and appropriately regulated at the state level where rigorous oversight is provided and laws are updated as needed or desired.

Strict licensing and practice requirements are imposed on every community and while state variations exist, they generally all address the core elements of operation and practice: residency agreements, disclosure of service costs, resident need assessments and care planning (pre- and post- admission), resident rights, community policies, staffing and training requirements (including dementia training), medication assistance services, food and dietary provisions, third-party provider offerings, resident safety, limitations on services, community survey requirements, physical plant and life safety mandates, and much more. In addition, assisted living is subject to local health department and fire safety rules and regulations.

State regulation of assisted living and memory care allows for a more responsive process when policymakers, industry, consumers, and other stakeholders call for a change in rules. ASHA and LeadingAge have jointly published a *Seniors Housing Regulatory Handbook* for the last 18 years, compiling the latest in state regulatory agency requirements for all 50 states and the District of Columbia. Over the last five years, 19 states on average each year reported changes to key licensure and/or regulatory requirements for assisted living, demonstrating the level to which states are actively engaged to ensure vigorous and ongoing oversight is in place.

Also noteworthy is that the four assisted living provider associations (ASHA, Argentum, Leading Age and NCAL) along with the National Association of State Regulatory Administrators (NARA) are currently working on the Quality in Assisted Living Collaborative (QALC) to develop Model Guidelines for states to consider adopting in key areas, such as infection prevention and control, dementia training and emergency preparedness. The group also seeks input from a designated workgroup of industry stakeholders, regulators, and consumers. These approaches to creating industry guidance or models are an appropriate and productive way to improve outcomes in assisted living, identify new challenges and inform future policy recommendations for assisted living. These initiatives should be encouraged.

The Long-Term Care Options for Older Adults is Limited

The *New York Times* series was more financially focused and called attention to a very real problem America's rapidly aging population is facing; how to pay for long-term care. Assisted living is largely a private pay model of care that grew in the late -1980's from consumers' desire for options other than a federally regulated nursing home. Our industry recognizes the challenges of meeting the growing demand and specifically meeting the needs of those in the middle-income market. A small percentage of providers engage in the Medicaid Waiver program in states that allow assisted living participation as a home and community-based service. It is a good option for Medicaid eligible seniors, but the dollars are limited, and it is not available for assisted living in all states.

It is noteworthy that among available settings, assisted living remains the lowest cost option for long-term care:

Provider	**Setting**	**Monthly Cost**	**Yearly Cost**
Home Health Care (44 hours per week/52 weeks)	Homemaker Health Aide	$5,148	$61,776
Assisted Living Community (12 months of care/housing)	Private, One Bedroom	$4,500	$54,000
Nursing Home Care (365 days of care)	Semi- Private Room	$7,908	$94,896
	Private Room	$9,034	$108,408
Adult Day Health Care (5 days per week/52 weeks)	Day Program	$1,690	$20,280

Source: Genworth, Monthly Median Costs: National (2021)

Note that home care is not a 24/7 service, nor does it provide housing, meals, snacks, utilities, housekeeping, and resident engagement activities which are included in the assisted living setting.

As ASHA wrote in a Letter to the Editor to the *New York Times*, "many Americans do have sufficient savings and home equity to pay for long-term care at home or in assisted living. But many have underestimated the consequences of longer life spans and have either been unable to adequately save or have not prepared for the costs associated with the myriad physical and cognitive care needs that are common at advanced ages."

Policymakers, along with stakeholders must collaborate to address ways to incentivize retirement savings, pursue policy options to reignite the long-term care insurance market and/or consider new government assistance programs to subsidize the cost of care. We look forward to working with the Committee to do that.

The Workforce Shortage Requires an "All of the Above Approach"

There is a workforce shortage in the overall health care industry, and it is especially challenging in the senior living industry. As most understand, the pandemic was and continues to be a significant contributor to the shortage. Assisted living providers are making great strides to attract and retain a solid workforce by offering higher wages and benefits, responding to the call for more flexibility in scheduling to address childcare and other obligations, offering enhanced training and creating career paths for team members. According to data from the Bureau of Labor Statistics (BLS), wages in key metropolitan statistical areas (MSAs) have increased by double digits in most markets for Certified Nursing Assistants since pre-COVID.

MSA	CNA Average Hourly Pay 2019	CNA Average Hourly Pay 2022	% Increase in Average Hourly Pay 2019 to 2022
Washington, DC	$15.20	$17.84	17.37
Philadelphia, PA	$14.70	$18.29	24.42
Boston, MA	$16.64	$19.26	15.75
New York, NY	$17.67	$21.87	23.77
Houston, TX	$13.68	$15.68	14.62
Chicago, IL	$14.37	$18.01	25.33
Detroit, MI	$14.60	$17.54	20.14
Milwaukee, WI	$13.91	$17.89	28.61
St. Louis, MO	$12.68	$16.67	31.47
Atlanta, GA	$13.36	$15.30	14.52
Seattle, WA	$15.97	$21.34	33.63
Miami, FL	$12.64	$15.90	25.79
Dallas, TX	$13.36	$16.04	20.06
Los Angeles, CA	$16.16	$18.85	16.65
Denver, CO	$16.49	$18.40	11.58
Portland, OR	$16.30	$20.53	25.95
San Francisco, CA	$21.28	$22.08	3.76
Omaha, NE	$15.04	$17.27	14.83
Salt Lake City, UT	$14.60	$16.74	14.66
Phoenix, AZ	$15.34	$18.42	20.08
Tampa, FL	$13.41	$16.58	23.64
Minneapolis, MN	$16.95	$19.83	16.99
Las Vegas, NV	$17.19	$18.48	7.50

Source: Bureau of Labor Statistics (BLS)

The work is hard and demands a person who has compassion for older adults. Not all workers in this country are suited for this mission driven work which makes the challenge even greater. There are simply not enough native-born workers to meet the current and future demand for long-term care. Left unresolved, it will ultimately impact the ability to care for older adults. It is time to look beyond our borders and give immigration reform serious attention. We understand the need to couple border security with legal immigration reform. We support efforts to address both challenges. However, there are thousands of people here in the U.S. awaiting work authorization. Therefore, we urge action to expedite work authorization documents for those who are currently eligible.

We also need to work toward creating a pipeline of caregivers in this country, through workforce training and development programs. Existing federal workforce development grant programs

should be made available to all providers to ensure the greatest reach for those willing to participate. Without care providers, the U.S. cannot responsibly care for its seniors.

The Value Proposition of Senior Living is Significant

Making the transition to senior living allows older adults the ability to be socially connected and feel engaged with life. This becomes more important as we age, and not just for mental health reasons. Isolation is a serious health risk for older adults. We now know that people who do not or cannot maintain connections with friends, family and neighborhood will experience greater numbers of chronic and life-limiting health problems, such as heart disease, diabetes, and cancer. The benefits of belonging to a community and spending leisure time productively are too important to ignore.

The industry welcomes the opportunity to create more awareness among the Senate Aging Committee about what the industry is achieving in senior care for residents, caregivers, families, and the broader healthcare system. The hard work and dedication of senior living professionals and the overwhelming resident and family satisfaction deserves to be recognized.

The aging population and demand for long-term care in the very near future requires policy makers to give serious thought to innovative approaches to create more options for older adults who need care and housing. We look forward to working with the Committee to advance opportunities to meet this critical need.

Center for Excellence in Assisted Living
CEAL@UNC

Center for Excellence in Assisted Living
University of North Carolina at Chapel Hill

Statement for the Record

United States Senate Special Committee on Aging

Hearing on "Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults"

January 25, 2024

The Center for Excellence in Assisted Living (CEAL) was established in 2003 in response to the U.S. Senate Special Committee on Aging's Assisted Living Workgroup Report, as a unique national collaborative of diverse organizations working together to promote excellence in assisted living. In 2023, CEAL joined with the University of North Carolina at Chapel Hill (UNC) to create a closer partnership with research and provide more capacity to advance the well-being of the people who live and work in assisted living through research, practice, and policy. Information about CEAL@UNC is available at its website.

CEAL@UNC appreciates the opportunity to submit this statement for the record to the Senate Special Committee on Aging regarding the hearing *Assisted Living Facilities: Understanding Long-Term Care Options for Older Adults*. The statement presents six interrelated topics that are central to understanding assisted living; each topic concludes with an issue that requires attention to improve assisted living going forward. The statement ends with potential actions for the future.

1. **Assisted living is referred to as a "*community*" rather than a "*facility*," reflecting its philosophy and variation.**
   The term "*community*" has been the preferred term for assisted living since the 1990's; in contrast to the word "*facility*," *community* intends to convey residential-style living, consumer autonomy, and person-centeredness.[1,2] In fact, assisted living is formally recognized as a home and community-based setting. Relatedly, the definition of assisted living is broad to allow for a range of person-centered options: *a congregate setting that includes "core services such as access to health-related, social and recreational services, as well as access to staff 24 hours daily. The core principles include resident-centered services and policies that promote each resident's quality of life, right to privacy, choice, dignity and independence as defined by that resident."*[3]
   - **Due to the range of assisted living communities and services, each community must provide clear and transparent information about their scope of services to allow consumers to make informed choices.**

2. **Assisted living is the largest provider of residential long-term care in the nation.**
   Most often, older adults and others who require supportive care initially receive that support from family and paid home care; when family and other home-based supports are no longer available or sufficient, they turn to residential care settings. Although there are more nursing home beds than there are beds/units/apartments in assisted living communities, half of older adults who require residential long-term care now receive it in assisted living (55% versus 45% in nursing homes); approximately 918,700 older adults reside in 31,400 assisted living communities across the nation.[4] However, the communities are disproportionately distributed; they are more often located in counties with a higher percentage of individuals who are non-Hispanic white (89% of residents are non-Hispanic white), and have a higher socioeconomic status and more education.[4,5]
   - **Expanding equitable access to assisted living services should be prioritized.**

3. **Assisted living is primarily private-pay, providing access to those who can afford it.**
   Assisted living evolved as a less expensive alternative to nursing home care for people who did not need intensive nursing services and could pay privately; it still largely relies on individuals' personal savings, retirement accounts, social security, pensions, and (if available) family members' incomes. The annual median cost for assisted living (in 2021) was $54,000,[6] which is out of reach for approximately 40% of middle-income older adults even after selling their home (but less expensive than nursing home care or around-the-clock home care).[7] Medicaid is available on a limited waiver basis to cover assisted living services (but not housing costs) in almost all states, but is available for roughly only one in five assisted living residents.[8]
   - **Steps must be taken to strengthen access to assisted living for the "forgotten middle" market of older adults.**

4. **Assisted living residents have significant care needs, and many have Alzheimer's disease or related dementia.**
   Health and supportive care options for older adults have been evolving over the last decades, changing the profile of assisted living residents. Shorter hospital stays have resulted in increased use of nursing homes for post-acute care following hospitalization, and individuals who do not require ongoing nursing care are now the residents of assisted living. Today, more than half of assisted living residents are 85 years of age or older, need help with mobility, and have medical, cognitive, and affective conditions.[9,10] Importantly, assisted living has become the largest residential care provider for persons with Alzheimer's disease or related dementia, including for persons with moderate or advanced dementia: 25% of communities are devoted to or have a unit devoted to memory care, compared to 14% of nursing homes.[11] Residents' care needs are multiple: based on Medicaid eligibility alone, 19% have needs that meet nursing home requirements,[8] and a notable portion receive end-of-life care in assisted living.[12]
   - **Service provision must consistently meet residents' needs for care.**

5. **The quality of assisted living care depends on the quality and quantity of staff; providing care is labor-intensive.**
   Staffing is the primary challenge for assisted living; wages are relatively low, and staff recruitment and retention are major concerns just as they are in nursing homes. Most residents' care needs are personal and supportive; in response, staff provide help with daily activities including bathing and locomotion, and attend to safety and social engagement.[4] Medical monitoring and medication management also are important, typically provided by non-nursing staff who have medication training. That said, nursing presence is more common in assisted living than in the past. Forty percent of communities have a registered nurse (RN); a similar percentage have a licensed practical/vocational nurse (LPN/LVN).[4] Depending on the community -- and consistent with the variability that is virtually definitional of assisted living -- available nursing services range from basic care such as monitoring vital signs to more complex care, such as providing intravenous medications.[13] Together with personal care assistants/aides, they provide roughly 4½ hours of care per day per resident, compared to 2¾ hours in nursing homes.[4] In addition to time, training is needed to help staff capably attend to residents' psychosocial care needs, especially for residents with dementia who commonly experience depression, irritability, agitation, and anxiety; all too often, these residents are treated with antipsychotic medications when staff do not have the time or are unaware of how to prevent or lessen their distress.[14,15]
   - **Sufficient numbers of well-trained staff are critically needed to strengthen assisted living care.**

6. **Families play a vital role in assisted living.**
   Families continue to provide care after a resident moves to assisted living, including monitoring health, well-being, and finances, and participating in end-of-life care.[16-18] The importance of families became especially evident during the COVID-19 pandemic when they became recognized as essential caregivers.[19-21] Families also are centrally involved in helping to choose an assisted living community for their relative, but often lack necessary information to make a knowledgeable decision about which communities would best meet their relative's needs and preferences.[22]
   - **Families require support to fulfil their role in assisted living to the best of their ability.**

Potential Actions

Numerous feasible solutions have been suggested that may improve care and outcomes in assisted living.[2] For example, related to the variability of assisted living, the need for consumer information, and the intent to promote person-centered care, solutions include (1) promoting consumer education using common definitions and providing relevant details (e.g., added charges, move-out policies); (2) endorsing standardized reporting (an effort that was begun by the federal government years ago, but not completed);[23] and (3) decoupling services from housing to promote choice. Access and equity could in part be addressed by (4) expanding Medicaid coverage; (5) diversifying housing options and modifying services; and (6) offering tax incentives and public subsidies to owners and operators who open the door to the forgotten middle market. The quality of care and outcomes could potentially be improved by (7) adopting regulations that encourage quality improvement (already being implemented in numerous states);[24] (8) promoting quality initiatives by implementing and evaluating promising programs, processes, and measures (for example, accreditation is currently being evaluated in the state of NC);[25] and (9) adhering to consensus recommendations for medical and mental health care.[10] Finally, staffing might become more sufficient if (10) guidance or standards for staff training, supervision, compensation, and other factors were explored; (11) supportive immigration policies were adopted;[11] (12) acuity-based staffing was established (which is actively being addressed in the state of OR);[26] and (13) funds were made available to support family involvement in care (for example, modeled off the U.S. Department of Veterans Affairs Program that provides stipends to family caregivers).[27] These examples are but a few of the potential solutions to address critical issues and improve care and outcomes in assisted living.

The Role of the Center for Excellence in Assisted Living@UNC

Since its inception 20 years ago, the mission of CEAL has been to advance the well-being of the people who live and work in assisted living through research, practice, and policy. Organizations involved in CEAL represent assisted living providers; nurses, physicians, and other clinicians; experts and advocates in Alzheimer's disease and dementia care; state agencies supporting long-term services and supports; leaders in eldercare transformation; workforce experts transforming quality direct care jobs; and numerous others. To note but a few of its efforts over the last years, CEAL has worked with researchers to develop quality measures for assisted living, examine the impact of potential minimum wage increases, and evaluate change in assisted living following the initial Assisted Living Workgroup Report provided to the U.S. Senate Special Committee on Aging in 2003.[28-32] Current efforts include consulting on the ongoing Centers for Disease Control and Prevention (CDC)-funded "Moving Needles" initiative to make routine immunization a standard of care in assisted living; leading the national Be Well in AL Coalition to promote adoption of recommended medical and mental health recommendations; compiling State Transitions Plans responsive to the Centers for Medicare & Medicaid Services (CMS) Home and Community-Based services regulations; and translating research for policy and practice, all available on the CEAL@UNC website.

CEAL@UNC welcomes the opportunity and stands poised to work with the Committee and other members of Congress in a bipartisan manner to advance excellence in assisted living.

References

[1] Wilson KB. Historical evolution of assisted living in the United States, 1979 to the present. Gerontologist 2007;47(S1):8-22.
[2] Zimmerman S, Carder P, Schwartz L, Silbersack J, Temkin-Greener H, Thomas KS, Ward K, Jenkens R, Jensen L, Johnson AC, Johnson J, Johnston T, Kaes L, Katz P, Klinger JH, Lieblich C, Mace B, O'Neil K, Pace DD, Scales K, Stone RI, Thomas S, Williams PJ, Williams KB. The imperative to reimagine assisted living. J Am Med Dir Assoc. 2022;23(2):225-234.
[3] Carder, P., Dys, S., Winfree, J. (2019). The Assisted Living Workgroup Report: A 15-Year Review. Washington, DC: Center for Excellence in Assisted Living [CEAL]. Available at theceal.org.
[4] Sengupta M, Lendon JP, Caffrey C, Melekin A, Singh P. Post-acute and long-term care providers and services users in the United States, 2017-2018. National Center for Health Statistics. Vital Health Stat 3(47). 2022. Available at https://stacks.cdc.gov/view/cdc/115346.
[5] Cornell PY, Zhang W, Smith L, Fashaw S, Thomas KS. Developments in the market for assisted living: residential care availability in 2017. J Am Med Dir Assoc. 2020;21(11):1718-1723.
[6] Genworth. Cost of Care Trends & Insights. Available at https://www.genworth.com/aging-and-you/finances/cost-of-care/cost-of-care-trends-and-insights.html/.
[7] Pearson CF, Murphy R, Gianattasio K, Loganathan, S. The Forgotten Middle: Housing & Care Options for Middle-Income Seniors in 2033. Available at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.norc.org/content/dam/norc-org/documents/standard-projects-pdf/NORC%20Forgotten%20Middle%202022%20-%20Analysis%20and%20Findings.pdf.
[8] Caffrey C, Sengupta M, Melekin A. Residential care community resident characteristics: United States, 2018. NCHS Data Brief, no 404. Hyattsville, MD: National Center for Health Statistics. 2021.
[9] Zimmerman S, Sloane PD, Reed D. Dementia prevalence and care in assisted living. Health Aff (Millwood). 2014;33(4):658-666.
[10] Zimmerman S, Sloane PD, Wretman CJ, Cao K, Silbersack J, Carder P, Thomas KS, Allen J, Butrum K, Chicotel T, Giorgio P, Hernandez M, Kales H, Katz P, Klinger JH, Kunze M, Laxton C, McNealley V, Meeks S, O'Neil K, Pace D, Resnick B, Schwartz L, Seitz D, Smetanka M, Van Haitsma K. Recommendations for medical and mental health care in assisted living based on an expert Delphi consensus panel: a consensus statement. JAMA Netw Open. 2022;5(9):e2233872.
[11] Zimmerman S, Stone R, Carder P, Thomas KS. Does assisted living provide assistance and promote living? (In press). Health Aff (Millwood).
[12] Hanson LC, Eckert JK, Dobbs D, Williams CS, Caprio AJ, Sloane PD, Zimmerman S. Symptom experience of dying long-term care residents. J Am Geriatr Soc. 2008;56(1):91-98.
[13] Beeber AS, Zimmerman S, Reed D, Mitchell CM, Sloane PD, Harris-Wallace B, Perez R, Schumacher JG. Licensed nurse staffing and health service availability in residential care and assisted living. J Am Geriatr Soc. 2014;62(5):805-811.
[14] Dobbs D, Zimmerman S, Carder P, Beeber AS, Palmertree SJ. Staff reports of behavioral expressions of persons with dementia in 250 assisted living communities. Gerontologist. 2022;62(2):169-180.
[15] Scales K, Zimmerman S, Miller SJ. (2018). Evidence-based nonpharmacological practices to address behavioral and psychological symptoms of dementia. Gerontologist, 58(S1):88–102.
[16] Coe NB, Werner RM. Informal caregivers provide considerable front-line support in residential care facilities and nursing homes. Health Aff (Millwood). 2022;41(1):105-111.
[17] Port CL, Zimmerman S, Williams CS, Dobbs D, Preisser JS, Williams SW. Families filling the gap: comparing family involvement for assisted living and nursing home residents with dementia. Gerontologist. 2005;45(S1):87-95.
[18] Williams SW, Zimmerman S, Williams CS. Family caregiver involvement for long-term care residents at the end of life. J Gerontol B Psychol Sci Soc Sci. 2012;67(5):595-604.
[19] Zimmerman S, Sloane PD, Katz PR, Kunze M, O'Neil K, Resnick B. The need to include assisted living in responding to the COVID-19 pandemic. J Am Med Dir Assoc. 2020;21(5):572-575.
[20] Kemp CL. #MoreThanAVisitor: families as "essential" care partners during COVID-19. Gerontologist. 2021;61(2):145-151.
[21] Zimmerman S. Families are not informal -- they are an essential solution to the workforce crisis in long-term care. J Am Med Dir Assoc. 2022;23(7):1121-1122.
[22] Zimmerman S, Cohen L, Horsford C. Group proposes public reporting for assisted living. Provider. 2013;39(12):40-42.
[23] U.S. Department of Health & Human Services. Assisted Living Disclosure Collaborative. Available at https://archive.ahrq.gov/research/findings/factsheets/aging/aldc/index.html
[24] American Health Care Association/National Center for Assisted Living. State Regulatory Resources. Available at https://www.ahcancal.org/Assisted-Living/Policy/Pages/state-regulations.aspx.
[25] Senate Bill 105: 2021 Appropriations Act, Sec. 9E.6: Adult Care Home Accreditation Pilot Program. February22, 2022. Available at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://dashboard.ncleg.gov/api/Services/BillSummary/2021/S105-SMSH-118(sl)-v-5.
[26] Oregon Department of Human Services. Acuity-Based Staffing. Available at www.oregon.gov/odhs/licensing/community-based-care/pages/acuity-based-staffing.aspx.
[27] Kuntz AA, Wanninger E, Lewis B. (2022). Caregiver support in a case of posttraumatic stress disorder and Lewy Body dementia. Federal Pract 2022; 39(5):226–231.
[28] Zimmerman S, Allen J, Cohen LW, Pinkowitz J, Reed D, Coffey WO, Reed P, Lepore M, Sloane PD; University of North Carolina-Center for Excellence in Assisted Living Collaborative. A measure of person-centered practices in assisted living: the PC-PAL. J Am Med Dir Assoc. 2015;16(2):132-137.
[29] Zimmerman S, Love K, Cohen LW, Pinkowitz J, Nyrop KA. Person-centeredness in home- and community-based services and supports: domains, attributes, and assisted living indicators. Clin Gerontol. 2014;37(5):429-445.
[30] Zimmerman S, Cohen LW, Washington T, Ward K, Giorgio P. Measures and Instruments for Quality Improvement in Assisted Living. Available at https://theceal.org/resources/measures-and-instruments-for-quality-improvement-in-assisted-living/
[31] Weiner JM, Elkins W, Lepore M. Impacts of Potential Minimum Wage Increases on Assisted Living and Continuing Care Retirement Communities. Available at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://theceal.org/wp-content/uploads/2017/09/RTI-CEAL-Minimum-Wage-Report-2017-FINAL.pdf.
[32] Carder P., Dys S, Winfree J. 15 Year Review: The Assisted Living Workgroup Report. Available at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://theceal.org/wp-content/uploads/2023/01/CEAL-Workgroup-Report-010920.pdf.

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00421087. Complaint IN00421087 - No deficiencies related to the allegations are cited. Survey dates: December 4, 5 and 6, 2023. Facility number: 014178 Residential Census: 127 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/11/23.	R 0000	No deficiencies noted, no plan of correction needed	
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 [redacted] TITLE Executive Director (X6) DATE 12/21/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determin 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 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.

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 record review and interview, the facility failed to ensure the fire department was invited to participate in scheduled fire drills at least every six months. This had the potential to affect all 127 residents residing in the facility. Finding includes: The annual fire drills were reviewed on 12/4/23 at 2:13 p.m. The monthly fire drill logs lacked documentation that the fire department was invited or attended any of the drills. Interview with the Maintenance Director on 12/4/23 at 9:19 a.m., indicated the fire department had not been invited to participate in any of the monthly drills.	R 0092	Community will meet with local Fire Chief and coordinate bi-annual fire drills for 2024. This will be completed and community will be in compliance by January 5, 2024. Moving forward, community will contact Fire Chief in December of each consecutive year to coordinate and schedule bi-annual fire drills with the local fire department.	01/05/2024
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certification scheduled for 8 of 33 shifts and current first aid certification for 33 of 33 shifts reviewed. Finding includes: Facility staffing schedules for 11/26/23 through 12/6/23 were reviewed on 12/6/23 at 9:45 a.m. The schedules indicated there were no staff members who were CPR or first aid certified on the following dates and shifts: Day Shift: 11/26/23 - 12/6/23 No certified first aide staff available. Evening Shift: 11/26/23 - 12/6/23 No certified first aide staff available Night Shift: 11/26/23 - 12/6/23 No certified first aide staff available. Evening Shift: 11/26/23, 11/27/23, 11/28/23, 12/1/23, 12/2/23, 12/3/23, 12/4/23, and 12/5/23. No certified CPR staff available. Interview with Business Office Manager on 12/6/23 at 12:20 p.m., indicated they were not	R 0117	Community will in-service and coordinate certification in CPR and First Aid of all clinical staff. This will be completed and community will be in compliance by January 5, 2024. Moving forward, the hiring manager, business office manager and ED will follow hiring process and ensure that current and new hires in the nursing department will remain current with required CPR and First Aid Certification. Monthly audits of CPR and First Aid Certifications will be audited during QI meetings. If any deficiencies or expiration of certifications are found, the employee will immediately be pulled off the schedule until the deficiency is rectified.	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	aware that they had to have coverage for CPR and First Aide for each shift, every day. They are working to fix the issue currently.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants.			

PRINTED: 12/06/2023
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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure all staff received annual inservice training related to six hour required training not completed by a Qualified Medication Assistant. (QMA 1) Finding includes: The Employee Records were reviewed on 12/6/23 at 9:45 a.m. There was no evidence QMA 1 had received annual inservice training. Interview with the Executive Director on 12/4/23 at 1:50 p.m., indicated none of the QMAs had completed the required training, except one who did hers independently. The Indiana Department of Health document, "QMA Annual Inservice Training", located on INhealth.gov website indicated, "QMA Annual Inservice Training (6 hours) must be completed every year and kept by the QMA. The six (6) hours of QMA Inservice must be obtained annually between January and December..."	R 0120	Community completed in-service and education to all staff on 12/12/2023 on importance and regulatory requirements of annual training/in-service and that the community utilizes Relias to satisfy this regulation. Staff were informed that if mandatory Relias training/in-service is not completed they will be removed from the schedule until completed. Community will complete weekly audits of past due mandatory Relias training/education in-services and discuss every Tuesday at morning meetings. Any employee out of compliance with required Relias training/in-services will be immediately removed from the schedule until it is completed. Community will audit compliance during monthly QI meetings for the next 6 months. QMA required 6 hour training courses were added to 10 QMA's currently employed in the community. Compliance to be met by January 5, 2024.	01/05/2024
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:			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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 the services to be provided. Based on observation, record review, and interview, the facility failed to ensure resident service plans were reviewed and signed by the resident or resident's representative for 6 of 8 service plans reviewed. (Residents 2, 3, 6, 4, 7 and 9) The facility also failed to ensure service plans were accurate and/ or complete related to not addressing ostomy and oxygen use, inaccurate for catheter care and not addressing self medication administration. (Residents 4, 8 and 9) Findings include: 1. Resident 2's record was reviewed on 12/4/23 at 9:15 a.m.	R 0217	Community will review all resident service plans for completion and accuracy. DON, ADON and ED will audit for inclusion of ostomy, oxygen, catheter care, self-administration, etc. Community will schedule and obtain signatures on all current service plans. Community will complete and be in compliance by January 5, 2024. Signed resident service plans will be maintained in a binder, in alphabetical order and will be	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Resident Service Plan, dated 12/2/23, was not signed by the resident and/or responsible party. 2. Resident 3's record was reviewed on 12/4/23 at 2:45 p.m. The Resident Service Plan, dated 11/29/23, was not signed by the resident and/or responsible party. 3. The closed record for Resident 6 was reviewed on 12/6/23 at 9:35 a.m. The Resident Service Plan, dated 5/2/23, was not signed by the resident and/or responsible party. Interview with the Assistant Director of Nursing on 12/5/23 at 12:39 p.m., indicated that all Resident Service Plans should have been signed by the resident and/or the responsible party. 4. Resident 4's record was reviewed on 12/4/23 at 1:32 p.m. The Comprehensive Resident Assessment Instrument, dated 11/30/23, indicated the resident was cognitively intact for daily decision making. The resident required oxygen therapy and had an ostomy. The Resident Service Plan, updated on 4/27/23, did not address the resident's ostomy or oxygen use. The Resident Service Plan was not signed by the resident. Interview with the Director of Nursing (DON) on 12/6/23 at 2:30 p.m., indicated the Resident Service Plan should have been signed by the resident and updated to reflect the use of oxygen and the ostomy.		audited at monthly QI meetings for the next 6 months.	

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. Resident 7's record was reviewed on 12/5/23 at 2:51 p.m. The Quarterly Assessment, dated 6/21/23, indicated the resident was cognitively intact for daily decision making. The Resident Service Plan, dated 5/3/23, was not signed by the resident and/or responsible party. Interview with the Assistant Director of Nursing on 12/5/23 at 12:39 p.m., indicated that all Resident Service Plans should have been signed by the resident and/or the responsible party. 6. Resident 8's record was reviewed on 12/5/23 at 9:47 a.m. Diagnoses included, but were not limited to, diabetes and congestive heart failure. The Comprehensive Resident Assessment Instrument, dated 11/14/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. The Resident Service Plan, updated 11/24/23, indicated the resident had a foley catheter. He required assistance with switching the gravity bag to a leg bag when needed, peri-care daily, and emptying the bag. The services provided included, but were not limited to, monitoring for complications of catheter use, performing peri-care, and monitoring for signs and symptoms of a urinary tract infection (UTI). There was no documentation related to monitoring the catheter, peri-care, or monitoring for signs and symptoms of a UTI. Interview with the Assistant Director of Nursing on 12/6/23 at 2:15 p.m., indicated the facility staff			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not instructed to perform any peri-care for the resident and there was no documentation of peri-care being completed for the resident. The Resident Service Plan needed to be updated. 7. Resident 9's record was reviewed on 12/4/23 at 9:56 a.m. The Comprehensive Resident Assessment Instrument, dated 7/20/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. The Resident Service Plan, updated 12/5/23, indicated the resident was able to use medication as directed with set-up and oversight by nursing staff. The Resident Service Plan was not signed by the resident. Interview with Resident 9 on 12/6/23 at 1:15 p.m., indicated the resident self-administered all medications. Interview with the Director of Nursing on 12/6/23 at 2:30 p.m., indicated there were no signed service plans for the resident and the service plan, dated 12/5/23, needed to be corrected as the resident self-administered all medications.			
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 store, serve, and prepare food under sanitary conditions related to dirty food equipment, food crumbs on clean surfaces,	R 0273	Community has scheduled a deep clean of entire kitchen on December 21, 2023. Community has scheduled an	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	undated food in the refrigerator and freezer, a food scoop stored improperly, serving dishes and storage containers stored improperly, food stored improperly in the freezer, and improper hand hygiene during food preparation for 1 of 1 kitchen areas observed (the main kitchen). This had the potential to affect the 127 out of 127 total residents who received food from the kitchen. Findings include: 1. During the Initial Kitchen Sanitation Tour with the Dietary Food Manager (DFM) on 12/4/23 at 9:00 a.m., the following was observed: a.. There were food crumbs and debris on a tray on the bottom storage shelf in the kitchen. b. There was a build up of food debris and grease on the side of the oven, top of the stove, and on the griddle. c. The bowls and plates were stored upright on the storage shelving. d. A large scoop was stored in both the flour and sugar bins. e. There were baking dishes stored upright on the storage shelving. f. There were cardboard boxes filled with food items stacked on the shelving in the walk-in freezer that were touching the ceiling. g. There was a container of cooked chicken unlabeled and undated in a Styrofoam to-go container in the salad prep fridge h. There was a plastic bag of unlabeled frozen		in-service with all dietary staff to provide education on proper food storage, proper dating of food and proper hand hygiene on December 21, 2023. Community Dietary Director and ED will complete weekly audits in kitchen of cleanliness, proper storage, proper dating of food and proper hand hygiene. Any and all deficiencies, if found, will be corrected immediately and continued education with dietary staff will continue. Audits and compliance will be reviewed during monthly QI meetings for the next 6 months.	

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	meat in the walk-in freezer. i. There was a package of opened butter with no label in the walk in fridge. Interview with the DFM at the time, indicated the above areas needed cleaned, items needed to be stored properly, and the food all needed proper labels. 2. During the observation of the tray line, on 12/5/23 at 10:56 a.m., Cook 1, was observed touching bread with gloved hands, touching the outside packaging of the bread, and then reaching into the bag and removing a piece of bread with the same gloved hand. She did not perform hand hygiene and don clean gloves before touching the bread. She was observed touching the outside of the salami packaging with gloved hands and then touching the salami with the same gloved hands without performing hand hygiene and donning clean gloves. Interview with the Dietary Food Manager at the time, indicated Cook 1 should have performed hand hygiene and donned clean gloves before touching the food. The Policy titled, "When to Wash Hands," indicated food employees shall lean their hands and exposed portions of their arms immediately before engaging in food preparation, and ...f) during food preparation, as often as is necessary to remove soil and contamination and to prevent cross-contamination when changing tasks ...h) before donning gloves for working with food; and i) after engaging in other activities that contaminate the hands."			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 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 record review and interview, the facility failed to ensure clinical records were accurate and complete related to no Physician notification of lab results, lack of documentation related to home health provided, insulin not given as ordered and not monitoring blood pressures as ordered for 4 of 8 records reviewed. (Residents 3, 4, 8 and 9) Findings include: 1. Resident 3's record was reviewed on 12/4/23 at 2:45 p.m. Diagnoses included, but were not limited to epilepsy, anxiety and radiculopathy. A Progress Note, dated 8/11/23, indicated the Physician had ordered to repeat the lab tests comprehensive metabolic panel, thyroid, Vitamin D level and lipid panel in one month. There was no documentation the labs were repeated in one month in the progress notes or lab results. Interview with the Director of Nursing (DON) on 12/5/23 at 3:35 p.m., indicated the resident had been unavailable on 9/13/23 when the lab personal was in the building to repeat the labs. The resident had been unavailable on multiple	R 0349	DON will complete daily audits of lab results and ensure notification of results provided to ordering Physician. DON will complete audit of current residents on Home Health, Hospice or other Ancillary services and ensure that it is documented in residents chart/service plan. Community will be in compliance with this by January 5, 2024. DON will complete daily audits of insulin administered and ensure all was administered as ordered. DON will complete daily audits of physician orders and ensure that all orders are being followed and documented. All above will be audited and discussed at monthly QI meetings for the next 6 months.	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occasions and the labs were not drawn until 10/11/23. The DON contacted the lab and they faxed the results of the labwork from 10/11/23. She indicated there was no documentation the Physician was notified of those results. 2. Resident 4's record was reviewed on 12/4/23 at 1:32 p.m. Diagnoses included, but were not limited to, falls, hemiparesis, and seizures. The Comprehensive Resident Assessment Instrument, dated 11/30/23, indicated the resident was cognitively intact for daily decision making. A Nurses' Note, dated 10/23/23 at 6:16 p.m., indicated the resident had returned from a 9 day hospital stay for a total shoulder arthroplasty surgery for a fracture. The resident informed the facility she would be contacting home health services to receive physical therapy. A Nurses' Note, dated 10/25/23 at 2:22 p.m., indicated the resident had a dry and intact dressing to the right shoulder. There was no documentation related to the resident receiving the home health services, updated Resident Service Plan, Physician's Orders regarding the incision site, or monitoring of the new skin condition. Interview with the Director of Nursing (DON) on 12/6/23 at 2:50 p.m., indicated she spoke with the resident and the incision site was to be addressed by home health care services, however the resident never forwarded that information to the facility. The facility should have been alerted sooner and documented in the chart regarding any Physician's Orders. The Resident Service Plan should have been updated.			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. Resident 8's record was reviewed on 12/5/23 at 9:47 a.m. Diagnoses included, but were not limited to, diabetes and congestive heart failure. The Comprehensive Resident Assessment Instrument, dated 11/14/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. A Physician's Order, dated 9/8/23, indicated Novolog (a diabetic insulin medication) 100 units/milliliter flex pen inject per sliding scale: 150-199 = 4 units, 200-299 = 6 units, 300-399 = 8 units three times daily. The Medication Administration Record, dated 11/9/23 at 4:00 p.m., indicated the resident had a blood sugar of 305 and was administered 0 units of Novolog. On 11/30/23 at 4:00 p.m., the resident's blood sugar was 333 and he received 0 units of Novolog. Interview with the Director of Nursing on 12/6/23 at 2:15 p.m., indicated the Physician's Orders should have been followed. 4. Resident 9's record was reviewed on 12/4/23 at 9:56 a.m. Diagnoses included, but were not limited to, anxiety, depression , and hyperlipidemia. The Comprehensive Resident Assessment Instrument, dated 7/20/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. A Physician's Order, dated 2/21/23, indicated a daily assessment for blood pressure. The clinical record lacked a blood pressure recorded on 3/1, 3/2, 3/6, 3/8, 3/10, 3/11, 3/12, 3/13,			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 3/14/23. Interview with the Director of Nursing on 12/6/23 at 2:15 p.m., indicated she was unable to find the documentation of blood pressures or refusals for those dates.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 2 closed records reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 12/5/23 at 2:51 p.m. The resident was admitted to the facility on 4/17/19. The resident discharged from the facility on 10/31/23. A Nurses' Note, dated 7/22/23 at 10:00 a.m., indicated the resident was transitioning out of the	R 0354	Community has scheduled in-service with all nursing staff on December 28, 2023, to educate on transfer/discharge forms. Copies of completed transfer/discharge forms will be stored in a binder in date and alphabetical order. Audit of the completion of transfer/discharge forms will be completed daily by DON/ADON. Compliance of transfer/discharge forms will be reviewed and audited during monthly QI meetings for the	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility to the hospital due to a fall. The last Nurses' Note, dated 10/31/21 at 12:00 p.m., indicated the resident was discharged to the hospital. There was no documentation of a transfer/discharge assessment or instructions completed for the resident. Interview with the Director of Nursing on 12/6/23 at 2:30 p.m., indicated she could not find any documentation related to the resident's transfer/discharge from the facility.		next 6 months.	
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 a current emergency information	R 0356	DON, ADON and ED will audit all current residents for accuracy and completeness of all emergency	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	file was complete for 5 of 6 residents reviewed. (Residents 2, 3, 4, 5 and 9) Findings includes: The emergency file binder was reviewed on 12/5/23 at 10:35 a.m.. The follow items were missing: a. Resident 2 did not have an emergency contact or phone number and hospital preference. b. Resident 3 did not have an emergency contact or phone number and no hospital preference. c. Resident 4 did not have an emergency contact or phone number and no hospital preference. d. Resident 5 did not have any information in the emergency binder. e. Resident 9 did not have an emergency contact or phone number and no hospital preference. Interview with the Director of Nursing on 12/5/23 at 1:30 p.m., indicated she was not aware the above items were missing from the emergency binder.		information. This audit will be completed by January 5, 2024, with compliance met on same date. DON and ADON will ensure that all new admissions moving forward will have complete emergency information and copies of Face Sheets placed in Emergency Evacuation Binder within 24 hours of admission to the community. Continued compliance of this regulation will be monitored and audited at monthly QI meetings for the next 6 months.	
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 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,			

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to not posting signage at the entrance or anywhere in the facility alerting visitors the facility was in outbreak status. The facility also failed to have a system in place for tracking infections. This had the potential to affect all 127 residents residing in the facility. Findings include: 1. Upon entering the facility on 12/4/23 at 8:30 a.m., there was no signage on the front entrance or reception desk that indicated there were COVID-19 positive residents currently in the building. There were isolation rooms throughout the building which had stop signs that indicated visitors should see the nurse prior to entering the room, and had isolation bins outside the doors. Interview with the Executive Director (ED) on 12/4/23 at 8:50 a.m., indicated there were currently 16 residents who were COVID-19 positive. Interview with the Director of Nursing (DON) on 12/6/23 at 10:40 a.m., indicated she was told signs were not necessary, but she would get them put up. The current policy, "COVID-19 Infection Control Policy", received from the ED on 12/5/23, indicated, "...Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection. Post visual alerts (e.g.	R 0407	Effective immediately, ED and DON will ensure the proper signage informing visitors of any infectious outbreaks current in the community. Infection Control program and tracking tool Inservice on December 18, 2023 completed by Regional Director of Clinical Service. DON and/or ADON will audit infection control tracking tool weekly x 4 weeks, monthly times x 5 months. QI will review audits at monthly meetings, this will be ongoing.	01/05/2024

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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	signs, posters) at the entrance and in strategic places...." 2. Interview with the DON on 12/5/23 at 1:48 p.m., indicated there were no logs or tracking documented related to infections. She indicated the Interdisciplinary Team would discuss who was on antibiotics during morning meetings. She indicated she knew it should be documented. There was no additional information provided for review.			

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0545
TTY: (800) 526-5812

FAX

To: [redacted]	From: [redacted]
	Bureau of Long Term Care
Fax: 815-939-8187	Date: 2/5/24
Re: Findings from Annual W/23	Pages: (including cover) 15

☐ Urgent ☑ For Review ☐ Please Comment ☑ Please Reply ☐ Please Recycle

Please sign + date for 2/1/24, date of exit and return to fax number above.

E-mail: hfswebmaster@illinois.gov

Internet: http://www.hfs.illinois.gov/

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 10**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative	Date
[redacted]	2/1/24
	Date
Signature of Bureau of Long Term Care Regional Supervisor	Date
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _3__ OF _10__**

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.220 Resident Participation d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). This requirement is not met as evidenced by: Resident TB test: Not completed for R1 Initiated Late for R2, R3, R4 Read late for R5, R6, R14, R15 No signs/symptoms for R8 2nd step not initiated for R13, R15		

Signature of SLF Representative_____ Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _4__ OF _10__**

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to the following: E) Documentation showing that the resident has taken, or refused to take the medication; and F) Signature or initials of employee providing oversight. This requirement is not met as evidenced by: Missing/blank initials for R10, R11, and R12.		

Signature of SLF Representative_____Date_____

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on146.235 Staffing l) The SLF provider shall ensure that all employees who have or may have contact with residents or access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. This requirement is not met as evidenced by: Background check not checked within 30 days of employment for E1, E2, E3, E4, and E5.		

Signature of SLF Representative_____Date_____

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). This requirement is not met as evidenced by: TB test read late for E4 and E6. 2nd step not read for E7 and E8.		

Signature of SLF Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _7__ OF _10__**

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. This requirement is not met as evidenced by: RAI not completed for R1 RAI completed late for R2, R11, R13, R17, R18 and R22. Inaccurate RAI for R15 and R20. Incomplete RAI for R19, R21 and R22.		

Signature of SLF Representative_____Date_____

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. This requirement is not met as evidenced by: Service Plan: Not completed for R1. Missing goals/what is important for R7, R24 and R26. Wrong Service Plan for R8, R25, R27, and R28. No initial choosing to receive services for R13. Remediated on-site. Service Plan not individualized for R14, R16, and R29. Service Plan completed late for R14 and R22.		

Signature of SLF Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _9__ OF _10__**

SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. This requirement is not met by: Quarterly evaluation late for R1, R7, E14, R23, R24, R29, R30, R31, R35, R36, and R37. Quarterly evaluation not signed by RN for R13, R24, R26, R32 and R33.		

Signature of SLF Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _10__ OF _10__**

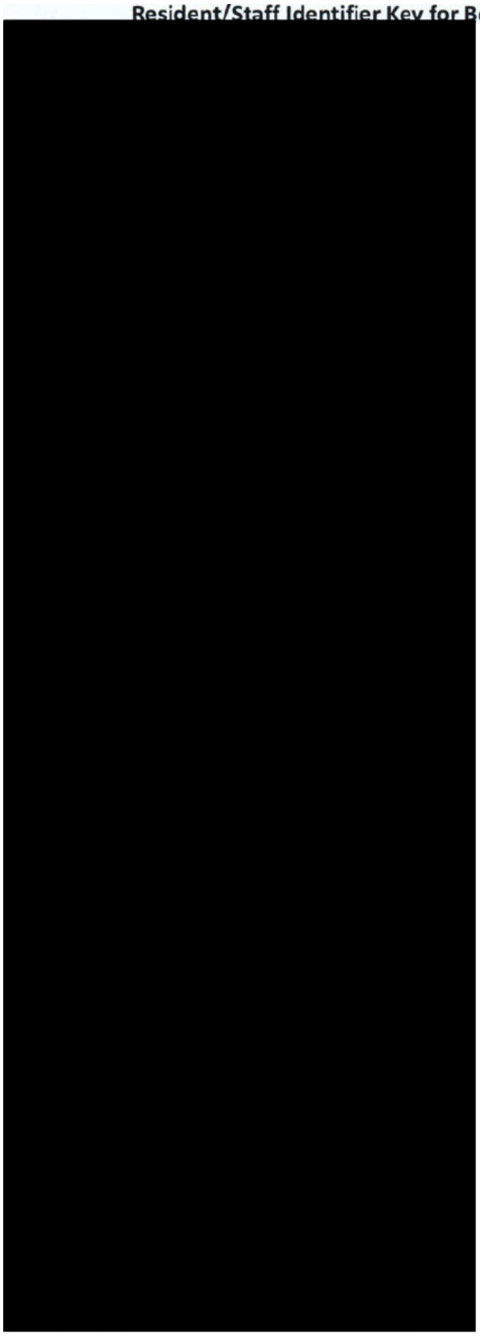
SLF NAME: Bowman Estates_____ REFERRAL DATE: __11/20/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLF RESPONSE**	**CORRECTION DATE**
Based on146.295 Emergency Contingency Plan e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. This requirement is not met as evidenced by: missing orientation for R1, R2, R3, R4, R5, R6, R7, R8, R9, R13, R14, R15, R16, R17, R19, R24, R25, R27, R28, R30, R32, R33, R35, R36, R38, R39, R40, R41, and R42.		

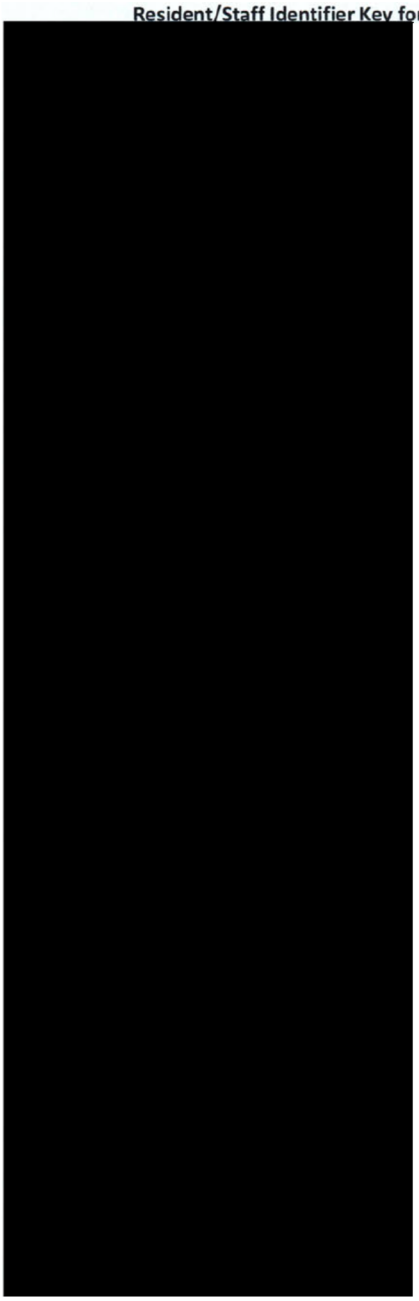
Signature of SLF Representative_____ Date_____

Resident/Staff Identifier Key for Bowman Estate WY23 Annual Review

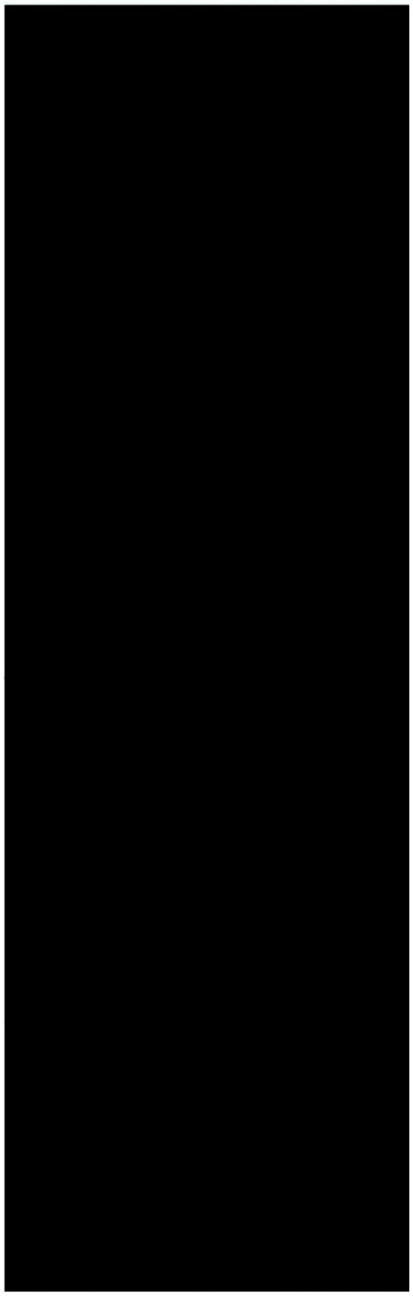


Resident/Staff Identifier Key for Bowman Estate Annual Review Con'd

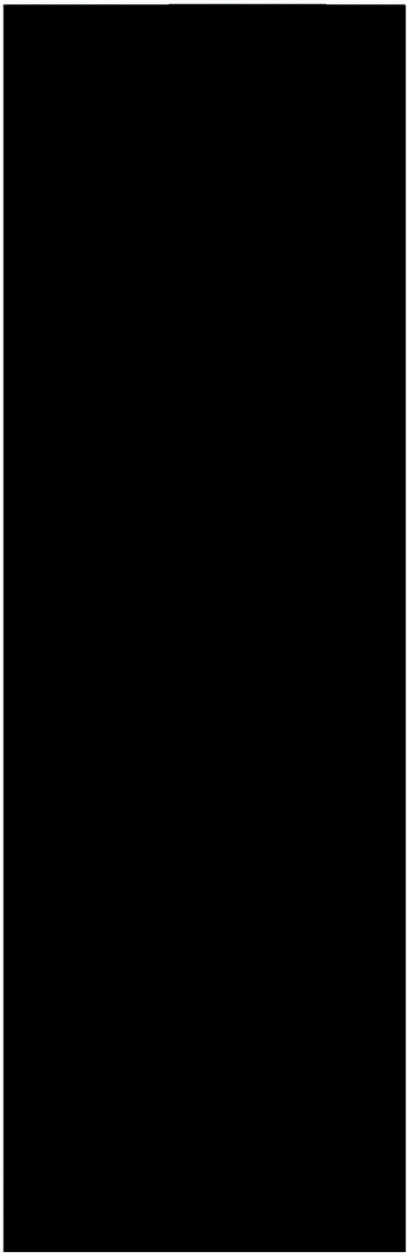
Resident/Staff Identifier Key for Bowman Estate WY23 Annual Con'd



Resident/Staff Identifier Key for Bowman Estate WY23 Annual Review Con'd



Resident/Staff identifier Key for Bowman Estate WY23 Annual Review Con'd



05-30-23;03:56PM; ;8159398187 # 1/ 2

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0545
TTY: (800) 526-5812

FAX

To: [redacted]	From: [redacted]
	Bureau of Long Term Care
Fax: 815-939-8187	Date: 5/30/23
Re: Clearance for FY22 Findings from annual	Pages: (including cover) 2

☐ Urgent ☐ For Review ☐ Please Comment ☑ Please Reply ☐ Please Recycle

Please sign and return to the fax number above.

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 0**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

5/30/23
Date

[redacted]

5/30/23 Cleared FY 23 onsite Findings
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS Page 1 of 2

SLP NAME: Brookside Estates Nicola

CHECK ONE:

( ) INTERIM CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) ANNUAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) CHANGE OF OWNERSHIP REVIEW FINDINGS: YES ☐ NO ☒

ENTRANCE DATE: 4/26/22 EXIT DATE: 2/2/2023

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW DATE OF COMPLAINT: _____

REFERRAL DATE: _____ REVIEW FINDINGS: YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW ( ) SECOND FOLLOW-UP REVIEW

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

Brookstone Estates Nursing CHOW 4/26/22

RESPONSE TO ON-SITE REVIEW FINDINGS Page 2 of 2

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 2.2.2023
Date

2/2/2023
Signature of Bureau of Long-Term Care HPSN Date

Signature of Bureau of Long Term Care Regional Supervisor Date

Signature of Bureau of Long Term Care Area Manager Date

Brookstone Estates Nursing
CHOW completed 4/26/22
NO findings

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS Page 1 of 2

SLP NAME: Brookstone Tuscola
CHECK ONE:

( ) **INTERIM CERTIFICATION REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **ANNUAL CERTIFICATION REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **CHANGE OF OWNERSHIP REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) ***GENERAL FINDINGS (Use for findings noted during informal visits to SLP)***
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

(✓) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: 3/30/23 END DATE: 4/17/23

FINDINGS CORRECTED: YES ☐ NO ☑

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

Brookhaven TW vola

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

4/12/23
Date

4/17/23
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

Exit after 1st Follow up AR FY 23
Not clear-out of compliance
146.2351

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of** 2

SLP NAME: Brookstone Estates, Tuscola
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO (X)

ENTRANCE DATE: 12.27.22 EXIT DATE: 3.13.23

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-complianee involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of tho ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 3.13.23
Date

3.13.23
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

02-16-23;10:01AM; ;8159398187 # 1/ 14

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0545
TTY: (800) 526-5812

FAX

To: [redacted]	From: [redacted]
	Bureau of Long Term Care
Fax: 815-939-8187	Date: 2/16/23
Re: Findings for FY 22 annual	Pages: (including cover) 14

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Please sign pages 109, 3 of 12 - 12 of 12 and fax back to the above fax number.

E-mail: hfswebmaster@illinois.gov Internet: http://www.hfs.illinois.gov/

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 3 OF 12**

PROVIDER NAME: Brookstone Estates tuscola REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Based on section 146.220 a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230, the following criteria shall be met prior to admission to the SLF: 4) Have name checked against the United States department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. This requirement is not met as evidenced by: R-1, R-2, and R-3 had untimely Background Checks. R-4 did not have an updated Background Check for the admit date of 4/19/21.	As per regulation 146.220 a) All Residents will have name checked Against the United States department of Justice Dru Sjodin National Offender Public website, the Illinois Sex Offender Registration website and the Illinois Department of Corrections registered sex offender database. Resident files will audited monthly for compliance by BOC for the next 60 days.	3/3/23

Signature of SLP Provider Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: 146.220 Resident have name checked for offender Complete monthly audit

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		BOC	2.24.23

Signature of Presenter: [redacted] Date: 2.24.23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page _____ of _____

(use additional pages if all employees do not fit on one page)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS
PART 146 SPECIALIZED HEALTH CARE DELIVERY SYSTEMS
SECTION 146.220 RESIDENT PARTICIPATION REQUIREMENTS

Section 146.220 Resident Participation Requirements

a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF:

1) Be age 22 years or over with a disability (as determined by the Social Security Administration) or elderly (age 65 years or over); and

2) Be screened by the Department or other State agency screening entity and found to be in need of nursing facility level of care and that SLF placement is appropriate to meet the needs of the individual. A new screen is not needed for a resident who is transferring between SLFs or comes from a nursing facility with no break in service. It is the admitting SLF's responsibility to ensure that a screening document is received from the transferring SLF or nursing facility. Private pay individuals may choose to be admitted into the SLF when the screening assessment does not justify nursing facility level of care; and

3) Be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. The developmental disability or mental illness must be determined by a qualified Department of Human Services screening agent; and

4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLF.

b) Private pay residents seeking to convert to Medicaid while residing in an SLF shall be screened by the Department using the DON prior to the point of conversion and must be found to be in need of nursing facility level of care before Medicaid payment may be authorized.

c) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

d) A Medicaid resident of the SLF shall not participate in any other federal Home and Community-Based Waiver Program.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

SLF NAME: Brookstone Estates Tuscola_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). This requirement is not met as evidenced by: R-1 and R-2' signs/symptoms checklist was completed prior to admit. R-4 did not have a TB test or signs/symptoms checklist for admit dates of 1/3/2020 and 4/19/21. R-5's 2nd step TB test was given too soon. R-6 did not have a TB test or signs/symptoms checklist. R-7's TB test and signs/symptoms Checklist was completed prior to R-7's admit date of 10/1/19.	As per regulation 146.220 d) All Residents will have TB skin test in accordance with the Control of TB code. Resident files will audited monthly for compliance by WS for the next 60 days.	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: 146.220 TB skin test

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

(use additional pages if all employees do not fit on one page)

Section 146.220 Resident Participation Requirements

a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF:

1) Be age 22 years or over with a disability (as determined by the Social Security Administration) or elderly (age 65 years or over); and

2) Be screened by the Department or other State agency screening entity and found to be in need of nursing facility level of care and that SLF placement is appropriate to meet the needs of the individual. A new screen is not needed for a resident who is transferring between SLFs or comes from a nursing facility with no break in service. It is the admitting SLF's responsibility to ensure that a screening document is received from the transferring SLF or nursing facility. Private pay individuals may choose to be admitted into the SLF when the screening assessment does not justify nursing facility level of care; and

3) Be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. The developmental disability or mental illness must be determined by a qualified Department of Human Services screening agent; and

4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLF.

b) Private pay residents seeking to convert to Medicaid while residing in an SLF shall be screened by the Department using the DON prior to the point of conversion and must be found to be in need of nursing facility level of care before Medicaid payment may be authorized.

c) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

d) A Medicaid resident of the SLF shall not participate in any other federal Home and Community-Based Waiver Program.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

Supportive Living Facility TB Testing Requirements

FACILITY WHOSE INDIVIDUAL RISK ASSESSMENT INDICATES LOW RISK (According to current facility TB risk assessment completed by the facility in collaboration with the local TB authority)	
2-Step Mantoux Test or whole blood interferon-gamma release assay TB screening test • Must be commenced within 7 days of employment or admission. • If a Mantoux test is done, the 1st step shall be read 48 hours to 7 days after administration. • If the 1st step of the Mantoux skin test is negative, the 2nd step of the Mantoux skin test shall be administered 7-21 days after the 1st step was administered. The 2nd step shall be read 48-72 hours after administration.	**Required** for all resident admissions, employee hires (including subcontractors), and volunteers; **EXCEPT in any of the following instances**: (1) Person has documentation of a TB screening test result read within the past 90 days. (2) Person has been part of a routine (annual) screening at previous residence or place of employment and can provide documentation that an annual TB screening test was done within the past 90 days. (3) Positive Reactors (see Positive Reactor section). (4) Person has documentation of a 1-Step within the past 12 months (see 1-Step section). (5) Person is being readmitted/rehired to the facility and the break in service has not been more than 12 months (see Waiver section). (6) For volunteers ONLY, upon the facility's request, the local TB authority may grant a waiver for TB testing requirements for volunteers (see Waiver section).
TB testing and other live virus vaccine: If a new resident or employee has had an H1N1 or seasonal flu live virus vaccine within 4 week of admission/hire – per CDC guidance, they should wait 4 weeks for TB testing if TB testing was not done at the same time ***ONLY the nasal spray is the live vaccine. If the person received an injection under the skin, it was NOT a live vaccine.***	1. If a new resident or employee provides documentation of receiving a live virus vaccine for either the seasonal flu or H1N1 within 4 weeks of admission or hire, the SLF will need to maintain the documentation in the resident or employee files. This documentation will allow the facility to remain in compliance with the Control of Tuberculosis Code. TB testing will need to be done 4 weeks after the Live virus vaccine for either seasonal flu or H1N1. 2. A signs and symptoms checklist will need to be completed within 7 days of admission or hire for new residents/employees who have had the live virus H1N1 vaccine and are waiting 4 weeks for the TB testing. If there are symptoms – referral to their physician and the local TB authority to assure no active TB will need to be done and documentation kept in the resident record or employee file.
If Mantoux skin test the 1st-Step • Must be commenced within 7 days of employment or admission. • Test shall be read within 48-72 hours after of administration.	Allowable in the following instance: (1) Person has documentation of a 1-Step within the past 12 months.

Positive Reactor • A person who has documentation of a previous positive TB test. • A person who tests positive on a test completed for admission/employment	Positive Reactors should **NOT** be given a TB skin test. A signs and symptoms checklist should be completed upon admission or hire. **Persons who test positive on the TB screening test completed for admission/employment should be referred to the local TB authority <u>and/or</u> their physician for follow up which will include but may not be limited to a chest x-ray.**
Signs & Symptoms Checklist • To be completed within 7 days of admission or hire (if applicable)	**Required** for: (1) **All new** resident admissions, **NO exceptions**. (2) **Only** new employees with a **documented positive TB skin test**.
Waivers • In certain cases, with documented consultation from the Local TB Authority, requirements for testing may be waived.	Waivers for TB testing may be obtained from the local TB Authority in the following instances: (1) Person is being readmitted/rehired to the facility and the break in service has not been more than 12 months. This also requires the person's own physician to provide written confirmation that in their opinion the person was at low risk for exposure to TB during the time frame they were not at the SLF. (2) For volunteers ONLY, upon the facility's request, the local TB authority may grant a waiver for TB testing requirements for volunteers.
FACILITIES WHOSE INDIVIDUAL RISK ASSESSMENT INDICATES MEDIUM RISK (According to current facility TB risk assessment completed by the facility in collaboration with the local TB authority)	
All of the above requirements must be followed, in addition to any procedures required by the local TB authority. This might include: • Annual TB screening test for all residents and employees. • Completion of annual signs & symptoms checklist for all residents and employees <u>with documented positive TB screening tests</u>.	
FACILITIES WHOSE INDIVIDUAL RISK ASSESSMENT INDICATES POTENTIAL FOR ONGOING TRANSMISSION (According to current facility TB risk assessment completed by the facility in collaboration with the local TB authority)	
• For facilities whose risk assessment is Potential for Ongoing transmission, All requirements for low risk, plus a contact investigation and testing as directed by the local TB authority	
THE FOLLOWING IS A RECOMMENDATION ONLY FOR LOW RISK BUT MAY BE REQUIRED FOR MEDIUM RISK AND POTENTIAL FOR ONGOING TRANSMISSION	
Signs & Symptoms Checklist (Routine) • To be completed annually.	**Recommended for:** (1) All residents, employees and volunteers with a **documented positive TB skin test.**

Note: If the previous positive TB screening test result is not documented, administer two-step skin test or offer Blood Assay for Mycobacterium Tuberculosis. This is the recommendation of CDC published in MMWR of December 30, 2005 page 29 Box 1.

R12-15-09

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _5__ OF 12_**

SLF NAME: Brookstone Estates Tuscola_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.235 Staffing I) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check. This requirement is not met as evidenced by: 5 staff had the HCW Registry checked late E-1, E-4, E-5, E-6, and E-8. 1 staff did not have Background checks completed and was sent home immediately. E-7. 10 staff did not have the six required websites checked, E-1, E-3, E-4, E-5, E-6, E-7, E-8, E-9, E-10, and E-11. 7 staff did not have the authorization signed prior to the first shift, E-1, E-4, E-5, E-6, E-7, E-9 and E-10 4 staff did not have the Registry Employment Verification checked within 30 days, E-1, E-6, E-7, and E-8.	As per regulation 146.235 staffing I) All employees will have HCWBC completed prior to start date and within 30 days of start date and annually thereafter. Fingerprint authorization form must be completed prior to start date. Employee files will be audited monthly for compliance by BOC and or designee for the next 60 days. ED to in service BOC on regulation.	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: Section 146.235 Staffing Fingerprint Authorization Forms Background Checks

Date of Inservice: 2.20.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		Bcm	2.20.23

Signature of Presenter: [redacted] Date: 2/20/23

NOTE: Attach any handouts given at inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.235 Staffing

a) The SLF shall have a manager or a qualified designee present at the SLF during normal business hours plus whenever necessary to ensure attention to the management and administration of the resident contracts. Staff shall have access to the manager or the manager's designee at all times. The manager shall designate a qualified individual capable of acting in an emergency during his or her absence from the SLF.

b) The manager shall have at least five years experience in providing health care services to adults with disabilities or the elderly population either in an assisted living program, inpatient hospital, long term care setting, adult day care or in a Department approved health related field. The manager shall also have at least two years of management experience.

c) The SLF shall have licensed and certified staff sufficient in number to meet the needs of the population being served.

d) Licensed nurses or certified nursing assistants on duty at the SLF shall not be utilized in an adjoining or other part of the building not certified as the SLF. This includes, but is not limited to, a nursing facility, assisted living facility, and independent living facility.

e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLF shall make changes in the training materials.

1) The SLF shall provide staff and subcontractors who provide direct care with:

A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment;

B) training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; and encouraging independence (these subjects shall be trained as part of staff orientation and at least annually thereafter);

C) documented training performed by qualified individuals in their area or areas of responsibility;

D) training geared toward the manner in which services are to be performed;

E) training that includes techniques for working with persons with disabilities and the elderly populations; and

F) in the case of an SLF serving persons with disabilities, disability specific sensitivity training conducted by an outside entity familiar with working with persons with disabilities. The training shall occur for all staff initially prior to certification, at staff orientation for new staff, and at least annually thereafter.

2) In the case of subcontractors, training by the SLF is not required if the SLF can document that similar training is being provided through the subcontractor's employer.

f) The SLF shall employ certified nursing assistants (CNAs) as follows:

1) Qualifications:

Must be 18 years of age or older and have successfully completed no later than 120 days after employment a nursing assistant training course or a Department of Public Health approved equivalent training and competency evaluation.

2) Names of CNAs shall be checked against the Illinois Department of Public Health's Health Care Worker Registry prior to employment.

3) Job responsibilities shall include, but not be limited to:

A) Follow and help carry out a resident's written service plan;

B) Provide personal care services for residents, including but not limited to bathing, eating, dressing, personal hygiene, grooming, toileting, ambulation and assistance with transfer;

C) Observe the resident's functioning, maintain written records of the observations and report any changes to the licensed nurse; and

D) Attend initial training, in-service training sessions and staff conferences.

g) The SLF shall employ or contract with a dietitian. The dietitian shall comply with

the following:

1) The dietitian shall be licensed under the Dietetic and Nutrition Services Practice Act [225 ILCS 30].

2) Job responsibilities shall include, but not be limited to, consultation and training in all food service procedures such as menu planning and review, food preparation, food storage, food service, safety, sanitation and management of therapeutic diets.

3) The dietician shall come on-site at least twice per quarter for a period of not less than a cumulative total of eight hours.

h) The SLF shall employ a minimum of one cook who shall have at least one year of experience in commercial food preparation.

i) Twenty-four hour response staff shall be at least 18 years of age and possess at least a high school diploma or a GED. Response staff shall be certified in emergency resuscitation. The staff shall respond to scheduled or unpredictable needs and emergency calls from residents.

j) Nurses on staff, or subcontracted, shall be licensed by the State of Illinois and shall be responsible for nursing services set forth in Section 146.230.

k) The SLF shall designate a trained staff person to be responsible for planning and directing social and recreational activities. This person shall be at least 18 years of age and possess at least a high school diploma or a GED.

l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check.

m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _6__ OF 12_**

SLF NAME: Brookstone Estates Tuscola_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). This requirement is not met as evidenced by: E-1 had a TB test that was positive but did not have a chest x-ray until 1/5/21. Signs/symptoms checklist was completed 11/2/2020 and 6/21/21. 2 staff had their TB test completed late, E-2 hired 5/4/21, TB test done 5/12/21 read 5/14/21. 2nd step done 5/16/21 read 5/18/21. E-3 was hired 3/10/21, TB test done 4/5/21 read 4/8/21. 2nd step done 4/12/21 read 4/15/21.	As per regulation 146.235 staffing m) All employees and volunteers will have a TB skin test in accordance with the control of TB code. Employee files will be audited monthly for compliance by BOC for the next 60 days.	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: 146.235 146.220 TB skin test

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.235 Staffing

a) The SLF shall have a manager or a qualified designee present at the SLF during normal business hours plus whenever necessary to ensure attention to the management and administration of the resident contracts. Staff shall have access to the manager or the manager's designee at all times. The manager shall designate a qualified individual capable of acting in an emergency during his or her absence from the SLF.

b) The manager shall have at least five years experience in providing health care services to adults with disabilities or the elderly population either in an assisted living program, inpatient hospital, long term care setting, adult day care or in a Department approved health related field. The manager shall also have at least two years of management experience.

c) The SLF shall have licensed and certified staff sufficient in number to meet the needs of the population being served.

d) Licensed nurses or certified nursing assistants on duty at the SLF shall not be utilized in an adjoining or other part of the building not certified as the SLF. This includes, but is not limited to, a nursing facility, assisted living facility, and independent living facility.

e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLF shall make changes in the training materials.

1) The SLF shall provide staff and subcontractors who provide direct care with:

A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment;

B) training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; and encouraging independence (these subjects shall be trained as part of staff orientation and at least annually thereafter);

C) documented training performed by qualified individuals in their area or areas of responsibility;

D) training geared toward the manner in which services are to be performed;

E) training that includes techniques for working with persons with disabilities and the elderly populations; and

F) in the case of an SLF serving persons with disabilities, disability specific sensitivity training conducted by an outside entity familiar with working with persons with disabilities. The training shall occur for all staff initially prior to certification, at staff orientation for new staff, and at least annually thereafter.

2) In the case of subcontractors, training by the SLF is not required if the SLF can document that similar training is being provided through the subcontractor's employer.

f) The SLF shall employ certified nursing assistants (CNAs) as follows:

1) Qualifications:

Must be 18 years of age or older and have successfully completed no later than 120 days after employment a nursing assistant training course or a Department of Public Health approved equivalent training and competency evaluation.

2) Names of CNAs shall be checked against the Illinois Department of Public Health's Health Care Worker Registry prior to employment.

3) Job responsibilities shall include, but not be limited to:

A) Follow and help carry out a resident's written service plan;

B) Provide personal care services for residents, including but not limited to bathing, eating, dressing, personal hygiene, grooming, toileting, ambulation and assistance with transfer;

C) Observe the resident's functioning, maintain written records of the observations and report any changes to the licensed nurse; and

D) Attend initial training, in-service training sessions and staff conferences.

g) The SLF shall employ or contract with a dietitian. The dietitian shall comply with

the following:

1) The dietitian shall be licensed under the Dietetic and Nutrition Services Practice Act [225 ILCS 30].

2) Job responsibilities shall include, but not be limited to, consultation and training in all food service procedures such as menu planning and review, food preparation, food storage, food service, safety, sanitation and management of therapeutic diets.

3) The dietician shall come on-site at least twice per quarter for a period of not less than a cumulative total of eight hours.

h) The SLF shall employ a minimum of one cook who shall have at least one year of experience in commercial food preparation.

i) Twenty-four hour response staff shall be at least 18 years of age and possess at least a high school diploma or a GED. Response staff shall be certified in emergency resuscitation. The staff shall respond to scheduled or unpredictable needs and emergency calls from residents.

j) Nurses on staff, or subcontracted, shall be licensed by the State of Illinois and shall be responsible for nursing services set forth in Section 146.230.

k) The SLF shall designate a trained staff person to be responsible for planning and directing social and recreational activities. This person shall be at least 18 years of age and possess at least a high school diploma or a GED.

l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check.

m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

Supportive Living Facility TB Testing Requirements

FACILITY WHOSE INDIVIDUAL RISK ASSESSMENT INDICATES LOW RISK (According to current facility TB risk assessment completed by the facility in collaboration with the local TB authority)	
2-Step Mantoux Test or whole blood interferon-gamma release assay TB screening test • Must be commenced within 7 days of employment or admission. • If a Mantoux test is done, the 1st step shall be read 48 hours to 7 days after administration. • If the 1st step of the Mantoux skin test is negative, the 2nd step of the Mantoux skin test shall be administered 7-21 days after the 1st step was administered. The 2nd step shall be read 48-72 hours after administration.	**Required** for all resident admissions, employee hires (including subcontractors), and volunteers; **EXCEPT in any of the following instances**: (1) Person has documentation of a TB screening test result read within the past 90 days. (2) Person has been part of a routine (annual) screening at previous residence or place of employment and can provide documentation that an annual TB screening test was done within the past 90 days. (3) Positive Reactors (see Positive Reactor section). (4) Person has documentation of a 1-Step within the past 12 months (see 1-Step section). (5) Person is being readmitted/rehired to the facility and the break in service has not been more than 12 months (see Waiver section). (6) For volunteers ONLY, upon the facility's request, the local TB authority may grant a waiver for TB testing requirements for volunteers (see Waiver section).
TB testing and other live virus vaccine: If a new resident or employee has had an H1N1 or seasonal flu live virus vaccine within 4 week of admission/hire – per CDC guidance, they should wait 4 weeks for TB testing if TB testing was not done at the same time ***ONLY the nasal spray is the live vaccine. If the person received an injection under the skin, it was NOT a live vaccine.***	1. If a new resident or employee provides documentation of receiving a live virus vaccine for either the seasonal flu or H1N1 within 4 weeks of admission or hire, the SLF will need to maintain the documentation in the resident or employee files. This documentation will allow the facility to remain in compliance with the Control of Tuberculosis Code. TB testing will need to be done 4 weeks after the Live virus vaccine for either seasonal flu or H1N1. 2. A signs and symptoms checklist will need to be completed within 7 days of admission or hire for new residents/employees who have had the live virus H1N1 vaccine and are waiting 4 weeks for the TB testing. If there are symptoms – referral to their physician and the local TB authority to assure no active TB will need to be done and documentation kept in the resident record or employee file.
If Mantoux skin test the 1st-Step • Must be commenced within 7 days of employment or admission. • Test shall be read within 48-72 hours after of administration.	Allowable in the following instance: (1) Person has documentation of a 1-Step within the past 12 months.

Positive Reactor • A person who has documentation of a previous positive TB test. • A person who tests positive on a test completed for admission/employment	Positive Reactors should **NOT** be given a TB skin test. A signs and symptoms checklist should be completed upon admission or hire. **Persons who test positive on the TB screening test completed for admission/employment should be referred to the local TB authority <u>and/or</u> their physician for follow up which will include but may not be limited to a chest x-ray.**
Signs & Symptoms Checklist • To be completed within 7 days of admission or hire (if applicable)	**Required** for: (1) **All new** resident admissions, **NO exceptions**. (2) **Only** new employees with a **documented positive TB skin test**.
Waivers • In certain cases, with documented consultation from the Local TB Authority, requirements for testing may be waived.	Waivers for TB testing may be obtained from the local TB Authority in the following instances: (1) Person is being readmitted/rehired to the facility and the break in service has not been more than 12 months. This also requires the person's own physician to provide written confirmation that in their opinion the person was at low risk for exposure to TB during the time frame they were not at the SLF. (2) For volunteers ONLY, upon the facility's request, the local TB authority may grant a waiver for TB testing requirements for volunteers.
FACILITIES WHOSE INDIVIDUAL RISK ASSESSMENT INDICATES MEDIUM RISK **(According to current facility TB risk assessment completed by the facility in collaboration with the local TB authority)**	
All of the above requirements must be followed, in addition to any procedures required by the local TB authority. This might include: • Annual TB screening test for all residents and employees. • Completion of annual signs & symptoms checklist for all residents and employees <u>with documented positive TB screening tests</u>.	
FACILITIES WHOSE INDIVIDUAL RISK ASSESSMENT INDICATES POTENTIAL FOR ONGOING TRANSMISSION **(According to current facility TB risk assessment completed by the facility in collaboration with the local TB authority)**	
• For facilities whose risk assessment is Potential for Ongoing transmission, All requirements for low risk, plus a contact investigation and testing as directed by the local TB authority	
THE FOLLOWING IS A RECOMMENDATION ONLY FOR LOW RISK BUT MAY BE REQUIRED FOR MEDIUM RISK AND POTENTIAL FOR ONGOING TRANSMISSION	
Signs & Symptoms Checklist (Routine) • To be completed annually.	**Recommended for:** (1) All residents, employees and volunteers with a **documented positive TB skin test.**

Note: If the previous positive TB screening test result is not documented, administer two-step skin test or offer Blood Assay for Mycobacterium Tuberculosis. This is the recommendation of CDC published in MMWR of December 30, 2005 page 29 Box 1.

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _7__ OF 12_**

SLF NAME: Brookstone Estates Tuscola_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy. R-3's standardized interview was not signed or dated. R-4 did not have a standardized interview for admit date of 4/19/21. R-6's pre assessment form was in the chart, but no nurses signature or date. R-8's standardized interview was completed late on 1/9/21. Resident admitted 1/7/21.	As per regulation 124.245. A standardized interview geared toward the Resident's service needs at or before time of occupancy. An RAI will be completed within 14 days after admission, annually and upon significant change in condition and completed by, or co-signed by an RN. Resident files will audited monthly for compliance by WS for the next 60 days.	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: Initial Assessment, RAI, Signatures & Dates 146.245 Assessments, Service Plan, Quarterly Evaluation

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

(use additional pages if all employees do not fit on one page)

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy.

b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.

c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

f) Service Plan for Identified Sex Offenders: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse that addresses the following:

1) the amount of supervision required by the individual to ensure the safety of all residents, staff and visitors; and

2) determination of approaches developed in the service plan are appropriate and effective in dealing with any behaviors specific to the identified offender.

g) Progress Notes: Progress notes shall be completed at least monthly to document

decline or improvement in resident status. A progress note does not have to be completed if there is no change in resident status. Any SLF staff may write progress notes.

h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _8__ OF 12_**

SLF NAME: Brookstone Estates Tuscola_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or registered nurse. This requirement is not met as evidenced by: R-3, R-4, R-6, R-7, R-8, R-9, R-10, and R-11 did not have an initial assessment within 24 hours of admit.	As per regulation 146.245. Assessments and service plans and quarterly evaluations. Initial assessments and service plan to be completed within 24 hours after admission that identifies needs and potential immediate problems. Each assessment will be completed by, or co signed by, a licensed practical nurse or registered nurse. Resident files will audited monthly for compliance by WS for the next 60 days.	3/3/23

Signature of SLF Representativ [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: Initial Assessment, RAI, Signatures & Dates 146.245 Assessments, Service Plan, Quarterly Evaluation

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy.

b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.

c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

f) Service Plan for Identified Sex Offenders: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse that addresses the following:

1) the amount of supervision required by the individual to ensure the safety of all residents, staff and visitors; and

2) determination of approaches developed in the service plan are appropriate and effective in dealing with any behaviors specific to the identified offender.

g) Progress Notes: Progress notes shall be completed at least monthly to document

decline or improvement in resident status. A progress note does not have to be completed if there is no change in resident status. Any SLF staff may write progress notes.

h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

SLF NAME: Brookstone Estates Tuscola REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. This requirement is not met as evidenced by: R-4 admitted 4/19/21, RAI of 6/7/21 not completed within 7-14 days of admit and not signed or co-signed by the RN. R-9 admitted 10/20/2020 and did not have a 2020 RAI completed. R-11's RAI of 5/11/21 was completed late and was not completed thoroughly. Section AA.4 was blank. R-12's RAI od 11/13/19 was not signed by the RN. R-13's RAI of 4/2/21 was scored "2" for housekeeping, laundry, and meals. ISP states staff completes these task, per staff interview ISP is correct. RAI was scored a "2" for meds, ISP states resident is independent. Per staff interview, ISP is correct. R-14's RAI of 7/30/21 was completed by the LPN and not co-signed by the RN until 9/16/21. R-15's RAI of 9/24/21 was not completed within 366 days of the previous assessment dated 3/30/2020.	As per regulation 146.245 Assessment and service plans will include coordination of services and be be indivualized that addresses the Residents health and behaviors. WS to audit files to verify ongoing compliance for the next 60 days,	3/3/23

Signature of SLF Representativ [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: Initial Assessment, RAI, Signatures & Dates 146.345 Assessments, Service Plan, Quarterly Evaluation

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy.

b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.

c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

f) Service Plan for Identified Sex Offenders: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse that addresses the following:

1) the amount of supervision required by the individual to ensure the safety of all residents, staff and visitors; and

2) determination of approaches developed in the service plan are appropriate and effective in dealing with any behaviors specific to the identified offender.

g) Progress Notes: Progress notes shall be completed at least monthly to document

decline or improvement in resident status. A progress note does not have to be completed if there is no change in resident status. Any SLF staff may write progress notes.

h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _10__ OF 12_**

SLF NAME: Brookstone Estates Tuscola_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health nd behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in the resident needs or preferences. This requirement is nit met as evidenced by: ISP's missing RN and resident's signatures, ISP completed prior to RAI, untimely or incomplete. R-1, R-4, R-5, R-8, R-9, R-13, and R-14.	As per regulation 146.245 Assessment and service plans will include coordination of services and be be indivualized that addresses the Residents health and behaviors. WS to audit files to verify ongoing compliance for the next 60 days,	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: Initial Assessment, RAI, Signatures & Dates 146.245 Assessments, Service Plan, Quarterly Evaluation

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]	[redacted]	WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy.

b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.

c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

f) Service Plan for Identified Sex Offenders: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse that addresses the following:

1) the amount of supervision required by the individual to ensure the safety of all residents, staff and visitors; and

2) determination of approaches developed in the service plan are appropriate and effective in dealing with any behaviors specific to the identified offender.

g) Progress Notes: Progress notes shall be completed at least monthly to document

decline or improvement in resident status. A progress note does not have to be completed if there is no change in resident status. Any SLF staff may write progress notes.

h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

SLF NAME: Brookstone Estates Tuscola REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse. This requirement is ut met as evidenced by: Quarterlies missing, late/untimely, missing signatures/dates. R-3, R-4, R-6, R-7, R-8, R-9, R-10, R-11, R-12, R-13, R-14, R-15, R-17 and R-18.	As per regulation 146.245 quarterly evaluation of the health and behavior status of each Resident will be completed using a department designated form and completed by or cosigned by an RN. Resident files will audited monthly for compliance by WS for the next 60 days.	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

270

Inservice Topic and Attendance Sheet

Inservice Topic: Initial Assessment, RAI, Signatures & Dates 146.245 Assessments, Service Plan, Quarterly Evaluation

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		WS	2.24.23

Signature of Presenter: [redacted] Date: 2/24/23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy.

b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.

c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

f) Service Plan for Identified Sex Offenders: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse that addresses the following:

1) the amount of supervision required by the individual to ensure the safety of all residents, staff and visitors; and

2) determination of approaches developed in the service plan are appropriate and effective in dealing with any behaviors specific to the identified offender.

g) Progress Notes: Progress notes shall be completed at least monthly to document

decline or improvement in resident status. A progress note does not have to be completed if there is no change in resident status. Any SLF staff may write progress notes.

h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _12__ OF 12_**

SLF NAME: Brookstone Estates Tuscola REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.295 Emergency Contingency Plan c) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. This requirement is not met as evidenced by: missing/untimely emergency plan orientation. R-4, R-6, R-7, R-8, R-9, R-11, R-17, and R-19.	As per regulation 146.295 each Resident will be oriented to the emergency plan within 10 days after admission. Documentation the orientation will be signed by Resident or Resident representative. Resident files will audited monthly for compliance by BOC for the next 60 days.	3/3/23

Signature of SLF Representative [redacted] Date 3/3/23

Inservice Topic and Attendance Sheet

Inservice Topic: 146.295

Date of Inservice: 2.24.23 Presenter: [redacted]

Time Inservice Started: _____ Ended: _____

Employee Name (use current schedules to insert names)	Employee Signature (employee signature at completion of inservice)	Title (position title)	Date (date inservice completed)
[redacted]		BOC	2.24.23

Signature of Presenter: [redacted] Date: 2.24.23

NOTE: Attach any handouts given at Inservice to Topic and Attendance Sheet and forward to Executive Director when completed.

Page 1 of 1
(use additional pages if all employees do not fit on one page)

Section 146.295 Emergency Contingency Plan

For the purpose of this Section, "emergency" means an event, as a result of a mechanical failure or natural force such as water, wind, fire or loss of electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the SLF.

a) Each SLF shall have a written plan, which shall be part of the SLF's Quality Assurance Plan, for protection of all persons in the event of mechanical failure or natural force emergency, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan shall:

1) address the physical and cognitive needs of residents and include special staff response, including the procedures needed to ensure the safety of any resident. The plan shall be amended or revised whenever any resident with unusual needs is admitted;

2) provide for the temporary relocation of residents for any emergency requiring relocation;

3) provide for the movement of residents to safe locations within the SLF in the event of a tornado warning or severe thunder storm warning issued by the National Weather Service;

4) provide for the health, safety, welfare and comfort of all residents when the heat index/apparent temperature, as established by the National Oceanic and Atmospheric Administration, inside the residents' living, dining, activities, or sleeping areas of the SLF exceeds a heat index/apparent temperature of 80°F, or falls below 55°F, for 12 hours or more;

5) address power outages, including how residents call for help, how resident safety is monitored, and how food spoilage is checked while power is out;

6) include contingencies in the event of flooding, if located in a flood plain; and

7) be reviewed by local emergency response entities, such as fire department, ambulance and EMT services. The emergency response entities shall direct recommendations to the SLF concerning the SLF's plan and any issues that could be life threatening, and the SLFs shall make changes to the plan, as appropriate.

b) All personnel employed on the premises shall be instructed in the emergency contingency plan and the use of fire extinguishers.

c) A diagram of emergency evacuation routes shall be posted in at least all corridors and common areas and all personnel employed on the premises shall be aware of the route.

d) There shall be a means of notification to the SLF when the National Weather Service issues a tornado warning covering the area in which the SLF is located. The notification mechanism must be other than commercial radio or television. Notification measures include being within range of local tornado warning sirens, an operable National Oceanic and Atmospheric Administration weather radio in the SLF, or arrangements with local public safety agencies (police, fire, ESDA) to be notified if a warning is issued.

e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.

f) The SLF shall conduct at least two drills per year. At least one drill shall cover evacuation during a fire and the other shall cover evacuation during a tornado.

g) The SLF shall evaluate the effectiveness of emergency plans, procedures and training.

h) Drills shall include residents, SLF personnel, and other persons in the SLF.

r) Drills shall include making a general announcement throughout the SLF that a drill is being conducted or sounding an emergency alarm. Drills may be announced in advance to residents.

j) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape.

k) A written evaluation of each drill shall be submitted to the SLF manager and the Quality Assurance Committee and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation.

l) Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence. This includes, but is not limited to, loss of electrical power in excess of an hour, physical injury suffered by residents during a mechanical failure or force of nature, evacuation of residents for any reason, and fire alarm activation that results in an on-site response by the local fire department. It does not include fire department response that is the result of resident cooking mishaps that only cause minimal smoke limited to a resident's apartment or false alarm as determined by the local fire department. This preliminary report shall include, at a minimum:

1) name and location of the SLF;

2) type of emergency;

3) number of injuries or deaths to residents;

4) names of residents involved in the emergency;

5) number of units not usable due to the occurrence;

6) estimate of the extent of damages to the SLF;

7) type of assistance needed, if any;

8) location of displaced residents, if any; and

9) other State or local agencies notified about the problem.

m) The SLF manager or designee shall submit a final report to the Department that includes how the emergency was handled, final outcome, who was involved, and what steps are being taken to prevent the situation in the future.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

On 5/1/2023 an audit was performed for April 2023 of Quarterly Assessment compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 6/1/2023 an audit was performed for May 2023 of Quarterly Assessment compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 7/1/2023 an audit was performed for June 2023 of Quarterly Assessment compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 5/1/2023 an audit was performed for April 2023 of Service Plan compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 6/1/2023 an audit was performed for May 2023 of Service Plan compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 7/1/2023 an audit was performed for June 2023 of Service Plan compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 5/1/2023 an audit was performed for April 2023 of RAI Assessment compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 6/1/2023 an audit was performed for May 2023 of RAI Assessment compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 7/1/2023 an audit was performed for June 2023 of RAI Assessment compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 5/1/2023 an audit was performed for April 2023 of TB compliance for Staff of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 6/1/2023 an audit was performed for May 2023 of TB compliance for Staff of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 7/1/2023 an audit was performed for June 2023 of TB compliance for Staff of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 5/1/2023 an audit was performed for April 2023 of TB compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

On 6/1/2023 an audit was performed for May 2023 of TB compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

[redacted]

On 7/1/2023 an audit was performed for June 2023 of TB compliance for Residents of Brookstone-Tuscola. Audit completed and in 100% compliance.

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of ____**

SLP NAME: _Brookstone Estates of Mattoon_____
CHECK ONE:

( ) INTERIM CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) FINAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) ANNUAL CERTIFICATION REVIEW FINDINGS: YES X ☐ NO ☐

ENTRANCE DATE: 4/25/23 EXIT DATE: 6/07/23

( ) CHANGE OF OWNERSHIP REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: EXIT DATE:

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: END DATE:

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: END DATE:

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: END DATE:

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office.
BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 6/16/23
Date

Signature of Bureau of Long Term Care HFSN — Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE ____ OF _____**

PROVIDER NAME: __Brookstone Estates of Mattoon_____ REFERRAL DATE: __6/06/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Finding #1: **Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting.** R-2 – Sex Offender checks dated 9/8/22 were completed after admission date of 8/25/22. R-5 – Sex Offender checks dated 10/7/22 were completed after admission date of 10/5/22. R-6 – Sex Offender checks dated 10/7/22 were completed after admission dated of 10/5/22.		

Finding #2: **Section 146.220 Resident Participation Requirements b) The SLP provider's assessment to determine if a potential resident's needs can be met by the SLP provider shall not occur until after the DON, or successor tool, assessment and other required PAS have been completed and determinations provided to the SLP provider.** R-10 – The facility failed to request a conversion screen prior to the point of conversion to verify R-10 needed nursing facility level of care. Admit date: 7/18/17 Admitting DON: 7/14/17 – Score 40 Conversion date: 3/1/22 Conversion screen: 4/27/23 – Score 60 **Finding #3:** **Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** R-1 – The TB signs and symptoms checklist dated 4/4/23 was completed greater than 7 days from admission date of 6/30/22. R-2 – Admission date is 8/25/22. No TB testing was provided for review. The TB signs and symptoms checklist dated 4/4/23 was completed greater than 7 days from admission. R-9 – Admission date is 8/31/22. The 2-step TB testing (1st step given 4/27/22, read 4/29/22; 2nd step given 5/4/22, read 5/6/22) was completed greater than 90 days from R-9's admission. The TB signs and symptoms checklist dated 4/4/23 was completed greater than 7 days from admission.		

Finding #4: **Section 146.235 Staffing g) The SLP provider shall employ or contract with a dietitian. The dietitian shall comply with the following: 3) The dietician shall come on-site at least twice per quarter for a period of not less than a cumulative total of eight hours.** The dietitian cumulative hours do not equal 8 hours per quarter. April – June 2022: 6/22/22 & 6/30/22 – 4 hours, 4/25/22 – 3.25 hours = 7.25 hours; October – December 2022: 11/18/22 – 2.5 hours, 12/15/22 – 3.75 hours, 12/29/22 – 1 hour = 7.25 hours; January – March 2023: 1/30/23 – 2 hours, 3/22/23 – 2 hours, 3/27/23 – 2 hours = 6 hours. **Finding #5:** **Section 146.235 Staffing l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check.**		

E-1 – Start dated 10/24/22 – Authorization signed late on 11/10/22, fingerprints not collected until 5/2/23. HCW Registry and Registry websites checked 11/10/22 after start date. Employment verification not completed. E-2 – Start dated 10/24/22 – HCW Registry and Registry websites checked 11/8/22 after start date. E-3 – Start date 4/3/23 – HCW Registry and Registry websites checked 4/24/23 after start date. E-4 – Start date 3/16/23 – HCW Registry and Registry websites checked 4/24/23 after start date. Employment verification dated 4/24/23 was completed greater than 30 days from start date. E-5 – Start date 2/1/23 – Fingerprints not collected until 5/2/23. The HCW Registry and Registry websites checked 4/24/23 after start date. Employment verification dated 4/24/23 was completed greater than 30 days from start date. E-6 – Start date 10/29/22 – Fingerprints not collected until 5/2/23. The HCW Registry and Registry websites checked 4/24/23 after start date. Employment verification dated 4/24/23 was completed greater than 30 days from start date. E-7 – Start date 9/12/22 – HCW Registry and Registry websites checked 4/27/23 after start date. Employment verification dated 4/22/23 was completed greater than 30 days from start date. E-8 – Start date 3/6/23 – HCW Registry and Registry websites checked 4/27/23 after start date. Employment verification dated 4/27/23 was completed greater than 30 days from start date. E-9 – Start date 4/10/23 – HCW Registry and Registry websites checked 4/25/23 after start date.		

Finding #6: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation a) Interview: The SLP provider shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy but not before the DON, or successor tool, and other required PAS assessments are completed and determinations provided to the SLP provider.** R-2 – Admission date 8/25/22. Standardized interview was not signed or dated. R-5 – Admission date 10/5/22. Standardized interview was not signed or dated. R-6 – Admission date 10/5/22. Standardized interview was not signed or dated. R-9 – Admission date 8/31/22. Standardized interview was not provided for review. **Finding #7:** **Section 146.245 Assessment and Service Plan and Quarterly Evaluation b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse.** R-1 – Admission date 6/30/22. Initial assessment and service plan not provided for review. R-2 – Admission date 8/25/22. Initial assessment and service plan not signed or dated. R-9 – Admission date 8/31/22. Initial assessment and service plan not provided for review.		

Finding #8: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** R-1 – RAI dated 7/14/22 was completed greater than 14 days from admission on 6/30/22. This same RAI contained blanks under A.A.4. Race and C.2. Communication device. R-2 – RAI dated 9/9/22 was completed greater than 14 days from admission on 8/25/22. This same RAI contained blanks under A.A.4. Race, A.A.5. Marital Status and J.1. Weight R-3 – RAI dated 11/8/22 was completed greater than 366 days from RAI dated 11/4/21. R-4 – RAI dated 11/5/22 was completed greater than 366 days from RAI dated 11/1/21. R-5 – RAI dated 10/18/22 contained blanks under A.A.4. Race, A.C. Customary Routine, and F.3.g. How resident used phone. R-6 – RAI dated 10/24/22 was completed greater than 14 days from admission on 10/5/22. This same RAI contained blanks under A.A.4. Race, A.C. Customary Routine, and F.3.g. How resident used phone. R-7 – Admission date was 12/20/22. RAI was not signed and not dated. This same RAI contains blanks under A.A.5. Marital Status, A.C. Customary Routine, O.c. Signature of nurse, O.d. Date of signature. R-9 – RAI dated 9/14/22 was completed greater than 14 days from admission date of 8/31/22.		

R-10 – RAI dated 7/24/22 contains blanks under A.A.4. Race. R-11 – RAI dated 4/7/23 was completed greater than 366 days from RAI dated 3/21/22. R-13 – RAI dated 9/27/22 contains blanks under A.A.4. Race. R-14 – RAI dated 11/15/22 contains blanks under A.A.4. Race, A.A.5. Marital Status, and A.B.3. Lifetime occupation. R-15 - RAI dated 11/5/22 was completed greater than 366 days from RAI dated 11/1/21. This same RAI contains blanks under A.A.4. Race and A.A.5. Marital Status. R-16 – RAI dated 4/24/23 was completed greater than 366 days from RAI dated 3/21/22. **Finding #9:** **Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.**		

R-1 – ISS provided was not dated. R-2 – ISP was not signed or dated by a registered nurse. R-3 – ISP dated 4/25/23 was completed greater than 7 days from RAI dated 11/8/22. R-4 – ISP dated 10/31/22 was completed prior to RAI dated 11/5/22. R-5 – ISP dated 11/4/22 was completed greater than 7 days from RAI dated 10/18/22. R-6 – ISP dated 4/25/23 was completed greater than 7 days from RAI dated 10/24/22. R-7 – ISP was not signed and was not dated. R-9 – ISP dated 12/27/22 was completed greater than 7 days from RAI dated 9/14/22. R-12 – ISS dated 11/6/22 was completed greater than 7 days from RAI dated 8/30/22. R-13 – ISS dated 10/10/22 was completed greater than 7 days from RAI dated 9/27/22. R-15 – ISS dated 11/28/22 was completed greater than 7 days from RAI dated 11/5/22.		

Finding #10: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** R-3 – The quarterly evaluation dated 8/4/22 was not signed by a registered nurse until 4/25/23, therefore was completed greater than 92 days from the quarterly evaluation dated 5/5/22. R-4 – The quarterly evaluation dated 2/6/23 was completed greater than 92 days from RAI dated 11/5/22. R-6 – The quarterly evaluation dated 4/25/23 was completed greater than 92 days from quarterly evaluation dated 1/17/23. R-7 – The quarterly evaluation dated 4/17/23 is unknown if completed within 92 days from R-7's RAI as the RAI is not singed and not dated. R-8 – The quarterly evaluation dated 11/18/22 was completed greater than 92 days from RAI dated 5/19/22. R-9 – The quarterly evaluation dated 12/19/22 was completed greater than 92 days from RAI dated 9/14/22. The quarterly evaluation dated 4/12/23 was completed greater than 92 days from quarterly evaluation dated 12/19/22.		

Signature of SLP Provider Representative_____Date_____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of __12___**

SLP NAME: _Brookstone Estates of Effingham____
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES X NO ☐

ENTRANCE DATE: _5/30/23_____ EXIT DATE: _6/20/23_____

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of _12____**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is jnstification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 4/20/23

Signature of SLP Provider Representative — Date

Signature of Bureau of Long Term Care HFSN — Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

0

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements, d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R-9 – The TB signs and symptoms checklist dated 8/24/22 which is prior to admission on 8/25/22. The 1st step TB test was documented as administered on 9/9/22 which is greater than 7 days from the admission date of 8/25/22. R-10 – The TB signs and symptoms checklist dated 11/11/22 which is prior to admission on 1/14/22.	**146.220 d):** Regional Director of Wellness will conduct an in-service with the Executive Director, Business Office Coordinator and Wellness Supervisor covering the following: • HFS Regulation 146.220 d • Pathway to Living Tuberculin Skin Test Policy A Quality Assurance Study will be completed for 90-days to assure residents receive their TB test and Signs & Symptoms Checklist completed in accordance with the HFS Regulation.	7/20/2023

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse. R-9 – The initial assessment and service plan was dated 9/9/22 which is greater than 24 hours from the admission on 8/25/22.	**146.245 b)** Regional Director of Wellness will conduct an in-service with the Executive Director and Wellness Supervisor covering the following: • HFS Regulation 146.245 (b) • Pathway to Living Assessment & Service Plan/Initial Assessment Policy A Quality Assurance Study will be completed monthly on all new residents assuring that the regulation has been met. Quality Assurance audit will be conducted by the Wellness Supervisor.	7/20/2023

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R-2 – RAI dated 5/9/23 was completed greater than 366 days from the RAI dated 4/27/22. R-9 – RAI dated 9/27/22 was completed greater than 14 days from the admission date of 8/25/22.	**146.245 c)** Regional Director of Wellness will conduct an in-service with the Executive Director and Wellness Supervisor covering the following: • HFS Regulation 146.245 (c) • Pathway to Living Assessment & Service Plan/Comprehensive Resident Assessment Instrument Policy A Quality Assurance Study will be completed monthly on all new residents assuring that the regulation has been met. Quality Assurance audit will be conducted by the Wellness Supervisor.	7/20/2023

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. R-3 – ISS dated 4/18/23 was completed greater than 7 days from the RAI dated 1/9/23.	**146.245 d)** Regional Director of Wellness will conduct an in-service with the Executive Director and Wellness Supervisor covering the following: • HFS Regulation 146.245 (d) • Pathway to Living Assessment & Service Plan Policy A Quality Assurance Study will be completed monthly on all new residents assuring that the regulation has been met. Quality Assurance audit will be conducted by the Wellness Supervisor.	7/20/23

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245d – Continued: R-4 – ISP dated 2/22/23 was completed prior to the RAI dated 3/10/23. ISP dated 2/22/23 does not address service needs identified on the RAI dated 3/10/23. F.3.b. Shopping and F.3.g. Phone use are coded "1" (Done with supervision/set-up). F.3h. Housekeeping and F.3.i Laundry is coded "3" (Done by others). R-5 – ISP dated 7/19/22 does not address service needs identified on the RAI dated 7/14/22. F.3.b. Shopping, F.3.c. Transportation, F.3.h. Housekeeping, F.3.i. Laundry are coded "3" (Done by others). F.3.g. Phone use is coded "1" (Done with supervision/set-up). R-6 – ISP dated 8/9/22 does not address service needs identified on the RAI dated 8/9/22. F.3.a. Medication is coded a "2" (Done with help).		

PROVIDER NAME: Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245d – Continued: R-7 – ISS dated 6/28/22 does not address service needs identified on the RAI dated 6/28/22: Dressing assistance, Pain and Fall monitoring. R-8 – ISS was undated and does not address finance assistance as indicated on the RAI dated 6/28/22.		

PROVIDER NAME: Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R-5 – Quarterly Evaluation dated 5/25/23 was completed greater than 92 days from the Quarterly Evaluation dated 2/21/23. R-6 – Quarterly Evaluation dated 5/8/23 was completed greater than 92 days from the Quarterly Evaluation dated 2/2/23. R-9 – No Quarterly Evaluation available for review between the RAI dated 9/27/22 and the MCO start date 2/1/23. (Greater than 92 days.) R-10 – Quarterly Evaluation dated 3/7/23 was completed greater than 92 days from the RAI dated 11/23/22.	**146.245 e)** Regional Director of Wellness will conduct an in-service with the Executive Director and Wellness Supervisor covering the following: • HFS Regulation 146.245 e) • Pathway to Living Assessment & Service Plan/Quarterly Policy A Quality Assurance Study will be completed monthly on all new residents assuring that the regulation has been met. Quality Assurance audit will be conducted by the Wellness Supervisor.	7/20/23

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: ____6/28/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Informational Notice dated 12/12/07 Re: Readmission of Resident From Nursing Facility: Residents of supportive living facilities (SLFs) who are admitted to a nursing facility must be discharged from the SLF on the Department's Recipient Data Base to allow admission data for the nursing facility to be added. An SLF may hold the resident's apartment during the nursing facility stay if it is anticipated to be a short-term stay. An SLF may hold the apartment free of charge or make arrangements with the resident's family to pay. The Resident Contract should provide the SLF's policy for holding an apartment for a short-term nursing facility stay, including the length of time the apartment will be held, the charge to hold the apartment and the need for the SLF to conduct an assessment prior to readmission to ensure the resident's needs can continue to be met by the SLF. If a resident returns to the same SLF from a nursing facility within 30 days without a break in service, a new Resident Assessment Instrument (RAI) and Service Plan (RSP) does not have to be completed unless there is a significant change in the resident's status. If there is no significant change, the RAI and RSP in place prior to the resident's discharge to the nursing facility must be reviewed and updated accordingly, within 24-hours of readmission to the SLF.	**Informational Notice dated 12/12/07** Regional Director of Wellness will conduct an in-service with the Executive Director and Wellness Supervisor covering the following: • **Informational Notice dated 12/12/07 Re: Readmission of Resident From Nursing Facility** • Pathway to Living Pre-screen and Assessment Policy A Quality Assurance Study performed by the Executive Director will be completed for 90-days on residents who are readmissions from nursing facilities to assure compliance with the **Informational Notice dated 12/12/07.**	7/20/23

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Information Notice 12/12/07 – Continued: **Since the resident is not technically discharged from the SLF, completion of future assessments remains on the same timeline. The SLF does not have to do the following at the time of readmission to the SLF if readmission from the nursing facility is within 30 days, without a break in service, from the date of the SLF discharge: Determination of Need (DON), sign a new Resident Contract, advance directives, sex offender registration website, and tuberculosis test.** R-1 was a readmission following a nursing home stay of > 30 days. Admitted to the nursing home on 10/12/22. Readmitted to the SLP on 11/14/22. **TB skin testing was not provided for review. Previous 2 step testing was documented in 2017. **A TB Signs and Symptoms Checklist was not completed within 7 days after the readmission of 11/15/22. **A standardized interview was not completed at or before the readmission date of 11/15/22.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __12__ OF _12____**

PROVIDER NAME: _Brookstone Estates of Effingham_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Informational Notice 12/12/07 – Continued: **An initial assessment and service plan was not completed within 24 hours after the readmission date of 11/15/22. **RAI dated 12/27/22 was completed greater than 14 days from the admission date of 11/15/22.		

Signature of SLP Provider Representati [redacted] Date 1/28/2023

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE ___ OF ____**

PROVIDER NAME: _Brookstone Estates of Emerald Glen of Olney_____ REFERRAL DATE: _1/31/24_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Finding #1: **Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 3) If further evaluation is necessary due to the suspicion of a developmental disability or serious mental illness, the developmental disability or serious mental illness must be determined by a qualified DHS-DDD ISC agent or DHS-DMH preadmission screening (PAS) agent. The presence of a developmental disability does not automatically preclude admission to the SLP unless there is the need of continuous active treatment for which the individual should be considered for other DHS-DDD services not available through the SLP. The presence of a serious mental illness does not automatically preclude admission to the SLP unless the psychiatric symptoms, behavioral risk, and major treatment adherence/engagement problem persist at a sufficiently serious level that exceeds the service capabilities of the SLP provider. The evaluation and determination of whether the needs are within the SLP provider capability or beyond the SLP provider capacity is determined by the DHS-DDD ISC or DHS-DMH PAS agent**		

Issues: *R-2:* *Admitted on 7/01/23. DON screen dated 6/22/23. No notice of PASRR Level I screen outcome available for review.* *R-3:* *Admitted on 4/28/23. DON screen dated 3/31/23. No notice of PASRR Level I screen outcome available for review.* *R-6:* *Admitted on 3/31/23. DON screen dated 3/08/23. No notice of PASRR Level I screen outcome available for review.* *R-7:* *Admitted on 4/10/23. DON screen dated 3/27/23. No notice of PASRR Level I screen outcome available for review.* *R-8:* *Admitted on 1/06/23. DON screen dated 1/06/23. No notice of PASRR Level I screen outcome available for review.* *R-9:* *Admitted on 2/25/23. DON screen dated 1/31/23. No notice of PASRR Level I screen outcome available for review.*		

Finding #2: **Section 146.235 Staffing e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) The SLP setting shall provide staff and subcontractors who provide direct care with: A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment** *Issues:* *E-1:* *No semi-annual training on file for review.* *E-4:* *Start Date: 7/05/23. No orientation training on file for review.* *E-5:* *Start Date: 7/05/23. No orientation training on file for review.* *E-6:* *Start Date: 8/21/23. No orientation training on file for review.* *E-7:* *Start Date: 8/17/23. No orientation training on file for review.* *E-8:* *No semi-annual training on file for review.* *E-9:* *No semi-annual training on file for review.* *E-10:* *No semi-annual training on file for review.* *E-11:* *No semi-annual training on file for review.* *E-12:* *No semi-annual training on file for review.*		

Finding #3:

Section 146.235 Staffing e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) The SLP setting shall provide staff and subcontractors who provide direct care with: B) training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy (these subjects shall be trained as part of staff orientation and at least annually thereafter)

E-1:
No annual training on file in the last year for review.

E-8:
No annual training on file in the last year for review.

E-9:
No annual training on file in the last year for review.

E-10:
No annual training on file in the last year for review.

E-11:
No annual training on file in the last year for review.

E-12:
No annual training on file in the last year for review.

Finding #4:
Section 146.235 Staffing h) The SLP provider shall employ a minimum of one cook who shall have at least one year of experience in commercial food preparation.

E-7:
Start Date: 8/17/23. No Food Management Training/Certificate.

E-15:
Start Date: 7/24/23. No Food Management Training/Certificate

Finding #5: **Section 146.235 Staffing l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check.** *Issues:* *E-4:* *Start Date: 7/05/23. HCW Background Check not performed until 10/24/23.* *E-5:* *Issue #1: Start Date: 7/05/23. HCW Background Check not performed until 7/13/23.* *Issue #2: 30-day Verification not performed until 11/03/23.* *E-6:* *Issue #1: Start Date: 8/21/23. HCW Background Check not performed until 10/24/23.* *Issue #2: No Fingerprinting performed.* **Remediated during review. E-7 Immediately taken off schedule until fingerprinting was completed. Fingerprinting completed on 11/03/23.* *E-7:* *Issue #1:* *Start Date 8/17/23. HCW Background Check not performed.* **Remediated during review. HCW Background Check Performed on 11/03/23.* *Issue #2: No fingerprinting was performed.* **Remediated during review. E-7 Immediately taken off schedule until fingerprinting was completed. Fingerprinting completed on 11/03/23.*		

E-13: *Start Date: 12/06/22. HCW Background Check not on file. Check would have been completed prior to CHOW. Last update on website on 5/17/23. Performed again on 10/24/23.* *E-14:* *Start Date: 5/14/23. HCW Background Check not on file. Check would have been completed prior to CHOW. Verified on website on 5/17/23. Performed again on 10/24/23.* *E-15:* *Start Date: 7/24/23. HCW Background Check not performed until 10/24/23.* *E-16:* *Start Date: 10/23/23. HCW Background Check not performed until 10/25/23. E-16 had a DQ (disqualifying conviction) dated 9/22/16 in which a waiver was applied for and denied on 2/05/20. *E-2 terminated E-16 prior to the beginning of next shift on 11/03/23. This was prior to the review of E-16's file.* **Finding #6:** **Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** *Issues:* *E-3:* *Start Date: 7/05/23. 2-step TB test not initiated until 10/13/22.* *E-5:* *Start Date: 7/05/23. 2-step TB test not initiated until 10/13/22.* *E-6:* *Start Date: 8/21/23. 2-step TB test not initiated until 10/13/22.* *E-7:* *Start Date: 8/17/23. No TB test on file.* *E-14:* *Start Date: 5/14/23. Step TB test not initiated until 10/17/23. 1st step read on 10/19/23. 2nd step administered on 10/24/23. 2nd step not due to be read on date of file review.*		

Finding #7: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** *Issues:* *R-1:* *Current RAI on file dated 7/11/23. No ISP on file/provided for review.* *R-2:* *Current RAI on file dated 7/12/23. No ISP on file/provided for review.* *R-4:* *Current RAI on file dated 10/04/23. Current ISS on file dated 10/19/23, which is > 7 days.* *R-5:* *Current RAI on file dated 5/17/23. Current ISS on file dated 10/19/23, which is > 7 days.* *R-10:* *Current RAI on file dated 10/12/23. No ISP on file/provided for review.*		

Finding #8: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** *Issue:* *R-1:* *No Quarterly Evaluation on file/provided for review since the RAI of 7/11/23.*		

Signature of SLP Provider Representative_____Date_____

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider Brookstone Estates of Fairfield ID # 861969144-002

Address 315 N Market St Freestanding (X) ~~Rehab NF ( )~~

City Fairfield Zip Code 62837

Phone # 618-842-5875 Fax # 618-842-5870

Occupancy Information

# of Single Occupancy Apts.	39	Current Medicaid Census	18
# of Double Occupancy Apts.	7	Current Private Pay Census	28
Total # of Apts.	46	**Total** Current Census	46
Maximum Potential Occupancy	53	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes (X) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (X) No ( )

Type of Certification Review (complete only one)	Entrance Date	Exit Date
Final		
Annual	4/2/23	4/14/23

REVIEW FINDINGS: YES (X) NO ( )

Ombudsman was notified on 5/2/23 about the date of the review.
Ombudsman participated in review: Yes (X) No ( )

Provider Manager/Designee Signature/Date _____

Review Team's Signature/Date [redacted]

Regional Supervisor Signature/Date _____

Area Manager Signature/Date _____

Bureau Chief Signature/Date _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

1. **Required Certifications/License**
   Does the SLP provider have documentation to verify compliance with the following during the past year?

Certification/License	Yes	No	N/A	Comment
Fire 146.210(a)(1)	X			5/7/23
Local Health and Food Preparation 146.215(c)(5)	X			5/2/23
Elevator (freestanding 2 or more levels = 1 for 75 or < apartments/2 for 76 or >apartments 146.210(a)(4)			X	
Other (list)			X	

General Policies 146.230 and 146.310	Yes	No	Comments
2. Is there a policy addressing potential resident inquiry and application for admission? 146.215(c)(4)(S)	[X]	[ ]	[ ]
3. Is there a Non-Discrimination policy? 146.215(c)(4)(T)	[X]	[ ]	[ ]
4. Is there a policy addressing resident rights? 146.215(c)(4)(H)	[X]	[ ]	[ ]
5. Is there a policy(ies) that supports residents' choice of services that meet their needs and preferences? **NOTE:** Examples include residents rights, involvement in assessment and service planning.	[X]	[ ]	[ ]
6. Does the resident discharge policy include relocation assistance? 146.215(c)(4)(I) and 146.255(i)	[X]	[ ]	[ ]
7. If the SLP provider manages residents' funds, is there a surety bond equal to or more than the amount of funds managed? 146.310(b) **NOTE:** Mark **N/A** if SLP provider is not providing this service. [X] NOT APPLICABLE	[ ]	[ ]	[ ]
8. If the SLP provider manages resident funds, are they kept in an account that is separate from SLP provider funds? **NOTE:** resident funds may ONLY be maintained in an account with other residents' funds. This applies to managed resident funds and direct-deposit of resident income. 146.310(a)(7) and 146.310(c) **NOTE:** Mark **N/A** if SLP provider is not providing this service. [X] NOT APPLICABLE	[ ]	[ ]	[ ]

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of _12____**

SLP NAME: _Brookstone Estates of Fairfield_____

CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES X NO ☐

ENTRANCE DATE: _6/12/23_____ EXIT DATE: __6/14/23_____

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) INCIDENT FOLLOW UP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

_____	_____
Signature of SLP Provider Representative	Date
_____	_____
Signature of Bureau of Long Term Care HFSN	Date
_____	_____
Signature of Bureau of Long Term Care Regional Supervisor	Date
_____	_____
Signature of Bureau of Long Term Care Area Manager	Date

PROVIDER NAME: _Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements, a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. R-1 – The Illinois Department of Corrections sex offender registry website check dated 5/11/22 was done as an inmate search and not a parolee search. (Remediated 6/12/23). R-4 – The Illinois Department of Corrections sex offender registry website check dated 10/24/22 was done as an inmate search and not a parolee search. (Remediated 6/12/23).		

PROVIDER NAME: Brookstone Estates of Fairfield REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 a 4 – Continued: R-5 – The Illinois Department of Corrections sex offender registry website check dated 4/14/23 was done as an inmate search and not a parolee search. (Remediated 6/12/23). R-6 – The Illinois Department of Corrections sex offender registry website check dated 3/28/23 was done as an inmate search and not a parolee search. (Remediated 6/12/23). The Dru Sjodin and the Illinois State Police sex offender registry checks were dated 3/28/23 which was after the 3/17/23 admission. R-7 – The Illinois Department of Corrections sex offender registry website check dated 8/4/22 was done as an inmate search and not a parolee search. (Remediated 6/12/23). R-8 - The Illinois Department of Corrections sex offender registry website check dated 10/5/22 was done as an inmate search and not a parolee search. (Remediated 6/12/23). The Dru Sjodin and the Illinois State Police sex offender registry checks were dated 10/5/22 which was after the 10/3/22 admission. R-9 – The Illinois Department of Corrections sex offender registry website check dated 11/25/22 was done as an inmate search and not a parolee search. (Remediated 6/12/23).		

PROVIDER NAME: Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 a 4 – Continued: R-10 - The Illinois Department of Corrections sex offender registry website check dated 6/11/22 was done as an inmate search and not a parolee search. (Remediated 6/12/23). The Dru Sjodin and the Illinois State Police sex offender registry checks were dated 6/11/22 which was after the 5/26/22 admission. R-11 - The Illinois Department of Corrections sex offender registry website check dated 4/3/23 was done as an inmate search and not a parolee search. (Remediated 6/12/23). The Dru Sjodin and the Illinois State Police sex offender registry checks were dated 4/3/23 which was after the 3/31/23 admission		

PROVIDER NAME: Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing, l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. For E-1, E-2, and E-3: The facility failed to have the Authorization signed prior to the first shift and to print/retain the six required registries, the HCWBC and the 30 days verification upon hire.		

PROVIDER NAME: Brookstone Estates of Fairfield REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse. R-6 – The Initial Assessment and 24-hour Service Plan was dated and signed 3/21/23 which is greater than 24 hours from admission date of 3/17/23. R-7 – The Initial Assessment and 24-hour Service Plan was dated and signed 4/2/23 which is greater than 24 hours from admission date of 3/31/23.		

PROVIDER NAME: Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R-2 – RAI dated 4/14/23 was completed greater than 366 days from the previous RAI dated 12/2/21. R-3 – RAI dated 4/14/23 was completed greater than 366 days from the previous RAI dated 2/23/22. R-4 – RAI dated 4/14/23 was completed greater than 14 days from the admission date of 10/25/22. R-5 – RAI dated 5/1/23 was completed greater than 14 days from the admission date of 4/17/23. R-8 – RAI dated 10/17/22 was completed greater than 14 days from admission date of 10/3/22.		

PROVIDER NAME: Brookstone Estates of Fairfield REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 c – Continued: R-11 – RAI dated 4/17/23 was completed greater than 14 days from admission date of 3/31/23. RAI is also coded incorrectly. Section F.1.B. Bathing is coded "0" (independent) however the ISP dated 4/21/23 documents R-11 requires assist of 1 staff for bathing. This was confirmed with nursing staff.		

PROVIDER NAME: _Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.		

PROVIDER NAME: _Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	**SLP RESPONSE**	**CORRECTION DATE**
Section 146.245 d – Continued: R-6 – The ISP dated 4/14/23 was not signed by a Registered Nurse within 7 days of the RAI dated 3/28/23. R-9 – The ISP dated 1/6/23 does not address R-9's pain. The RAI dated 1/6/23 documents Section I.2.a. "Pain" coded as a "1" for less than daily. I.3.a. "Headache" was documented as the localized site. R-10 – The ISP dated 6/7/22 was completed prior to the RAI dated 6/8/22. R-11 – The ISP dated 4/21/23 does not address services identified on the RAI dated 4/17/23. The RAI dated 4/17/23 documents F.3.h. Housework and F.3.i. Laundry as "3" (Done by others).		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _12___ OF _12____**

PROVIDER NAME: _Brookstone Estates of Fairfield_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R-2 – The Quarterly Evaluation dated 9/15/22 was completed greater than 92 days from the Quarterly Evaluation dated 6/2/22. The Quarterly Evaluation dated 3/16/23 was completed greater than 92 days from the Quarterly Evaluation dated 10/26/22. R-4 – No admission RAI was completed until 4/14/23. R-4's admission dated was 10/25/22. The first Quarterly Evaluation would have been due on or before 2/6/23 if an admission RAI had been completed. The Quarterly Evaluation was dated 2/7/23 (1 day late). R-10 – The Quarterly Evaluation dated 9/15/23 was completed greater than 92 days from the RAI dated 6/8/22.		

Signature of SLP Provider Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE ___ OF ___**

PROVIDER NAME: _Brookstone Estates of Paris_____ REFERRAL DATE: __1/25/24_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Finding #1: **Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 2) Be screened by the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON), or successor tool, screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. If the individual is transferring directly from a nursing facility and has a history of a developmental disability or serious mental illness, as evidenced in the medical history accompanying the individual, the SLP provider must submit a referral for a specialized evaluation to be completed by the DHS Division of Developmental Disabilities (DHS-DDD) Independent Service Coordination (ISC) agency or the Division of Mental Health (DHS-DMH) Preadmission Screening Resident Review (PASRR) agency to evaluate for need for active treatment or the existence of serious functional risks and needs associated with the diagnosis to determine if they exceed the capacity of the SLP setting. Private pay individuals may choose to be admitted into the SLP setting when the screening assessment does not justify nursing facility level of care**		

Issues: *R-5:* *Admit Date: 12/17/22. The DON screening was not completed until 12/18/22, which is late.* *R-12:* *Admit Date: 3/06/23. The DON screening was not completed until 3/07/23, which is late.* **Finding #2:** **Section 146.220 Resident Participation Requirements c) Private pay residents seeking to convert to Medicaid while residing in an SLP setting shall be screened by the Department using the DON or successor tool, prior to the point of conversion and must be found to be in need of nursing facility level of care before Medicaid payment may be authorized.** *Issues:* *R-10:* *R-10 admitted on 10/12/20 as Private Pay. DON screen was done prior to admission on 10/08/20, however, R-10 converted to Medicaid on 2/15/23. The SLP failed to obtain a conversion screen. The screening agency was contacted, and a conversion screen was completed on 11/14/23 with a score of 64.* *R-11:* *R-11 admitted on 8/15/20 as Private Pay. DON screen was done prior to admission on 6/17/20, however, R-11 converted to Medicaid on 2/15/23. The SLP failed to obtain a conversion screen. The screening agency was contacted, and a conversion screen was completed on 11/14/23 with a score of 34.*		

Finding #3: **Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** *Issues:* *R-9:* *Admit date: 1/03/23. The 2-step TB skin test was not initiated until 1/10/23, which is 1 day late.* *R-12:* *R-12's 2nd step of the TB skin test was administered on 3/15/23 and read on 3/16/23, which is <48 hours and too soon.* *R-14:* *Original Admit Date: 3/21/22. Discharged on 1/08/23 to a Nursing Facility and then re-admitted on 2/22/23, which was >30 days.* *Issue #1:* *No 1-step or 2-step TB skin test was administered.* *Issue #2:* *The Signs and Symptoms of TB Check was not completed until 3/27/23, which is >7 days from admission.*		

Finding #4: **Section 146.230 Services b) Nursing Services 5) All nursing services shall be provided in accordance with the Nurse Practice Act [225 ILCS 65].** *Issues:* *R-11:* *Documentation in the Nursing Notes provided indicated that on 6/14/23 a CNA flushed R-11's ears with a solution. An interview with R-11 on 11/14/23, at approximately 2:00pm, revealed that R-11 was unable to confirm this procedure being done. Nursing Staff notified that this procedure should be carried out by a licensed nurse and not the CNA.* **Finding #5:** **Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 2) The services identified in subsection (d)(1)(D) shall only be delivered by a licensed nurse. d) Medication Administration, Oversight and Assistance in Self-Administration 1) The SLF shall provide the following: D) Assisting residents in the removal of the medication from the container and assisting the resident in consuming or applying the medication when requested to do so by the resident (i.e., placing a dose in a container and placing the container to the mouth of the resident).** *Issue:* *R-8:* *The standardized interview of 1/07/23 indicated that R-8 requires crushed medications. Observation of the resident's pill crushing device on the counter in R-8's apartment. Interview with the staff nurse revealed R-8 was unable to crush medications independently and that CNA's were crushing the medications.* **Central Office was notified via email on 11/15/23 and Nursing staff was made aware that CNA's are not allowed to crush medications. This practice was immediately discontinued.*		

Finding #6: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** **c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** *Issues:* *R-2:* *The current RAI on file is dated 9/08/23. The previous RAI on file is dated 9/05/22. The current RAI was completed > 366 days from the previous one.* *R-3:* *The RAI of 8/04/23 was coded incorrectly. "Medications" was coded as a 3, however, the licensed nurse verified that R-3 should be coded as a 2, pharmacy set-up and medication reminders.* *R-6:* *Admit Date: 5/28/23. The RAI was completed, signed, and dated on 7/03/23, which is >7-14 days.* *R-13:* *Admit Date:7/04/23. The RAI was completed, signed, and dated on 8/02/23, which is >7-14* *days.* *R-14:* *Original Admit Date: 3/21/22. Discharged on 1/08/23 to a Nursing Facility and then re-admitted on 2/22/23, which was >30 days. The RAI was not completed until 3/17/23, which is >7-14 days.*		

Finding #7: **Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency, and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** *Issues:* *R-1:* *No ISS/ISP on file for review.* *R-3:* *No ISS/ISP on file for review.* *R-4:* *The ISP of 1/20/23 does not address F.3.b. "Shopping" which is coded a (2), done with help from others on the RAI of 1/16/23.* *R-7:* *The ISS of 4/13/23 does not address that R-7 receives assistance with managing incontinent supplies as indicated on the RAI of 4/13/23.* *R-8:* *The ISP of 3/10/23 does not address "Medications", "Housework", or "Laundry" services provided as indicated on the RAI of 3/10/23.* *R-12:* *Issue #1:* *The ISP of 4/10/23 was completed > 7 days from the RAI of 3/14/23.* *Issue #2:* *The ISP of 4/10/23 does not address medication assistance as indicated on the RAI of 3/14/23, which is coded a (2) for done with help.*		

R-13: *Issue #1:* *The ISP of 7/18/23 was completed prior to the RAI of 8/02/23.* *Issue #2:* *The ISP of 7/19/23 does not address "Finances" as indicated on the RAI of 8/02/23, which was coded (3), done by others.* *R-14:* *Original Admit Date: 3/21/22. Discharged on 1/08/23 to a Nursing Facility and then re-admitted on 2/22/23, which was >30 days. The ISP was completed on 3/14/23, which was prior to the RAI completed on 3/17/23.* **Potential Finding #8:** **Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** *Issues:* *R-4:* *The Quarterly Evaluation of 4/24/23 was completed >92 days from the RAI of 1/16/23. Also, the QE of 10/26/23 was completed >92 days from the QE of 7/24/23.* *R-12:* *The Quarterly Evaluation of 6/14/23 was completed >92 days from the QE of 3/14/23.* *R-13:* *The Quarterly Evaluation of 11/01/23 does not address a fracture of the right wrist that occurred after a fall on 8/31/23. R-13 subsequently had this fracture throughout the quarter.*		

Signature of SLP Provider Representative_____ Date_____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of __2___**

SLP NAME: __Brookstone Estates of Paris_____
Check One:

( ) INTERIM CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION REVIEW FINDINGS: YES X ☐ NO ☐

ENTRANCE DATE: 11/13/23 EXIT DATE: _____

( ) CHANGE OF OWNERSHIP REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW DATE OF COMPLAINT:_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW ( ) SECOND FOLLOW-UP REVIEW

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐
(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of __2___**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 1-25-24
Date

Signature of Bureau of Long Term Care HFSN — Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 11**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 1-10-24
Date

1.10.24
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

POC: 1.24.24
30day: 2.9.24
Follow up: 2.12.24-2.27.24

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 3 OF 11

SLF NAME: Brookstone- Rantoul REFERRAL DATE: 8.9.23

Initial ✓ First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. RAI inaccurate, sections blank: R1, R3		

Signature of SLF Representat [redacted] Date 1/10/2024

SLF NAME: Brookestone- Rantoul REFERRAL DATE: 8.9.23

Initial (✓) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. ISS/ISP not completed, inaccurate and/or completed prior to RAI: R3, R4, R5		

Signature of SLF Representa [redacted] Date 1/10/24

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 5 OF 11

SLF NAME: Brookestone- Rantoul REFERRAL DATE: 8.9.23

Initial (✓) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 1) The SLF shall provide the following: A) Reminding the resident to take his or her medications; B) Taking medication from where it is stored in the apartment and handing it to the resident when requested to do so by the resident; C) Opening or uncapping medication containers for residents; and D) Assisting residents in the removal of the medication from the container and assisting the resident in consuming or applying the medication when requested to do so by the resident (i.e., placing a dose in a container and placing the container to the mouth of the resident). 2) The services identified in subsection (d)(1)(D) shall only be delivered by a licensed nurse. CNAs removing medications from packaging and/or placing medications into residents' mouths- Stop immediately. Only a licensed nurse can administer medications.		

Signature of SLF Representa [redacted] Date 1/10/24

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 6 OF 11

SLF NAME: Brookestone- Rantoul REFERRAL DATE: 8.9.23

Initial (✓) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
146.230 d) 3) A-E Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not be limited to, the following: A) Name of resident; B) Name of medication, dosage, directions, and route of administration. C) Date and time medication is scheduled to be administered; D) Date and time medication was administered; and E) Signature or initials of employee administering the medication. R1: holes in the MAR; medication administration not documented. MARs in use are not Medication Administration Records, they are missing dose and frequency, there is no scheduling noted and the label at the top is "Medication Reminder"		

Signature of SLF Representati [redacted] Date 1/10/24

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 7 OF 11

SLF NAME: Brookestone-Rantoul REFERRAL DATE: 8.9.23

Initial ✓ First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
146.230 d) 3) B Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not be limited to, the following: B) Name of medication, dosage, directions, and route of administration. R1, R2, R3: Medication lists do not correspond with physician order set, medication (blood monitoring device) not listed on MD orders and/or POS not signed.		

Signature of SLF Representa [redacted] Date 1/10/24

SLF NAME: Brookstone- Rantoul REFERRAL DATE: 8.9.23

Initial (Y) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
146.230 d) 4) E-F Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to, the following: E) Documentation showing that resident has taken, or refused to take, the medication; and F) Signature or initials of employee providing oversight. R1, R2, R3, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17 R18, R19: blanks on the medication reminder sheets (no staff initials to document medication assistance where required)		

Signature of SLF Representa[redacted] Date 1/10/24

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 9 OF 11

SLF NAME: Brookstone- Rantoul REFERRAL DATE: 8.9.23

Initial (✓) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION	SLF RESPONSE	CORRECTION DATE
146.230 b) 5) Section 146.230 Services b) Nursing Services 5) All nursing services shall be provided in accordance with the Nurse Practice Act [225 ILCS 65]. R1: parameters of Blood Glucose given by MD are not being followed.		

Signature of SLF Representat[redacted] Date 1/10/24

[redacted]

From: [redacted]
Sent: Thursday, May 11, 2023 10:55 AM
To: [redacted]
Subject: FW: 2023 Annual Review

[redacted]
Executive Director
Brookstone Estates of Vandalia
1607 West Fillmore Street Vandalia IL 62471
Main: 618-283-9825
[redacted]

[redacted]
Sent: Thursday, May 11, 2023 10:05 AM
[redacted]
Subject: 2023 Annual Review

CAUTION: This email originated from outside of the organization. DO NOT click links or open attachments unless you recognize the sender and know the content is safe. If you are unsure about an attachment or have questions, please contact IT Support.

[redacted]
Your 2023 annual review has been cleared with no findings!
Thanks to you and your team for the hard work and effort, enjoy New York!
[redacted]

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

Exit Conference

ASSISTED LIVING & SHARED HOUSING
(ILLINOIS DEPARTMENT OF PUBLIC HEALTH/DIVISION OF LONG-TERM CARE)

EXIT DATE: 9/26/23 **SURVEY TYPE:** Annual

ESTABLISHMENT: Brookstone Estates of Olney

VIOLATIONS:

295.2040-Disaster Preparedness
295.3030-Initial Health Evaluations for Direct Care, including TB
295.3040-Health Care Workers Back Ground Checks- Not verified
295.4000- Physician Certifications
295.4010-Service Plan

Violations will be reviewed by Supervisor and can be subject to change pending the review.

RECOMMENDATION FOR LICENSURE/PENDING CO REVIEW:

[redacted]

DATE

9/26/23
DATE

618-680-6200 618-680-6257
PHONE & FAX NUMBER

(LEAVE COPY WITH ESTABLISHMENT)

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider Brookstone Estates of Robinson ID # 861916914400B7

Address 1101 N. Monroe St. Freestanding (X) ~~Rehab NF ( )~~

City Robinson Zip Code 62454

Phone # 618-544-46663 Fax # 618-544-8984

Occupancy Information

# of Single Occupancy Apts.	20	Current Medicaid Census	28
# of Double Occupancy Apts.	22	Current Private Pay Census	13
Total # of Apts.	42	**Total** Current Census	41
Maximum Potential Occupancy	64	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes (X) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (X) No ( )

Type of Certification Review (complete only one)	Entrance Date	Exit Date
Final		
Annual	9/25/23	9/27/23

REVIEW FINDINGS: YES ( ) NO (X)

Ombudsman was notified on 9/20/23 about the date of the review.
Ombudsman participated in review: Yes ( ) No ( )

Provider Manager/Designee Signature/Da[redacted]

Review Team's Signature/Date

Regional Supervisor Signature/Date

Area Manager Signature/Date

Bureau Chief Signature/Date

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of** 3

SLP NAME: Brookstone Estates of Robinson
CHECK ONE:

( ) INTERIM CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) FINAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) ANNUAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☒

ENTRANCE DATE: 9/26/23 EXIT DATE: 9/27/23

( ) CHANGE OF OWNERSHIP REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: EXIT DATE:

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:**

REFERRAL DATE: **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: END DATE:

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: END DATE:

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: END DATE:

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 3**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

9/27/23
Date

9/27/23
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider: **Cambridge House of Maryville** ID# **202536384001**

Address: **696_0_State Route 162** Freestanding (**X**) Rehae :F ( )

City: **Maryville** Zip Code 62=0_,6=2

Phone# **618-288-2211** Fax# **618-288-2299**

Occupancy Information

# of Sin,zle Occupancy Apts.	0	Current Medicaid Census	77
# of Double Occupancy Apts.	103	Current Private Pay Census	18
Total# of Apts.	**103**	**Total** Current Census	95
Maximum Potential Occupancy	**206**	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes(/.-) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes ('/) No ( )

Type of Certification Review • **complete only one**	**Entrance Date**	**Exit Date**
Final		
Annual	6-20-23	7/18/23

REVIEW FINDINGS: YES ()<(NO ( )

Ombudsman was notified on 6-5-23 / about the date of the review.
Ombudsman participated in review: Yes ( ) No ( )

[redacted]

Regional Supervisor Signature/Date _____

Area Manager Signature/Date _____

Bureau Chief Signature/Date _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM 0
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of** _..Q_

SLP NAME: **Cambridge House of Maryville**
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES a NO ☐

ENTRANCE DATE: 10/17/22 EXIT DATE: 7/18/23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES☐ NO☐

BEGIN DATE: END DATE:

( ) **FIRST FOLLO\V-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1'') BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

RESPONSE TO ON-SITE REVIEW FINDINGS Pagc2ori____

For non-compUance found during an interim review or interhn/final completed simultaneously-

The Response to On-Site Review Findings fonn must be provided to the SLP provider within ten working days ofter the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings fonn to the Bl TC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the dale it was received from the review team to correct the non-compliance. No extension of lhe ten-day period will be granted, BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up conlinues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC centrnl office.
BLTC central office will take action to suspend or tenninate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within len working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is lo be later than 30 days from the dale that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, lhe SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or talce other appropriate steps to detem1ine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, lhe regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action lo apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

7 /li/a':)

?}t_h,Date

Date

Signature of Bureau of Long Tenn Care Regional Supervisor Date

Signature of Bureau of Long Term Care Area Manager Date

RESPONSE TO ON-SITE REVIEW FINDINGS Page ___ of ___

SLF NAME Cambridge House of Maryville REFERRAL DATE:
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Particigation Reguirements		
a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to **the SLP setting:** 4 **Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting.** **R7** record review admission date 11/2/22. The 3 required sex offender checks were not completed until after admission on 11/21/22 after the facility had conducted a quality assurance review. Resident was not identified as an offender on the ISP, IDOC or National sex offender websites.	The Administrator will educate/Inservice the Move-in-Coordinator on Compliance with the 3 required Sex Offender checks prior to admission. The Administrator will audit 10% of new resident move-in files monthly to ensure compliance with the Sex Offender Registry check requirements.	On or before 8/16/23 On or before 8/16/23

Signature of SLF Representativ Date /Ol /a 2,

93531506.2

RESPONSE TO ON-SITE REVIEW FINDINGS Page or

SLF NAME CambridGe I-louse or Maryville REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns. resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Usea resident and/or employee identifier key (R-1. R-2, etc. for residents and E-1, E-2. etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must indmJe rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements a) The SLP selling may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 2) Be screened b) the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DI IS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON). or successor tool. screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. If the individual is transferring directly from a nursing facility and has a histor) of a developmental disability or serious mental illness. as evidenced in the medical history accompanying the individual. the SLP provider must submit a referral for a specialized evaluation to be completed by the OHS Division of Developmental Disabilities (DHS-DDD) Independent Service Coordination (!SC) agency or the Division of Mental Health (DHS-DMH) Preadmission Screening Resident Review (P ASRR) agenc) to evaluate for need for active treatment or the existence of serious functional risks and	The Administrator will educate/Inservice the Move-in Coordinator on the requirements that all DONs must be less than 90 days before admission. The Administrator will audit 10% of new resident move-in files monthly to ensure compliance with all DONs completed less han 90 days of admission.	On or before 8/16/23 On or before 8/16/23

93531506.2

(Continued)

needs associated with the diagnosis to determine if they exceed the capacity of the SLP setting. Private pay individuals may choose to be admitted into the SLP setting when the screening assessment docs not justify nursing facility level of care;

R4 record review. Admission date 1/5/23 The Determination of Need Screening was dated 10/4/22 which is greater than 90 days and resident was admitted from home. Facility noted the DON was greater than 90 days and had resident rescrccned 1/27/23 score 30.

R6 record review. Admission date per state is I 0/l /22. the facility has an admission date of 2/16/12. The H FS 2536 lntcragcncj Screening was completed I /4/22 hO\\CVer rc ident was admitted from private home. A new HFS 2536 was completed 1113/22 for a conversion screen \\ ith a score of 12 and indicated Nursing Facilit), Supportive Living, or ICF/DD not appropriate. The facility has contacted the CCU 3 times per telephone and emailed them twice and has not received a response. 6/29/23 the CCU responded to the foci lity and stated that the) are aware the score was incorrect and will rescreen resident on 6/30/23.

Signature Of SL F Representativc/ [redacted] Date t/ol/6)3

RESPONSE TO ON-SITE REVIEW FINDINGS Page

SLF NAME Cumbridge House of Mumilk REFERRAL DATE:

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key {R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (\lusl include rule die)	SLF RESPONSE	CORRECTION CATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, n registered professional nurse.** RI record review. Resident Assessment Instrument dated 1/17/23 section HI diseases for Diabetes was left blank. RI was hospitalized and when returned discharge summary had a diagnosis of Diabetes Mellitus. RI was started on Januvia on 10/17/19.	The Administrator will monitor compliance by completiqg an audit of I0% of resident records each month. Section 146.245c) Section 146.245d) The DON and Staff Nurse will be in-serviced by the Director of Health Services on the requirements that all Comprehensive Resident Assessments, Quarterly Evaluations, and written service plans will by, or co-signed by, a Registered Nurse and on the proper completion of Comprehensive Resident Assessments and Individual Service Plans. Each resident RAI and Service Plan Identified in the findings will be e-evaluated by the DON and/or StafTNurse, and corrections completed s necessary to renect the resident's current/correct status.	On our before 18116/23 On our before 8 /16/23 On our before 18116/23

Signature of SLF Representative-:../- V [redacted] Date 7/3//&3

1:1r-0 11 Ito

93531506.2

368

RESPONSE TO ON-SITE REVIEW FINDINGS Page of

SLF NAME Cambridge House of Mm:yvillc REFERRAL DATE:
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-I, R-2. etc. for residents and E-I, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include mlc die)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quart rl Evaluation d) Service Plan: Within seven days after completion of the RA!, a written service plan shall be developed by, or co-signed by, a registered professional nurse. with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. RI record review Resident Assessment dated 1/17/23 F3a medications coded (1). Individual Support Plan dated 1/17/23 does not address set up of medications or ordering. R2 record review. Individual Support Plan was dated by RN 6/16/23 completed prior to Resident Assessment dated 6/17/23. Possible date error. ISP does not address dressing as		

93531506.2

Resident/Staff Identifier Key
Cambridge House of Maryville Annual Review###

R-1 Name : [redacted]
Private Pay/Medicaid: 354646887
[redacted]

R-2 Name: [redacted]
Private Pay/Medicaid: 350012357
[redacted]

R-3 Name: [redacted]
Private Pay/Medicaid: Private
[redacted]

R-4 Name: [redacted]
Private Pay/Medicaid: 099034134
[redacted]

R-5 Name: [redacted]
Private Pay/Medicaid: 401912001
[redacted]

R-6 Name: [redacted]
Private Pay/Medicaid: 360169957
[redacted]

R-7 Name: [redacted]
Private Pay/Medicaid: 361603947
[redacted]

R-8 Name:
Private Pay/Medicaid:
Apartment #:

R-9 Name:
Private Pay/Medicaid:
Apartment #:

R-10 Name:
Private Pay/Medicaid:
Apartment#:

R-11 Name:
Private Pay/Medicaid:
Apartment #:

Resident/Staff Identifier Key

E-1 Name:
Staff Position:

E-2 Name:
Staff Position:

E-3 Name:
Staff Position:

E-4 Name:
Staff Position:

E-5 Name:
Staff Position:

E-6 Name:
Staff Position:

E-7 Name:
Staff Position:

E-8 Name:
Staff Position:

E-9 Name:
Staff Position:

E-10 Name:
Staff Position:

Z-1 Name:
Staff Position:

Z-2 Name:
Staff Position:

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of _____**

SLP NAME: Cambridge House of O'Fallon

CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS: YES X** NO ☐

ENTRANCE DATE: 10/31/23 EXIT DATE: 11/30/23

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) INCIDENT FOLLOW UP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of _____**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

_____	11/30/23
Signature of SLP Provider Representative	Date
_____	_____
Signature of Bureau of Long Term Care HFSN	Date
_____	_____
Signature of Bureau of Long Term Care Regional Supervisor	Date
_____	_____
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE ____ OF ____**

PROVIDER NAME: Cambridge House of O'Fallon REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
<u>146.210 Structural Requirements</u> **s) Waste Removal** **3) Solid waste containers for use inside and outside shall be insect-proof, rodent-proof, fire-proof, non-absorbent and water-tight containers with tight fitting lids.** During facility tour on 10/31/23, 1 of the 4 dumpster lids outside was open and up. Remediated by E3.	This plan of correction does not constitute an admission of liability on the part of the provider and such liability is hereby denied. The submission of this plan does not constitute agreement by the provider that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. **(146.210)** The Executive Director will educate and provide an in-service with all staff on the proper closure of dumpster lids. The Maintenance Director will do daily check to ensure lids are closed.	On or before 12.29.23 On-going

93531512.2

<u>146.220 Resident Participation Requirements</u> **a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting:** **4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting.** **R1** record review admission 9/22/22. All three required sex offender checks completed 9/27/22, not prior to admission. **R2** record review admission 11/3/22. All three required sex offender checks completed timely on 10/24/22. On national search, Nevada was temporarily unavailable and was not rechecked. **R3** record review admission 8/31/22. All three required sex offender checks completed timely on 8/29/22. On national search, New Hampshire was temporarily unavailable and was not rechecked. **R20** record review admission 5/12/23. All three required sex offender checks completed timely on 4/17/23. On national search, Minnesota was temporarily unavailable and was not rechecked. **R30** record review admission 5/19/23. All three required sex offender checks completed timely on 4/26/23. On national	**(146.220 a)** The Executive Director will educate and provide an in-service with the Move In Coordinator and Business Office Manager on the requirements of checking the registered sex offender database properly. The Executive Director will conduct an audit of admission documentation for sex offender checks to ensure compliance.	On or before 12.29.23 Immediate and On-going

search, Mississippi was temporarily unavailable and was not rechecked. **R32** record review original admit date 6/19/19. Resident discharged to hospital 7/24/23 then to SNF on 7/26/23. Readmission from SNF 9/19/23. The three required sex offender checks completed 9/27/23, not prior to readmission. **R36** record review admission 1/23/23. All three required sex offender checks completed timely on 1/13/23. On national search, Michigan was temporarily unavailable and was not rechecked. **R38** record review admission 1/27/23. All three required sex offender checks completed timely on 1/13/23. On national search, Michigan was temporarily unavailable and was not rechecked.		
<u>146.230 Services</u> **b) Nursing Services** **5) All nursing services shall be provided in accordance with the Nurse Practice Act [225 ILCS 65].** **R40** record review nursing notes indicate resident transferred to ER on 6/3/23 due to pain related to recent fall. No incident report or nursing notes on file about a recent fall.	**(146.230 Services, b, 5)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on Incident Report Policy and Documentation – Licensed Nursing Policy. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	On or before 12/29/23

<u>146.230 Services</u> **n) Daily Check** **The SLF shall implement a system to check on the welfare of each resident daily.** **R4** record review daily wellness checks blank on 8/4/23 and 10/24/23. **R10** record review daily wellness check blank on 10/24/23. **R13** record review daily wellness checks blank on 8/18/23 and 10/24/23. **R14** record review daily wellness check blank on 9/7/23. **R15** record review daily wellness check blank on 10/24/23. **R17** record review daily wellness check blank on 9/7/23. **R20** record review daily wellness checks blank on 10/24/23 and 10/27/23. **R22** record review daily wellness check blank on 10/24/23. **R23** record review daily wellness check blank on 10/24/23. **R27** record review daily wellness check blank on 10/24/23. **R28** record review daily wellness checks blank on 8/12/23, 8/26/23, 9/2/23, and 9/18/23. **R33** record review daily wellness checks blank on 8/4/23 and 10/24/23.	**(146.230 Services, n)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the Daily Wellness Check Policy. The Executive Director and Regional Director of Clinical Services will educate and provide an in-service with all Certified Nursing Assistants on the Daily Wellness Check Policy. Previous days Daily Wellness Check record will be brought to morning meeting daily and audited for full compliance.	Immediate and Ongoing On or before 12/29/23 On or before 12/29/23 Immediate and Ongoing
<u>146.235 Staffing</u> **l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical, or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with**	**(146.235 1)** The Executive Director will conduct and inservice with the Business Office Manager on background check requirements for new employees. The Executive Director will do an audit of new hire background checks to ensure compliance	On or before 12.29.23 On-going

duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. **E4** record review start date 2/10/23. Healthcare worker and registry sites checked late on 2/13/23. Fingerprint authorization 2/13/23, not prior to start date. Fee app fingerprint not done until 7/26/23. **<u>146.235 Staffing</u>** **m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** **E5** record review start date 6/28/23. 1st step TB completed 12/23/21, read 12/26/21. 2nd step TB 1/4/22, read 1/7/22, greater than 90 days before hire. **E6** record review start date 7/24/23. 1st step TB completed 7/31/23, read 8/3/23. 1st step completed greater than 7 days of hire. **E8** record review start date 10/19/23. 1st step TB completed 10/26/23, read 10/29/23. 1st step completed greater than 7 days of hire.	**(146.235 Staffing, m)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on Tuberculosis Skin Testing and Follow Up. Licensed Nursing Staff to audit employee TB binder monthly to ensure full compliance.	On or before 12/29/23 Immediate on Ongoing

<u>146.245 Assessment and Service Plan and Quarterly Evaluation</u> **b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse.** **R32** record review readmission 9/19/23. No initial assessment and service plan completed.	**(146.245 Assessment and Service Plan and Quarterly Evaluation, b)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on Admitting a Resident Policy. Director of Nursing or designated staff will turn in Nursing Checklist for New Admissions to Executive Director on each new admission when completed. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	On or before 12/29/23 Immediate and Ongoing
<u>146.245 Assessment and Service Plan and Quarterly Evaluation</u> **c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** **R4** record review RAI dated 5/7/23 was not co-signed by RN. **R5** record review RAI completed 5/25/23, not within 366 days of previous RAI completed 5/16/22. **R6** record review RAI completed 2/27/23, not within 366 days of previous RAI completed 2/24/22. **R7** record review RAI completed 8/20/23, not within 366 days of previous RAI completed 8/15/22. Section G3. Appliances coded as doesn't use but G4 coded able to manage incontinence supplies independently. **R8** record review RAI dated 8/22/23 Section F3i. laundry coded (3). During interview, resident stated does all laundry per self.	**(146.245 Assessment and Service Plan and Quarterly Evaluation, c)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the Service Plan Policy with RAI being completed within 14 days after admission, annually and upon a significant change in the residents mental or physical status and completed or co-signed by a RN. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	Immediate and Ongoing On or before 12/29/23 Immediate and Ongoing

R11 record review RAI dated 7/8/23 is not signed by RN. **R12** record review RAI completed 10/10/23, not within 366 days of previous RAI completed 10/4/22. **R16** record review RAI completed 8/22/23, not within 366 days of previous RAI completed 8/10/22. RAI is not signed by RN. Section E. Mood and behavior patterns is blank. **R17** record review RAI completed 2/17/23. Section H1a. diabetes mellitus not checked. ISP dated 2/17/23 states that resident is diabetic. Section F3a. medications coded (0), F3c. transportation coded (0). ISP states that resident needs assistance with ordering and setting up medications, should be coded (1). ISP states resident can set up transportation with assist from staff/family, transportation should be coded (2). **R19** record review admission 6/30/23. RAI completed 10/3/23, not within 7-14 days of admission. **R20** record review admission 5/12/23. RAI completed 11/1/23, not within 7-14 days of admission. RAI not co-signed by RN. **R22** record review RAI completed 11/5/23, not co-signed by RN. **R23** record review admission 5/3/23. RAI completed 5/19/23, not within 7-14 days of admission. Section J3. Oral problems and J4. Oral status left blank. **R27** record review admission 3/31/23. RAI completed 4/17/23, not within 7-14 days of admission. Section C1. Hearing left blank. **R28** record review admission 1/26/23. RAI completed 2/15/23, not within 7-14 days of admission. **R29** record review RAI completed 11/5/23, not co-signed by RN. **R31** record review RAI completed 10/18/23, not within 366 days of previous RAI completed 8/25/22. Section G1. Coded occasionally incontinent. G3. Coded resident does not use		

incontinence supplies but G4. Coded resident is incontinent and able to mange incontinent supplies independently. **R32** record review readmission 9/19/23. RAI completed 10/27/23, not within 7-14 days of readmission. **R34** record review admission 6/22/23. RAI completed 10/18/23, not within 7-14 days of admission. **R35** record review admission 5/2/23. RAI completed 5/17/23, not within 7-14 days of admission. **R36** record review admission 1/23/23. RAI completed 2/13/23, not within 7-14 days of admission. **R37** record review admission 2/21/23. RAI completed 3/24/23, not within 7-14 days of admission. **R38** record review admission 1/27/23. RAI completed 2/10/23, not within 7-14 days of admission. RAI not co-signed by RN. **R39** record review admission 1/18/23. RAI completed 11/1/23, not within 7-14 days of admission.		
<u>146.245 Assessment and Service Plan and Quarterly Evaluation</u> **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency, and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan**	**(146.245 Assessment and Service Plan and Quarterly Evaluation, d)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the Service Plan Policy. Service plans will be completed or co-signed by an RN. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	On or before 12/29/23

shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. **R4** record review ISP completed 7/28/23. Not within 7 days of RAI completed 5/7/23. **R11** record review ISS completed 10/3/23. Not within 7 days of RAI completed 7/8/23. ISS does not address anticoagulant; resident takes Plavix 75 mg daily. ISS lists resident receiving PT/OT, no physician orders found for therapy. **R13** record review ISP completed 9/28/23. Not within 7 days of RAI completed 5/24/23. **R15** record review ISP completed 10/27/23. Not within 7 days of RAI completed 10/16/23. **R16** record review ISP dated 8/22/23 is not signed by RN. Resident did not sign ISP to receive SLP services or that they received resident's rights. Resident out to hospital 11/1/23, unable to remediate. **R18** record review ISP dated 4/13/23 is not signed by resident, resident did not indicate to choose SLP services or did not initial that they received resident rights. Remediated 11/7/23. **R20** record review ISS completed 11/1/23, not co-signed by RN.		Immediate and Ongoing

R21 record review ISS signed by RN 10/27/23, not within 7 days of RAI completed 9/8/23. **R22** record review ISP dated 11/8/23 is not co-signed by RN. ISP is not signed by resident; resident did not indicate to choose SLP services or did not initial that they received resident rights. Remediated 11/8/23. **R25** record review ISS completed 11/19/22, should have been ISP. **R27** record review ISP dated 4/17/23 is not co-signed by RN. Meals not addressed on ISP. RAI dated 4/17/23 section F3f. meals coded (3). **R29** record review ISP dated 11/7/23 is not co-signed by RN. ISP is not signed by resident; resident did not indicate to choose SLP services or did not initial that they received resident rights. Remediated 11/7/23. **R30** record review ISP signed by RN 10/3/23, not within 7 days of RAI completed 6/1/23. **R31** record review ISP in record dated 8/25/22 and updated ISP that is not dated or signed by RN as to when it was completed. ISP is not signed by resident; resident did not indicate to choose SLP services or did not initial that they received resident rights. Resident out to hospital on 11/8/23 so unable to remediate. **R35** record review ISP signed by RN 10/3/23, not within 7 days of RAI completed 5/17/23. **R37** record review ISP dated 3/24/23 is not co-signed by RN.		

R38 record review ISP dated 2/10/23 is not co-signed by RN. **R40** record review ISP signed by RN 9/20/23, not within 7 days of RAI completed 4/10/23. ISP is not signed by resident; resident did not indicate to choose SLP services or did not initial that they received resident rights. Remediated 11/8/23.		
<u>146.245 Assessment and Service Plan and Quarterly Evaluation</u> **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** **R12** record review quarterly evaluation (QE) completed 3/28/23, next QE 9/28/23, not within 92 days of previous QE. **R13** record review RAI completed 5/24/23. No QE available that was due by 8/23/23. **R14** record review QE completed 8/16/22, next QE 11/21/22, greater than 92 days. QE completed 5/17/23, no QE available that was due by 8/16/23. **R15** record review QE completed 4/6/23. Next assessment was RAI dated 10/16/23, no QE available that was due in July. **R16** record review QE completed 2/13/23, next QE 5/17/23, not within 92 days of previous QE. No further QEs to review.	**(146.245 Assessment and Service Plan and Quarterly Evaluation, e)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the Quarterly Assessment Policy. Quarterly assessments will be completed or co-signed by an RN. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	On or before 12/29/23 Immediate and Ongoing

R17 record review QE completed 5/17/23. No QE available that was due by 8/16/23. **R18** record review RAI completed 4/13/23, next QE completed 10/19/23, not within 92 days of previous assessment. **R22** record review QE completed 5/5/23. No QE available that was due by 8/4/23. **R23** record review RAI completed 5/19/23. No QE available that was due by 8/18/23. Resident was not MCO until 10/1/23. **R24** record review RAI completed 2/9/23, next QE completed 5/17/23, not within 92 days of previous assessment. No more QEs completed since 5/17/23. **R25** record review RAI completed 11/19/22, no QEs completed since RAI. Resident not MCO until 10/1/23. **R26** record review RAI completed 4/20/23, next QE completed 10/19/23, not within 92 days of previous assessment. **R27** record review RAI completed 4/17/23, next QE completed 10/19/23, not within 92 days of previous assessment. **R28** record review RAI completed 2/15/23, next QE completed 8/8/23, not within 92 days of previous assessment. **R29** record review QE completed 2/10/23, next QE completed 5/17/23, not within 92 days of previous assessment. **R30** record review RAI completed 6/1/23, next QE completed 10/3/23, not within 92 days of previous assessment.		

R31 record review QE completed 11/21/22, next QE 5/17/23, not within 92 days of previous QE. Next assessment is RAI dated 10/8/23. **R33** record review QE completed 4/14/23, next QE completed 9/21/23, not within 92 days of previous assessment. **R35** record review RAI completed 5/17/23. No QEs completed. Nursing noted QEs not done due to resident being MCO, but HFSN clarified that resident was FFS. **R36** record review RAI completed 2/13/23, next QE completed 5/17/23, not within 92 days of previous assessment. No more QEs completed. **R37** record review RAI completed 3/24/23, next QE completed 6/25/23, not within 92 days of previous assessment. Next QE completed 10/20/23, not within 92 days of previous assessment. **R38** record review RAI completed 2/10/23. No QEs completed since RAI.		
<u>146.245 Assessment and Service Plan and Quarterly Evaluation</u> **h) The SLP manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, the reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLP staff shall**	**(146.245 Assessment and Service Plan and Quarterly Evaluation, h)** The Regional Director of Clinical Services will educate and provide an in-service with the Executive Director and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the Notification of Changes in Resident Status Policy and Documentation Policy. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	On or before 12/29/23 Immediate and Ongoing

be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities. **R9** record review resident sent to hospital on 8/16/23. No family notification documented. **R22** record review resident sent to hospital on 5/3/23 for cellulitis. No family notification documented. **R27** record review resident sent to hospital on 6/2/23 for excessive fluid/edema. No family notification documented. **R36** record review per incident report, resident fell on 7/7/23 in the lobby bathroom and bathroom sink fell on top of resident. Complaints of hip pain and left shoulder pain. No nursing notes documentation. No family notification documented. **R38** record review resident sent to hospital on 6/1/23 for pain. No family notification documented. **R40** record review resident sent to hospital for abnormal vital signs on 6/8/23. No family notification documented.		
<u>146.295 Emergency Contingency Plan</u> **e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.** **R27** record review admission 3/31/23. Oriented to emergency plans on 4/10/23, not within 10 days of admission.	**(146.295, e)** The Executive Director will educate and provide in-service education to the Move In Coordinator on the Emergency Contingency Plan. The Executive Director will audit 10% of resident charts monthly to ensure full compliance.	On or before 12.29.23 On-going

R30 record review admission 5/19/23. Oriented to emergency plans prior to admission on 5/16/23, not within 10 days after admission. **R32** record review readmission 9/19/23. No orientation to emergency plans found on file since readmission.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE ____ OF _____**

PROVIDER NAME: _____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**

Signature of SLP Provider Representative_____Date_____

93531512.2

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider **Cambridge House of Swansea** ID # **205840952001**

Address: **3900 Sullivan Drive** Freestanding (**X**) Rehab J>IF ( )

City **Swansea** Zip Code **""62::.,2::,:2"'6' ----------**

Phone# **618-234-8910** Fax # **618-234-8920**

Occupancy Information

# of Single Occupancy Apts.	0	Current Medicaid Census	74
# of Double Occupancy Apts.	**103**	Current Private Pay Census	22
Total # of Apts.	**103**	**Total** Current Census	410
Maximum Potential Occupancy	**206**	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes(V) No( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP pro_Ji'der reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (1/) No ( )

Type of Certification Review (circle one)	Entrance Date	Exit Date
Final		
Annual	3/14/23-3/20/23	5/4/23

REVIEW FINDINGS: YES (v(t:9)

Ombudsman was notified on ..:J/Jl'Jj about the date of the review.
Ombudsman participated in review: Yes ( ) (Jf,)

Provider Manager/Designee Signature/Date [redacted]

Regional Supervisor Signature/Date _____

Area Manager Signature/Date _____

Bureau Chief Signature/Date _____

10/1/22

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM / /
RESPONSE *TO* ON-SITE REVIEW FINDINGS **Page 1 of** *J_/jL*

SLP NAME: **Cambridge House of Swansea**
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

() **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES NO☐

ENTRANCE DATE: 3/14/23 EXIT DATE:

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety ofresidents and/or staff.

BEGINDATE: EXIT **DATE:**

()**COMPLAINT REVIEW** **DATE OF COMPLAINT:.**

REFERRAL DATE: **REVIEW FINDINGS:** YES☐ NO☐

BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1") BEGIN DATE: END **DATE:**

FINDINGS CORRECTED: YES ☐ **NO☐**

(2nd)BEGIN **DATE:** END **DATE:**

FINDINGS CORRECTED: YES ☐ NO☐

10/1/22

RESPONSE TO ON-SITE REVIEW FINDINGS **Page2of&**

Fornon-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office.
BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within IO working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative [redacted] Date

Date

Signature ofBnreau of Long Term Care Regional Supervisor Date

Signature of Bureau of Long Term Care Area Manager Date

SLF NAME Cambridge House of Swausea REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (*Must* include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Particil!ation Reguirements		
a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: **4) Have name checked against the United States Deµartment of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting** **RS** record review re-admission from nursing facility 1/25/22 sex offenders were not re checked on readmission. Sex offender websites were checked 12/12/19. **R31** record review readmitted to SLF on 6/27/22. R31 was discharged on 3/28/22 to hospital and then to nursing facility was gone greater than 30 days. Sex offender checks were not redone upon readmission on 6/27/22.		

Signature of SLF Representative _____ Date

93531513.2

110 ——————————

10/1/22

935315132

RESPONSE TO ON-SITE REVIEW FINDINGS Page !/ oru.//:f-

SLF NAME Cambridge House of Swansea REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Snbmit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	SLF RESPONSE	CORRECTION DATE

Section 146.230 Services **d) Medication Administration, Oversight and Assistance in Self-Administration** **4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to, the following** E) **Documentation showing that resident has taken, or refused to take, the medication; and** **F) Signature or initials of employee providing oversight.** **R14** record review Medication Reminders for the month of March 2023 have blanks for 3/5, 3/7, 3/12, 3/20, and 3/23/23. December 2022 blank on 12/24/22. November 4th and 6th. **R17** record review Medication Reminders for January 2023 has blanks on 1,5,7,14,15,24,28 and 29th. December 2022 has blanks for 3.7.10.13.15.18.and 29th. **R18** record review Medication Reminder blank for December 29, 2022. **R19** record review Medication Reminders blank for 2/3, 2/14 and 2/17/23.		

(J){lfirYA.v

btfl

R21 record review Medication Reminders for January 2023 blank for 5,7,12,13,20 and the 23rd. December 2022 24th blank. F3a Medications coded (2) on RAI dated 1/10/23.		

Signature of SLF Representative_____ Date _____

10/1/22 110

400

SLF NAME Cambridge House of Swansea REFERRAL DATE:
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLF RESPONSE**	CORRECTION DATE
Section 146.230 Services **g) Housekeeping** **1) The SLF shall provide for general housekeeping services at least weekly (house cleaning, bed making, changing of linens, dusting and vacuuming).** **Rll** resident interview stated has not had apartment cleaned in 2 months. Has had bed linens changed weekly. **R14** resident interview stated has not had apartment cleaned in over a month. No odors or dust noted F3h. housekeeping coded (3). Done by staff. **R21** apartment observation 3/21/23 noted large amount of dust on the television and TV stand. F3h Housekeeping is coded a (3) on RAI completed 1/10/23. **R22** resident interview stated has not had apartment cleaned in 4-6 weeks. Has had bed linens changed weekly.		

Signature of SLF Representative _____ Date_____

110

1w1a2

93531513.2

RESPONSE TO ON-SITE REVIEW FINDINGS Page 1 of 41

SLF NAME Cambridge House of Swansea REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION <Must include rule cite)	**SLF RESPONSE**	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly		

Evaluation **c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change** in **the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** **RI** record review admission date 9/2/22 Resident Assessment Instrument completed 3/13/23. Completed greater than 7-14 days after admission. **R2** record review admission date 7/19/22 Resident Assessment Instrument completed 3/13/23. Completed greater than 7-14 days after admission. **R3** record review admission date 7/19/22 Resident Assessment Instrument completed 8/4/22. Completed greater than 7-14 days after admission. **R4** record review admission date 11/23/22 Resident Assessment Instrument completed 1/17/23. Greater than 7-14 days after admission.		

Continued

R6 record review admission date 12/12/22 Resident Assessment Instrument completed 1/12/23. Greater than 7-14 days after admission.

R7 record review admission date 6/10/22 Resident Assessment Instrument completed 6/28/22. Greater than 7-14 days after admission.

R9 record review admission date 10/11/22 Resident Assessment Instrument completed 11/12/22. Greater than 7-14 days after admission.

RIO record review Resident assessment Instrument completed 12/14/21 with the next Resident Assessment being completed 1/11/23. Greater than 366 days.

RII record review admitted 11/22/23 no Resident Assessment Instrument has been completed.

R13 record review Resident Assessment Instrument completed 8/23/22 F3f. meals coded (1) coded incorrectly verified per RN should be coded a (3).

RIS record review last Resident Assessment Instrument completed 1/7/22 no current RAI on file.

R16 record review Resident assessment completed 1/11/23. The previous RAI was completed 1/7/22 greater than 366 days.

R17 record review Resident Assessment Instrument completed 3/22/23. The previous RAI was completed 10/26/21 greater than 366 days.

Continued **R18** record review Resident Assessment Instrument completed 1/17/23 previous RAI was completed 11/01/21greater than 366 days. F3a medications is coded a (3) resident receives verbal reminders with assistance and lock box should be coded (2). **R19** record review Resident Assessment Instrument completed 1/11/23. The previous RAI was completed 1/4/22 greater than 366 days. **R20** record review last Resident Assessment Instrument completed 1/10/22. Remediated 3/21/23 to complete LOCD. **R22** record review Resident Assessment Instrument completed 1/19/23. The previous RAI was completed 11/4/21greater than 366 days. **R23** record review admission date 9/30/22 Resident Assessment Instrument completed 1/11/23. Completed greater than 7-14 days after admission. **R24** record review admission date 11/4/22. No Resident Assessment Instrument was completed Remediated 3/21/23 to complete LOCD. **R25** record review admission date 8/19/22. No Resident Assessment Instrument was completed Remediated 3/21/23 to complete LOCD. **R26** record review admission date 8/13/22. No Resident Assessment Instrument was completed Remediated 3/21/23 to complete LOCD.	Y4Lt	

Continued

R27 record review admission date 12/14/22. Resident assessment Instrument completed 1/12/23. Completed greater than 7-14 days.

R28 record review admission date 10/3/22. Resident assessment Instrument completed 10/18/22. Completed greater than 7-14 days.

R29 record review facility Admission date 9/5/22. State has admission date of 10/1/22. No Resident Assessment Instrument was completed. Remediated onsite to complete LOCO.

R30 record review admission date 9/21/22. No Resident Assessment completed upon review. Remediated to complete LOCO.

R31 record review admission date 6/27/22.Resident Assessment Instrument was completed 7/1/22 completed earlierthan 7-14 days.

R34 record review admitted 12/7/22. Resident Assessment Instrument was completed 1/17/23 greater than 7-14 days after admission.

R36 record review admission date 6/16/22 per facility. Sample admission date is 6/20/22. Resident Assessment Instrument was completed 7/1/22 which is greater than 7-14 days per facility admission date.

R37 record review facility admission date 2/17/22 Resident Assessment Instrument was completed 3/6/22 section 83 cognitive skills for daily decion making was blank. No new assessment was completed. Remediated 3/17/23 to complete

LOCO. **Continued:** **R38** record review facility admission date 1/22/23. Resident Assessment Instrument was not completed until 3/14/23. **R39** record review admission date 1/17/23. There was no Resident assessment Instrument completed. Remediated onsite to complete LOCO.		

Signature of SLF Representative_____Date

SLF NAME Cambridge House of Swansea REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION **(Must include rule cite)**	SLF RESPONSE	CORRECTION DATE
Service Plan and Quarterl:i:: Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. R9 record review Resident Assessment Instrument completed 11/12/22. Individual Support Plan was not completed until 3/13/23 greater than 7 days.		

Continued: **RIO** record review Individual Support Plan dated 1/11/23 was not signed by the resident. **Remediated 3/22/23.** Resident did not initial if chooses to receive services from the SLP, or that they had received a copy of resident rights. Finances and handling of cash was not addressed on ISP both were coded a (3) on the RAI dated 1/11/23. **RII** record review admitted 11/22/22 no Resident Assessment or Induvial Support Plan has been completed for resident. **R13** record review no current Individual Support Plan. The last Individual Support Plan was completed 10/26/21. Resident did not sign that they chose SLP services or received a copy of resident rights. **R15** record review last Individual Support Plan completed 1/7/22 no current ISP. On file. Resident did not initial that they chose to receive SLP services or had received a copy of Resident Rights. **R18** record review Resident Assessment Instrument completed 1/17/23. Informational Service Summary was dated 1/26/23. (Timelessness of assessment is not relevant for question). **R20** record review No current ISP or ISS on file. Last Individual Support completed was 1/10/22. **R23** record review Resident Assessment Instrument dated 1/11/23. ISS from MCO dated 1/30/23. R23 was MCO beginning 1/1/23. **R24** record review no ISP or ISS was completed. **R25** record review no ISP or ISS was completed.		

Continued:

R26 record review no ISP or 155 was completed.

R29 record review admission date 9/5/22. No ISP or 155 was completed.

R30 record review admission date 9/21/22. No ISP or 155 was completed.

R39 record review admission date 1/17/23. No ISP or 155 was completed. Resident did not initial they choose SLP services or that resident was provided referral information nor given a copy of resident rights.

u

Signature of SLF Representative
10/1/22

Date
110

RESPONSE TO ON-SITE REVIEW FINDINGS Page /j of/2c...:<-i.

SLF NAME Cambridge House of Swansea REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly:		

Evaluation **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** **RIO** record review Quarterly evaluation were completed 3/15/22 and 6/10/22 none has been completed since. **Rll** record review resident admitted 11/22/22. No Resident assessment or Quarterly evaluations have been completed. **R12** record review Resident Assessment Instrument completed 7/14/22. No Quarterly evaluation on file after that assessment. **R13** record review Resident Assessment Instrument completed 8/23/22. No quarterly Evaluations have been completed after RAI. **R14** record review Quarterly Evaluation completed 6/10/22 with the next Quarterly Eval completed 9/30/22 (late) greater than 92 days. None completed since.		

Continued: **RIS** record review RAI completed 1/7/22. Quarterly evaluation completed 3/29/22 with the next Quarterly evaluation being completed 7/1/22 was due 6/28/22 (greater than 92 days). No further quarterlies have been completed. **R26** record review admitted 8/13/22. No Resident Assessment or Quarterly Evaluations completed. MCO began 2/1/23. **R28** record review Resident Assessment completed 10/18/22. No Quarterly evaluation was completed. was due 1/17/23. **R29** record review. No Resident Assessment or Quarterly evaluations completed. MCO as of 2/1/23. **R30** record review. No Resident Assessment or Quarterly evaluations completed. **R33** record review Resident Assessment Instrument was completed 4/26/22. No quarterly evaluations have been completed. **R35** record review Resident Assessment Instrument was completed 4/25/22. No quarterly evaluations were completed. **R37** record review last Quarterly evaluation was completed 6/2/22. No further quarterly evaluations were completed.		

Signature of SLF Representative_____.Date
10/1/22 110 _ _ _ _ _ _ _ _ _

Resident/Staff Identifier Key
Cambridge House of Swansea Annual Review 3/14-3/22/23

R-1 Name: [redacted]
Private Pay/Medicaid: 049727530
[redacted]

R-2 Name: [redacted]
Private Pay/Medicaid: 211661897
[redacted]

R-3 Name: [redacted]
Private Pay/Medicaid: 167781442
[redacted]

R-4 Name: [redacted]
Private Pay/Medicaid: 359318946
[redacted]

R-5 Name: [redacted]
Private Pay/Medicaid: 383034022
[redacted]

R-6 Name: [redacted]
Private Pay/Medicaid: 082298134
[redacted]

R-7 Name: [redacted]
Private Pay/Medicaid: 116663899
[redacted]

R-8 Name: [redacted]
Private Pay/Medicaid: 143355733
[redacted]

R-9 Name: [redacted]
Private Pay/Medicaid: 212645782
[redacted]

R-10 Name: [redacted]
Private Pay/Medicaid: 965816564
[redacted]

R-11 Name: [redacted]
Private Pay/Medicaid: 361319726
[redacted]

Resident/Staff Identifier Key

R-12 Name: [redacted]
Private Pay/Medicaid: *N/A*
[redacted]

R-13 Name: [redacted]
Private Pay/Medicaid: *N/A*
[redacted]

R-14 Name: [redacted]
Private Pay/Medicaid: *N/A*
[redacted]

R-15 Name: [redacted]
Private Pay/Medicaid: *N/A*
[redacted]

R-16 Name: [redacted]
Private Pay/Medicaid: 390935005
[redacted]

R-17 Name: [redacted]
Private Pay/Medicaid: 365299429
[redacted]

R-18 Name: [redacted]
Private Pay/Medicaid: 387573496
[redacted]

R-19 Name: [redacted]
Private Pay/Medicaid: 348654369
[redacted]

R-20 Name: [redacted]
Private Pay/Medicaid: 369675418
[redacted]

R-21 Name: [redacted]
Private Pay/Medicaid: 349651422
[redacted]

R-22 Name: [redacted]
Private Pay/Medicaid: 348693748
[redacted]

}

Resident/Staff Identifier Key

R-23 Name: [redacted]
Private Pay/Medicaid: 425213030
[redacted]

R-24 Name: [redacted]
Private Pay/Medicaid: 352368575
[redacted]

R-25 Name: [redacted]
Private Pay/Medicaid: 392517801
[redacted]

R-26 Name: [redacted]
Private Pay/Medicaid: 422421883
[redacted]

R-27 Name: [redacted]
Private Pay/Medicaid: 346933088
[redacted]

R-28 Name: [redacted]
Private Pay/Medicaid: 425249927
[redacted]

R-29 Name: [redacted]
Private Pay/Medicaid: 423296730
[redacted]

R-30 Name: [redacted]
Private Pay/Medicaid: 364761635
[redacted]

R-31 Name: [redacted]
Private Pay/Medicaid: 361319726
[redacted]

R-32 Name: [redacted]
Private Pay/Medicaid: 394616627
[redacted]

R-33 Name: [redacted]
Private Pay/Medicaid: 422927772
[redacted]

Resident/Staff Identifier Key

R-34 Nfillle: [redacted]
Private Pay/Medicaid: 426956777
[redacted]

R-35 Nfillle: [redacted]
Private Pay/Medicaid: 157679176
[redacted]

R-36 Name: [redacted]
Private Pay/Medicaid: 362854218
[redacted]

R-37 Name: [redacted]
Private Pay/Medicaid: 422922617
[redacted]

R-38 Name: [redacted]
Private Pay/Medicaid: 427714837
[redacted]

R-39 Name: [redacted]
Private Pay/Medicaid: 969087857
[redacted]

R-40 Nfillle:
Private Pay/Medicaid:
Aparhnent #:

R-41 Name:
Private Pay/Medicaid:
Aparhnent #:

R-42 Name:
Private Pay/Medicaid:
Apartment #:

R-43 Nfillle:
Private Pay/Medicaid:
Apartment #:

R-44 N=e:
Private Pay/Medicaid:
Aparhnent #:

Resident/Staff Identifier Key

E-1 Name: [redacted]
Staff Position: Manager

E-2 Name: [redacted]
Staff Position: Director of Nursing

E-3 Name: [redacted]
Staff Position: Dietary Aide

E-4 Name:
Staff Position:

E-5 Name:
Staff Position:

E-6 Name:
Staff Position:

E-7 Name:
Staff Position:

E-8 Name:
Staff Position:

E-9 Name:
Staff Position:

E-10 Name:
Staff Position:

E-11 Name:
Staff Position:

E-12 Name:
Staff Position:

E-13 Name:
Staff Position:

E-14 Name:
Staff Position:

E-15 Name:
Staff Position:

Resident/Staff Identifier Key

Z-1 Name:
Staff Position:

Z-2 Name:
Staff Position:

Facility Name: CARRIAGE COURT OF GROVE CITY

Survey Findings

Specific Cited Code	Substandard Care	Immediate Jeopardy
R - 0369	No	No
R - 0614	No	No
R - 0615	No	No
R - 0657	No	No

Records: 1 - 4 of 4

Finding for regulation: R - 0369

Based on record review, review of facility policy, and staff interview, the facility failed to ensure all pets received annual checkup and vaccinations. This affected one (Feline #1) of five pet records reviewed. This had the potential to affect all 30 residents residing in the facility.

Findings include:

Review of the veterinarian records for Feline #1 revealed the last examination was performed on 11/27/20. The veterinarian record revealed all examinations and vaccinations were due on 11/27/21.

Interview on 02/01/22 with Executive Director #500 (ED) verified the veterinarian records were overdue. ED #500 stated the family was going to make an appointment that day.

Review of the facility's policy titled Visiting Pets dated 05/26/21 revealed staff will ensure that any pet, regardless of ownership, will not jeopardize the health, safety, comfort, treatment, or well-being of residents or staff. Policy states that copies of current veterinarian health certificates are to be maintained on file at the Community and all vaccinations and local licensing requirements are met.

Finding for regulation: R - 0614

Based on record review and staff interview, the facility failed to conduct fire drills on all three shifts every three months. This had the potential to affect all 30 residents residing in the facility.

Findings include:

Review of the fire drill reports from 01/01/21 to 12/31/21 revealed the facility completed fire drills on day shift on 01/27/21, 02/28/21, 03/29/21, 08/30/21, 10/19/21, and 12/16/21. On second shift, the facility completed three fire drills on 05/10/21, 07/29/21, and 11/26/21. On third shift, the facility completed only one fire drill on 09/23/21.

Interview on 02/01/22 at 1:14 P.M. with Maintenance Director #600 verified there was only one drill conducted on third shift and only three drills conducted on second shift.

Finding for regulation: R - 0615

Based on observation and interviews, the facility failed to conduct a tornado drill during the months of March through July. The facility census was 30.

Findings include:

Review of the facility's disaster drills from 01/01/21 to 12/31/21 revealed there was no tornado drill performed in 2021.

Interview on 02/01/22 at 1:14 P.M. with Maintenance Director #600 verified there was no tornado drill completed in 2021.

Finding for regulation: R - 0657

Based on observations, facility record review, and staff interviews, the facility failed to maintain safe water temperatures in the resident rooms. This affected six resident rooms. This had the potential to affect all 30 residents residing in the facility.

Findings include:

Observations on 02/01/22 of the resident room's water temperatures revealed the following:

- At 9:02 A.M., Room 60 was 124 degrees Fahrenheit (F).
- At 10:43 A.M., Room 54 was 122 degrees F.
- At 10:49 A.M., Room 58 was 122 degrees F.
- At 10:58 A.M., Room 51 was 124 degrees F.
- At 10:59 A.M., Room 53 was 122 degrees F.
- At 11:00 A.M., Room 62 was 122 degrees F.

Observation on 02/01/22 at 12:06 P.M. with Maintenance Director #600 verified the thermostat on the facility's two water heater tanks was set at 130 degrees F. Maintenance Director #600 turned thermostats down to 120 degrees F.

Review of the facility's water temperature log dated 01/25/22 revealed Room 31 was 129 degrees F, Room 41 was 128 F, and Room 57 was 126 degrees F. On 01/18/22, the water temperature log had the following recordings: Room 37 was 125 degrees F, Room 48 was 130 degrees F, and Room 59 was 125 degrees F and on 01/09/22, Room 48 was 130 degrees F, and Room 59 was 124 degrees F.

Interview on 02/01/22 at 10:55 A.M. with Executive Director (ED) #700 verified no residents have had any instances with burns or complaints about water temperatures. ED #700 stated all higher water temperatures were on the Assisted Living area and residents were able to adjust the water faucets.

Interview on 02/01/22 at 11:15 A.M. with Maintenance Director #600 verified the water temperatures have been running 124 degrees F and upwards to 130 degrees F on the new section. Maintenance Director #600 stated he thought the regulation was 130 degrees F.

Ohio Dept Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 84 Total Census: 43 County: Fayette Administrator: [redacted] Survey Type: Annual	R 0000		
R 0127	O.A.C. 3701-16-06 (E)(2) Qualifications And Health of Personnel O.A.C. 3701-16-06 (E)(2) Staff members who provide personal care services in a residential care facility, except licensed health professionals whose scope of practice include the provision of personal care services, shall meet the following training requirements: (2) Have documentation that, prior to providing personal care services without supervision in the facility, the staff member met one of the following requirements: (a) Successfully completed training or continuing education that shall cover, as is necessary to meet the needs of residents in the facility, the following: (i) The correct techniques of providing personal care services as required by the staff member's job responsibilities; (ii) Observational skills such as recognizing changes in residents' normal status and the facility's procedures for	R 0127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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 0127	Continued From page 1 reporting changes; and (iii) Communication and interpersonal skills. The training or continuing education shall be provided by a registered nurse or a licensed practical nurse under the direction of a registered nurse and be sufficient to ensure that the staff member receiving the training can demonstrate an ability to provide the personal care services. The facility may utilize other health care professionals acting within the scope of the professional's practice as part of the training or continuing education; or (b) Successfully completed the training and competency evaluation program and competency evaluation program approved or conducted by the director under section 3721.31 of the Revised Code; or (c) Successfully completed the training or testing requirements in accordance with the medicare condition of participation of home health aide services, 42 C.F.R. 484.4 (November 6, 2014) and 42 C.F.R. 484.36 (June 18, 2001); This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide the required training to a staff member who provided personal care services to residents. This affected one of four staff members reviewed for trainings. This had	R 0127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0127	Continued From page 2 the potential to affect all 43 residents residing in the facility. Findings include: Review of the employee file revealed Nurse Aide #2 was hired on 06/08/23 and had no signed training documents by a registered nurse (RN) or licensed practical nurse (LPN) recording Nurse Aide #2's ability of observational skills, communication, and interpersonal skills. Interview with the Business Office Manager #6 on 09/14/23 at 2:20 P.M. verified the required training documents were not in Nurse Aide #2's employee file.	R 0127		
R 0131	O.A.C. 3701-16-06 (E)(6) Qualifications And Health of Personnel O.A.C. 3701-16-06 (E)(6) Staff members who provide personal care services in a residential care facility, except licensed health professionals whose scope of practice include the provision of personal care services, shall meet the following training requirements: (6) Staff members serving special populations not identified in paragraphs (E)(3) and (E)(4) of this rule shall have: (a) Two hours of initial training in the care of such residents within fourteen days of the first day of work; and (b) Four hours of continuing education in the care of such residents annually. The	R 0131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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 0131	Continued From page 3 four hours of continuing education may count towards the of continuing education requirement of paragraph (E)(7) of this rule. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide the employees, who provide personal care services to residents,the required two hours of initial training of care for the residents. This affected one of four staff members reviewed who provided personal care services. This had the potential to affect all 43 residents residing in the facility. Findings include: Review of the employee file revealed Nurse Aide #2 was hired on 06/08/23 and she provided personal care services to the residents. Nurse Aide #2 did not have record of two hours of initial training within 14 days of her first day of work. Interview with the Business Office Manager #6 on 09/14/23 at 2:43 P.M. verified Nurse Aide #2 did not have the initial two-hour training for care of the residents in her employee file, and could not verify the initial two-hour training was completed.	R 0131		
R 0137	O.A.C. 3701-16-06 (I) Qualifications And Health of Personnel O.A.C. 3701-16-06 (I) The operator or	R 0137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0137	Continued From page 4 administrator shall ensure that each staff member, other than a volunteer who does not provide personal care services, receives and complete orientation and training applicable to the staff member's job responsibilities within three working days after beginning employment with the residential care facility. A staff member shall not stay alone in the residential care facility with residents until the staff member has received the orientation and training required under this paragraph and the general staff training in fire control and evacuation procedures required under paragraph (P) of rule 3701-16-13 of the Administrative Code. The orientation and training required by this paragraph shall include at least: (1) The physical layout of the residential care facility; (2) The staff member's job responsibilities; (3) The residential care facility's policies and procedures; (4) How to secure emergency assistance; and (5) Residents' rights. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide the	R 0137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0137	Continued From page 5 required orientation and training to staff members. This affected two of the five staff members reviewed for trainings. This had the potential to affect all 43 residents residing in the facility. Findings include: Review of the employee files revealed Culinarian Staff #1 was hired on 06/09/23 and Nurse Aide #2 was hired on 06/08/23. Culinarian Staff #1 and Nurse Aide #2 did not receive orientation and training documents regarding the home's policies and procedures, resident rights, and fire control and evacuation procedures. Interview with Business Office Manager (BOM) on 09/14/23 at 2:43 P.M. verified Culinarian Staff #1 and Nurse Aide #2 did not receive orientation and training documents regarding the facility's home policies and procedures, resident rights, and fire control and evacuation procedures.	R 0137		

Ohio Dept Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 84 Total Census: 43 County: Fayette Administrator: [redacted] Survey Type: Post Survey Revisit A Post Survey Revisit was conducted on 09/14/23 for all previously cited licensure violations. All violations have been corrected as of 09/14/23. However, non-compliance was found at the time of the annual survey.	R 0000		

Ohio Department of Health

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

Ohio Dept Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 84 Total Census: 43 County: Fayette Administrator: [redacted] Survey Type: Post Survey Revisit A Post Survey Revisit was conducted on 09/14/23 for all previously cited licensure violations. All violations have been corrected as of 09/14/23. However, non-compliance was found at the time of the annual survey.	R 0000		

Ohio Department of Health

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

Ohio Dept Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 84 Total Census: 43 County: Fayette Administrator: [redacted] Survey Type: Post Survey Revisit A Post Survey Revisit was conducted on 09/14/23 for all previously cited licensure violations. All violations have been corrected as of 09/14/23. However, non-compliance was found at the time of the annual survey.	R 0000		

Ohio Department of Health

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

Ohio Dept Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2056R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 84 Total Census: 43 County: Fayette Administrator: [redacted] Survey Type: Post Survey Revisit A Post Survey Revisit was conducted on 09/14/23 for all previously cited licensure violations. All violations have been corrected as of 09/14/23. However, non-compliance was found at the time of the annual survey.	R 0000		

Ohio Department of Health

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

Ohio Dept Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2058R	A. BUILDING _____ B. WING _____	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE COURT OF WASHINGTON COURT HOUSE	500 NORTH GLENN AVENUE WASHINGTON COURT HOU OH, 43160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 84 Total Census: 43 County: Fayette Administrator: [redacted] Survey Type: Post Survey Revisit A Post Survey Revisit was conducted on 09/14/23 for all previously cited licensure violations. All violations have been corrected as of 09/14/23. However, non-compliance was found at the time of the annual survey.	R 0000		

Ohio Department of Health

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

11-28-23;04:15PM;HFS ;3127931985 # 1/ 29

DEPT OF HEALTHCARE AND
FAMILY SERVICES
BUREAU OF LONG TERM CARE
200 S WYMAN ST #307C
ROCKFORD, IL 61101
815-987-7733 Direct OFFICE
Fax: (217) 557-5061

facsimile transmittal

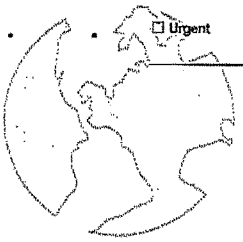
To: [redacted]/Churchview Fax: 773 471 3935

From: HFS BLTC ROCKFORD REG Date: 11-28-23

Re: 12-13-22 Churchview Annual Pages: 23 pages to Follow

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle



CONFIDENTIAL

Please sign pages 2 of 2 and page 16 of 25. A plan of correction is due within 14 days and no plan of correction can be greater than 30 days. Thank you. [redacted]

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS Page 1 of 2

SLP NAME: Churchview

CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ~~☒~~ LW

ENTRANCE DATE: 12-13-22 EXIT DATE: 11-28-23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS Page 2 of 2

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative [redacted]	Date
Signature of Bureau of Long Term Care HFSN [redacted]	Date 11/28/23
Signature of Bureau of Long Term Care Regional Supervisor	Date 11-28-23
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Churchview REFERRAL DATE: 11-28-23
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing **e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials.** **1) The SLP setting shall provide staff and subcontractors who provide direct care with:** **A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment.**		

Section 146.235 Staffing **e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials.** **1) The SLP setting shall provide staff and subcontractors who provide direct care with:** **A) Continued** **E2** hired 4/13/222, new employee training dated 8/1/22-late. **E5** hired 914/22, no training on file for Non-discrimination & Residnet Inquiry & Application. **E6** hired 10/15/21, no training done for Non-discrimination & Resident Inquiry and Application. **E9** hired 9/14/222, no training completed for Non-discrimination & Resident Inquiry & Application. **E13** hired 11/12/19, no training done for Non-discrimination $ Resident Inquiry & Application. **E14** hired 5/11/22, new employee training dated 8/2/22-late.		

Section 146.235 Staffing l) **The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check.** E1 hired 3/30/22, no documentation of IL Dept of Correction Wanted Fugitive background check; Inmate Search, Dept of Correction Sex Registrant and Health Care Registry checked on 4/5/22-late. E2 hired 4/13/22, no date on Inmate search, no Documentation of Wanted Fugitive check and Dept of Sex Registrant checks. **Remediated**		

Section 146.235 Staffing l) **continued** **E3** hired 12/3/21, no date on registry update, no date on inmate background check, no date on Sex Registrant and Wanted Fugitive background checks. **Remediated** **E4** hired 10/12/22, Health Care Worker Registry checked late on 1213/22. Registry updated late on 12/13/233. National Background Check dated 10/21/22-late., Wanted Fugitive and Parolee check not dated. **Remediated** **E5** hired 9/29/22, no date on Health Care Worker Registry check, Inmate Search, Wanted Fugitive, and Parolee background checks. **Remediated** **E6** hired 10/15/21, no date on IL Sex Offender check, Sex Registrant, Inmate and Wanted Fugitive background check. **Remediated** Registry updated late on 12/13/22. **E7** hired 10/4/22, Health Care Registry Check not dated, no date on Inmate, Parolee and Wanted Fugitive background checks. No IL Sex offender Checks on file. **Remediated** **E8** hired 6/16/22, Health Care Registry Check not dated, no background check on file and no results of Fingerprints. **Remediated** **E9** hired 9/14/232, no date on Health Care Registry Check, Parolee and IL Sex Offender Background Checks. **Remediated** National Background check dated 9/28/22-late.		

Section 146.235 Staffing **l) continued** **E10** hired 4/13/233, no date on Wanted Fugitive, IL Sex Offender, Parolee Sex Offender, and Inmate Background checks. **Remediated** E11 hired 11/3/22, no date on Sex Registrant background check amd Wanted Fugitive and Inmate background check not on file. **Remediated** **E66** - hire date was September 14, 2022. According to the document FEE APP done on 09-21-2022 (LATE). According to the authorization and disclosure was signed 8/25/22.		

Section 146.220 Resident Participation Requirements a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF: 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLF. **R10-** Admitted 12/20/2019, no date on Dept of Correction background check-remediated. **R18-** Admit date 7/15/20, National Sex Offender and IL State police background checks dated 12/19/22.Dept of Correction had no date and remediated on 12/22/22. **R22-** Admitted 11/24/21, Dept of Correction and National Sex offender background checks done on 11/26/22. **R23-** Admit 6/17/22, Three required sex offender background checks dated 9/16/22- late.		

Section 146.220 Resident Participation Requirements b) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF: 4) continued **R25**- Admit date 5/20/22, three required sex offender background checks dated 6/1/22-late. **R27**- Admit date 11/8/21, three required sex offender background checks dated 11/9/21. **R28**- Admit date 9/26/19, three required sex offender background checks dated 11/9/21. **R30** admitted 8/31/21, three required sex offender background checks done late dated 12/19/22. **R34** admitted 6/8/22; three required background checks dated late on 6/10/23. **R35** admitted 8/13/21; three sex offender background checks done late, IL State Police-not dates, Dept of Correction dated 10/9/21 and National dated 1/3/23. **R36** admitted 11/24/20, IL State Police sex offender background checks dated 1/3/23-late.		

Section 146.220 Resident Participation Requirements c) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF: 4) continued **R39** admitted 2/4/21; IL State Police check dated 12/26/22, National Background check dated 2/5/21 and Dept of Correction background check dated 12/27/22. **R40** admitted 3/18/22, Dept of Correction background check dated 12/27/22. **R42** admitted 12/1/21, IL State Police background check not dated, remediated, Dept of Correction background check dated 12/27/22-late. **R43** admitted 7/20/22 Dept of Correction parolee background check done 12/27/23-late. **R44** admitted 10/20/21, no date on IL State Police background check remediated, Dept of Correction dated 12/27/23-late and National Sex offender check date12/29/22-late. **R45** admitted 5/7/21, IL State Police dated 5/19/21-late. **R46** admitted 6/21/22, Dept of Correction background check dated		

12/27/22-late. **Section 146.220 Resident Participation Requirements** d) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF: 4) continued **R47** admitted 6/1/22, Dept of Correction background check dated 12/27/22-late. **R49** admitted 6/16/22, Dept of Correction background check dated 12/27/22 and National Background check dated 9/16/22-late. **R50** admitted 10/27/20; IL State Police check not dated, remediated 1/6/23, National Background check dated 10/28/20 and Dept of Correction background check dated 10/28/20. **R51** admitted 6/17/22; IL State Police check dated 9/6/22, National Background check dated 9/6/22 and Dept of Correction background check dated 12/27/22. **R52** admitted 6/9/22; IL State Police check dated 6/10/22, National Background check dated 6/10/22 and Dept of Correction background check dated 12/27/22. **R54**- Admitted 6/7/22; Dept of Corrections background checks dated 12/27/22-late.		

R55- Admitted 6/30/21; Background checks dated 7/21/21-late. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** **c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** **R3-** Admitted 4/1/22, RAI cosigned by RN 4/19/22. **R4-** Admitted 10/12/22, RAI cosigned by RN 10/28/22. **R6-** Admitted 10/12/22, RAI cosigned by RN 10/28/22. **R9-** Admitted 9/21/21, RAI signed by RN late on 1/4/22. **R10-** Admitted 12/20/2019, RAI signed by RN late on 1/2/20. **R11-** Admitted 6/2/22, RAI signed by RN late on 6/19/22. **R12-** Admitted 3/23/21, RAI cosigned RN on 4/14/21. **R23-** Admitted 6/24/23, RAI signed by RN 7/11/22-late. **R25-** Admitted 5/20/22, RAI signed by RN 6/4/22-late. **R26-** Admitted 7/11/22, RAI signed by RN 8/3/22-late. **R28-** Admitted 9/26/19, RAI signed by RN 10/14/19-late. **R29-** Admitted 4/25/22, RAI signed late on 5/17/22. **R30-** Admitted 8/31/21, RAI signed by RN late on 12/29/22. **R31-** RAI dated 3/9/22 not signed by the RN. **R32-** Admit date 10/19/21; RAI initiated 11/2/21and cosigned by RN on 1/4/22-late. **R33** admitted 2/3/21, RAI cosigned by RN 2/24/21-late. **R36** admitted 11/24/20, RAI cosigned by RN 4/6/21-late.		

R37 admitted 6/10/22, RAI cosigned by RN on 6/24/22-late. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** **c) Comprehensive Resident Assessment: Continued** **R38** admitted 7/20/21, RAI cosigned by RN on 12/29/22-late. **R41** admitted 3/17/22; RAI cosigned by RN on 3/31/22-1day late. **R42** admitted 12/1/23, RAI cosigned by the RN on 12/30/22-late. **R43** admitted 7/20/22, RAI cosigned by the RN on 8/3/22-late. **R44** admitted 10/20/21, RAI cosigned by the RN on 1/4/22-late. **R45** admitted 5/7/21, RAI cosigned by the RN on 5/25/21-late. **R46** admitted 6/21/22; RAI cosigned by RN 7/11/22-late **R47** admitted 6/1/21; RAI cosigned by RN 7/12/21-late. **R48** admitted 4/26/21; RAI cosigned 5/25/21-late. **R49** admitted 6/16/22; RAI cosigned by RN 7/1/22-late. **R50** admitted 6/16/22; RAI cosigned by RN 1/9/23-late. **R51** admitted 6/17/22; RAI cosigned by RN 7/1/22-late. **R52** admitted 6/9/22; RAI cosigned by RN 6/24/22-late. **R53** admitted 6/7/22; RAI cosigned by RN 6/24/22-late. **R55** admitted 10/27/20; RAI cosigned by RN 8/2/21-late.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. **R2-** Based on RAI dated 10/28/22, ISP dated 10/16/22 is out of sequence. **R3-** Facility did an ISS dated 4/19/22, PP and FFS, ISP was required. **R4-** Facility did an ISS dated 10/28/22, PP and FFS, ISP was required.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: **R5-** ISS dated 5/24/22 not signed by an RN-remediated while on site. **R7-** Based on RAI dated 9/26/22, ISS dated 12/12/22 is out of sequence. **R9-** Admitted 9/21/21, MCO started 3/1/22, ISS dated 1/4/22 instead of ISP. **R10-** RAI dated 1/2/20, ISP dated 1/30/20-late. **R18-** Facility used an ISS dated 7/28/20 (didn't become MCO) until 10/1/21. **R11-** Admitted 6/2/22, ISS dated 6/19/22 instead of an ISP completed. **R20-** Resident not enrolled in a MCO, ISS done instead of an ISP. **R21-** ISP dated 2/5/20 not reviewed and signed by the resident or designee. **R22-** Facility did an ISS dated 12/7/21, at the time ISP was required. **R24-** Facility did an ISS dated 7/7/22, at the time ISP was		

required. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** d) Service Plan: continued **R25-** Facility did an ISS dated 6/4/22, at the time ISP was required. **R26-** Facility did an ISS dated 8/3/22, at the time ISP was required. **R31-** ISS dated 3/16/22 not signed by the RN. **R32-** ISP dated 1/1/21completed prior to RAI dated 1/4/22, out of sequence. **R33-** RAI dated 2/24/21, ISS dated 2/8/21-out of sequence. **R36-** RAI dated 4/6/21, ISP dated 11/4/20-out of sequence. **R39** ISS dated 4/14/21, RAI dated 2/24/21, out of sequence. **R50-** RAI dated 1/9/23, ISP dated 1/6/23-out of sequence. **R55-** ISS signed by RN 1/4/22; RAI dated 8/2/21.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** **R1**- Quarterly dated 10/7/22 was not signed by the RN. **R2**- Quarterly dated 4/27/22 and 3rd Quarterly dated 7/2/22 were not signed by the RN. **R3**- Quarterlies dated 7/10/22 and 10/7/22 was not signed by the RN. **R11**- Quarterlies dated 9/15/22 and 12/13/22 not signed by the RN. **R14**- Quarterly dated 8/12/22 not signed by RN. **R16**- Quarterlies dated 2/6/22, 6/9/22 and 12/622 doesn't have an RN signature. **R20**- Quarterly dated 11/1/22 not co-signed by an RN. **R21**- Quarterlies dated 9/28/22 and 12/26/22 has no RN signatures. **R26**- Quarterly dated 11/1/22 doesn't have a RN signature.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **h) The SLP manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, the reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLP staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.** R8- Resident fell and had dislocation of the Rt arm on 9/26/22, was sent to the hospital, family not notified.		

Signature of SLP Provider Representative_____Date_____

The following requires remediation but is not a finding:

c) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

R4- Signs and Symptoms checklist done prior to admission. Admitted 10/21/22, checklist completed 10/12/22. Requires a TB checklist after admission.

R33- Timeframe between administration of 1st and 2nd step mantoux is 6 days. Step 1 dated 2/3/23 and step 2 dated 2/9/21. Requires a proper two step.

Section 146.295 Emergency Contingency Plan

e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.

R4- Oriented to Emergency Plan prior to admission. Admitted 10/21/22, oriented to the Emergency Plan 10/12/22. Should have an orientation after admission.

Resident Identifier

[redacted]

6/4/18

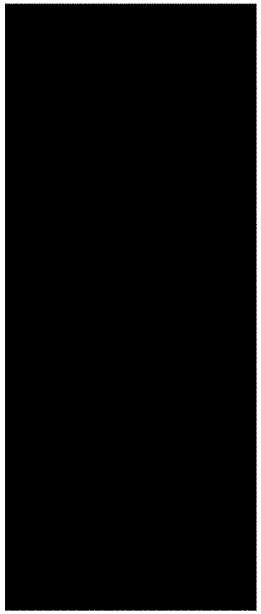
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]



Employees

E1- [redacted]
C.N.A.

6/4/18

E2- [redacted]
C.N.A.

E3- [redacted]
C.N.A

E4- [redacted]
C.N.A.

E5- [redacted]
C.N.A.

E6 [redacted]
C.N.A.

E7- [redacted]
Housekeeper

E8- [redacted]
C.N.A.

E9- [redacted]
Housekeeper

E10- [redacted]
Maintenance Director

E11- [redacted]
Dietary Aide

E12- [redacted]
C.N.A.

Churchview 12/2022 Annual Findings

E66- Name- [redacted] HOUSEKEEPING.

86

6/4/18

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 22**

SLP NAME: Deer Path of Huntley Annual Review 8/21/2023

CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES X☐ NO ☐

ENTRANCE DATE: 8/21/2023 EXIT DATE: 9/21/2023

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) INCIDENT FOLLOW UP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office.
BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

_____	_____
Signature of SLP Provider Representative	Date
_____	_____
Signature of Bureau of Long Term Care HFSN	Date
_____	_____
Signature of Bureau of Long Term Care Regional Supervisor	Date
_____	_____
Signature of Bureau of Long Term Care Area Manager	Date

PROVIDER NAME: Deer Path of Huntley Annual Review 8/21/2023 REFERRAL DATE: 8/21/2023
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements a.) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 3.) If further evaluation is necessary due to the suspicion of a developmental disability or serious mental illness, the developmental disability or serious mental illness must be determined by a qualified DHS-DDD ISC agent or DHS-DMH preadmission screening (PAS) agent. The presence of a developmental disability does not automatically preclude admission to the SLP unless there is the need of continuous active treatment for which the individual should be considered for other DHS-DDD services not available through the SLP. The presence of a serious mental illness does not automatically preclude admission to the SLP unless the psychiatric symptoms, behavioral risk, and major treatment adherence/engagement problem persist at a sufficiently serious level that exceeds the service capabilities of the SLP provider. The evaluation and determination of		

PROVIDER NAME: Deer Path of Huntley Annual Review 8/21/2023 REFERRAL DATE: 8/21/2023
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
whether the needs are within the SLP provider capability or beyond the SLP provider capacity is determined by the DHS-DDD ISC or DHS-DMH PAS agent; and Based on document review, it was determined that the SLP failed to ensure that every resident had received a SLP Initial Screen, prior to admission, to ensure they are appropriate for the SLP setting. Findings include: 1. R4 was admitted to the SLP on 3/18/2023. The SLP did not complete the SLP Initial Screen, that determines that R4 is appropriate for the SLP setting, prior to R4's admission. R4's SLP Initial Screen was dated 8/23/2023. 2. R5 was admitted to the SLP on 3/15/2023. R5's SLP Initial Screen indicated that SLP comprehensive assessment was required. The SLP did not ensure that the SLP comprehensive assessment was completed prior to admission, as required. R5 was determined to be appropriate for the SLP setting on 8/28/2023.		

PROVIDER NAME: Deer Path of Huntley Annual Review 8/21/2023 REFERRAL DATE: 8/21/2023
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. Based on document review, it was determined that the SLP failed to ensure that residents' name is checked against the three required sex offender websites, prior to admission to the SLP.		

PROVIDER NAME: Deer Path of Huntley Annual Review 8/21/2023 REFERRAL DATE: 8/21/2023
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Findings include: 1. R10 was admitted to the SLP on 3/17/2023. R10's name was checked against the three required sex offender websites on 9/28/2022, more than 5 months prior to admission. Remediated onsite, the SLP checked R10's name against the three required websites on 8/22/2023. 2. R24 was admitted to the SLP on 2/15/2023. R24's three required sex offender websites were checked on 9/28/2022. That was more than 90 days prior to admission. Remediated onsite and rechecked on 8/22/2023.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __7__ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: __8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Based on document review, it was determined that the SLP did not ensure that every prospective resident had a TB signs and symptoms completed within 7 days of admission or readmission to the SLP. Findings include: 1. R11 was readmitted to the SLP on 12/8/2022. R11 did not have a TB signs and symptoms checklist completed upon readmission, as required. 2. R23 was admitted to the SLP on 7/23/2022. R23's TB signs and symptoms was completed on 7/18/2023, not within 7 days of admission as required.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __8__ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023__ REFERRAL DATE: __8/21/2023__
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
Based on document review, it was determined that the SLP did not ensure that every prospective resident had a TB skin test in accordance with the Control of Tuberculosis Code. Findings include: 1. R20 was admitted to the SLP on 4/6/2023. R20's TB first step Mantoux was administered on 4/6/2023 and read on 4/8/2023. R20's chart lacked evidence that a second step Mantoux was administered. Remediated onsite: R20's first step Mantoux was administered on 8/22/2023. 2. R23 was admitted to the SLP on 7/23/2022. R23's TB first step Mantoux was administered on 7/26/2023, not within 7 days of admission as required.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __9__ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023__ REFERRAL DATE: __8/21/2023__
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
FINDING: Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to, the following: F) Signature or initials of employee providing oversight. Based on document review, it was determined that the SLP failed to ensure that medication oversight was completed for every resident, according to their oversight needs. Findings include: 1. R12 was admitted to the SLP on 5/24/2016. R12's medication assistance sheets were reviewed for May 2023, June 2023, and July 2023. R12's medication reminder for 6/2/2023 at 4:00 PM and 4:01 PM was left blank. All other days and times were completed with nursing staff initials.		

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023__ REFERRAL DATE: __8/21/2023__
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
2. R13 was admitted to the SLP on 2/1/2017. R13's medication assistance sheets were reviewed for May 2023, June 2023, and July 2023. R13's medication assistance for 5/6/2023 at 2:00 PM, 5/8/2023 at 2:00 PM, 5/23/2023 at 9:00 PM, and 6/21/2023 at 4:00 PM were all left blank. All other days and times were completed with nursing staff initials. 3. R14 was admitted to the SLP on 8/22/2018. R14's ISS and RAI indicated that R14 received medication reminders and opening and handing medication to resident. R14's medication assistance sheets were reviewed for May 2023, June 2023, and July 2023. R14's medication assistance for 5/7/2023 at 12:00 PM, 5/11/2023 at 8:00 PM, 5/16/2023 at 12:00 PM, and 5/23/2023 at 12:00 PM were all left blank. All other days and times were completed with nursing staff initials. 4. R17 was admitted to the SLP on 8/23/2013. R17's RAI and ISS indicated that R17 received medication reminders to take medications. R17's medication reminder sheets were reviewed for May 2023, June 2023, and July 2023. R17's medication reminder for 6/25/2023 at 11:00 AM was left blank. All other days and times		

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023__ REFERRAL DATE: _8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
were completed with nursing staff initials. 5. R18 was admitted to the SLP on 8/12/2020. R18's RAI and ISS indicated that R18 received medication reminders and handing medication to resident. R18's medication assistance sheets were reviewed for May 2023, June 2023, and July 2023. R18's medication assistance for 6/13/2023 at 8:00 PM was left blank. All other days and times were completed with nursing staff initials. 6. R25 was admitted to the SLP on 3/25/2022. R25's RAI and ISS indicated that R25 received medication reminders and handing medication to resident. R25's medication assistance sheets were reviewed for April 2023, May 2023, and June 2023. R25's medication assistance for 4/3/2023 at 12:00 PM, 4/16/2023 at 12:00 PM, 4/27/2023 at 12:00 PM, 4/27/2023 at 2:00 PM, 4/28/2023 at 6:00 AM and 2:00 PM, 4/29/2023 at 6:00 AM and 2:00 PM, 4/30/2023 at 6:00 AM and 2:00 PM, 5/2/2023 at 8:00 PM, 5/3/2023 at 12:00 PM, 5/4/2023 at 8:00 PM, 5/6/2023 at 12:00 PM, 5/9/2023 at 12:00 PM, 5/11/2023 at 12:00 PM, 5/31/2023 at 8:00 PM, 6/2/2023 at 8:00 PM, 6/3/2023 at 4:00 PM, and 6/5/2023 at 4:00		

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023__ REFERRAL DATE: __8/21/2023__
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
PM were left blank. All other days and times were completed with nursing staff initials. 7. R26 was admitted to the SLP on 8/12/2020. R26's RAI and ISS indicated that R18 received medication reminders and handing medication to resident. R26's medication assistance sheets were reviewed for May 2023, June 2023, and July 2023. R26's medication assistance for 5/4/2023 at 8:00 PM and 5/25/2023 at 12:00 PM were left blank. All other days and times were completed with nursing staff initials.		

PROVIDER NAME: _Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: ___8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) The SLP setting shall provide staff and subcontractors who provide direct care with: F) in the case of an SLP setting serving persons with physical disabilities, disability specific sensitivity training conducted by an outside entity familiar with working with persons with disabilities. The training shall occur for all staff initially prior to certification, at staff orientation for new staff, and at least annually thereafter. Based on record review, it was determined that the SLP failed to provide new hired employees with disability sensitivity training within 30 days of hire. Findings include: 1. E9 was hired on 7/7/2023. The SLP did not provide E9 with disability specific sensitivity training.		

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: __8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
2. E4 was hired on 1/25/2023. The SLP did not provide E4 with disability specific sensitivity training. 3. E5 was hired on 5/19/2023. The SLP did not provide E5 with disability specific sensitivity training. 4. E20 was hired on 5/15/2023. The SLP did not provide E20 with disability specific sensitivity training. Based on record review, it was determined that the SLP failed to provide employees with annual disability specific training. Findings include: 1. E13 was hired on 2/2/2022. The SLP did not provide E13 with annual disability specific sensitivity training. 2. E15 was hired on 8/5/2019. The SLP did not provide E15 with annual disability specific sensitivity training. 3. E23 was hired on 10/25/2021. The SLP did not provide E23 with annual disability specific sensitivity training. 4. E24 was hired on 1/29/2016. The SLP did not provide E24 with annual disability specific sensitivity training.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _15___ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: ___8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
5. E25 was hired on 12/27/2013. The SLP did not provide E25 with annual disability specific sensitivity training. 6. E26 was hired on 11/15/2018. The SLP did not provide E26 with annual disability specific sensitivity training. 7. E27 was hired on 10/11/2017. The SLP did not provide E27 with annual disability specific sensitivity training. 8. E28 was hired on 12/1/2020. The SLP did not provide E28 with annual disability specific sensitivity training.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _16___ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: __8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
Section 146.235 Staffing l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. Based on record review, it was determined that the SLP failed to complete the registry employment verification within 30 days of hire. Findings include:		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _17___ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: ___8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
1. E1 was hired on 7/12/2023. The SLP did not complete the registry employment verification within 30 days of hire. 2. E2 was hired on 6/9/2023. The SLP did not complete the registry employment verification within 30 days of hire. 3. E5 was hired on 5/19/2023. The SLP did not complete the registry employment verification within 30 days of hire. 4. E6 was hired on 6/16/2023. The SLP did not complete the registry employment verification within 30 days of hire. 5. E7 was hired on 6/26/2023. The SLP did not complete the registry employment verification within 30 days of hire. 6. E8 was hired on 6/27/2023. The SLP did not complete the registry employment verification within 30 days of hire. 7. E9 was hired on 7/7/2023. The SLP did not complete the registry employment verification within 30 days of hire. 8. E12 was hired on 7/16/2023. The SLP did not complete the registry employment verification within 30 days of hire.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _18___ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: ___8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
9. E16 was hired on 1/20/23. The SLP did not complete the registry employment verification within 30 days of hire. 10. E18 was hired on 4/18/2023. The SLP did not complete the registry employment verification within 30 days of hire. 11. E19 was hired on 6/19/2023. The SLP did not complete the registry employment verification within 30 days of hire. 12. E20 was hired on 5/15/2023. The SLP did not complete the registry employment verification within 30 days of hire.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _19___ OF __22___**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: ___8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). Based on document review, it was determined that the SLP failed to administer a tuberculin skin test, in accordance with the Control of Tuberculosis Code, to every employee. Findings include: 1. E1 was hired on 7/12/2023. The SLP completed the TB signs and symptoms for E1 on 7/31/2023, not within the required 7 days of hire. 2. E2 was hired on 6/9/2023. The SLP has not completed the TB signs and symptoms. The SLP has not administered the first step and second step Mantoux TB screening. 3. E3 was hired on 11/7/2022. The SLP administered the first step Mantoux TB screening on 11/7/2022 but did not administer the second step Mantoux within the required timeframe. The SLP administered the first step Mantoux was administered on 8/1/2023 and second step Mantoux		

PROVIDER NAME: Deer Path of Huntley Annual Review 8/21/2023 REFERRAL DATE: 8/21/2023
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
was administered on 8/10/2023. 4. E4 was hired on 1/25/2023. The SLP administered the first step Mantoux TB screening on 1/20/2023 but did not administer the second step Mantoux within the required timeframe. The SLP completed E4's TB signs and symptoms on 5/18/2023. 5. E5 was hired on 5/19/2023. The SLP administered the first step Mantoux TB screening on 7/21/2023 and second step Mantoux was administered on 7/31/2023. It was not administered within the required 7 days of hire. E5's TB signs and symptoms was completed on 7/21/2023. 6. E6 was hired on 6/16/2023. The SLP did not complete the TB signs and symptoms. The SLP did not administer the TB Mantoux screening.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _21___ OF _22____**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: __8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.295 Emergency Contingency Plan e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. Based on document review it was determined that the SLP failed to orient every resident to the emergency plans within ten days after the resident's admission. Findings include: 1. R9 was admitted to the SLP on 9/8/2020 and then readmitted on 11/4/2022. The SLP did not reorient R9 to the emergency plans upon readmission to the SLP. 2. R11 was readmitted to the SLP on 12/8/2022. The SLP did not reorient R11 to the emergency plans upon readmission to the SLP. 3. R21 was readmitted to the SLP on 11/25/2022. The SLP did not reorient R21 to the emergency plans upon readmission to the SLP.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _22___ OF __22___**

PROVIDER NAME: __Deer Path of Huntley Annual Review 8/21/2023_____ REFERRAL DATE: ___8/21/2023_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
4. R22 was admitted to the SLP on 12/13/2022. R22 was not oriented to the SLP's emergency plans, upon their readmission to the SLP. 5. R23 was admitted to the SLP on 7/23/2022. R23 was oriented to the SLP's emergency plans on 8/18/2022, not within 10 days after admission.		

Signature of SLP Provider Representative_____Date_____

93531541.2

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of** 6

SLP NAME: Eagle Ridge, Decatur
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐

ENTRANCE DATE: 11-28-23 EXIT DATE: 12-28-23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of** 6

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will complete a follow-up within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] Date

12.28.23
Date

Signature of Bureau of Long Term Care Regional Supervisor Date

Signature of Bureau of Long Term Care Area Manager Date

PROVIDER NAME: Eagle Ridge, Decatur REFERRAL DATE: Annual 11.28.23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
146.215(o) advanced directive not completed- R9 (re-admit), R32 **146.220(a)(2) DON screening not completed/late-** R9, R11, R28, R39, R40 **146.220(a)(4) Sex Offender Websites not checked/late/incomplete-** R9 (re-admit), R16, R27, R28, R30, R33, R35, R38, R41 (all remediated) **146.220(d) TB and/or Signs and Symptoms screening late/not completed-** R1, R2, R8, R12, R13, R25, R26, R27, R37- late R9, R14 re-admit not completed Remediate immediately if not already started R31 s/sx late; TB has no read date, has results recorded remediate/retest immediately R32 s/sx late; No TB testing remediate/retest immediately R35, R36, R41 no 2 step TB testing or s/sx check list performed for resident; facility to initiate on 11.30.29 remediate/retest immediately **146.230(d)(3)(D-E) & 146.230(d)(4)(E-F) missing medication**		

reminders- R42, R43, R44, R45, R46, R48 **146.235 (m) TB testing/Signs and Symptoms not completed -** E5, E6, E7, E8, E9, E10, E11- (remediated) **146.240(a) Signed contract not done-** R9 (re-admit) Remediate immediately, R32 remediated **146.245(a) Standardized interview not completed/not signed/dated/late-** R1, R9(re-admit), R26, R32, R36(re-admit) **146.245(b) Initial Assessment/Service Plan late/not done/not signed/dated/completed-** R1, R2, R4, R5, R6, R9, R10, R13, R14, R26, R32, R36, R41 **146.245(c) RAI not completed timely/accurately/thoroughly/not signed -** R1, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R28, R30, R31, R32, R33, R34, R35, R36, R37, R39, R40, R42, R47, R48, R49- late R2- section F) 2) B) and F) 4) blank. Remediate R27- Late; F(h), K(3), and K(4)-all left blank. Remediate R29, R38- late, resident uses walker-danger of fall not marked, RAI inaccurate. Remediate R41 late, RAI meds F(a)=0 per ISP and nursing meds=1 (verbal time reminder with set up). Remediate R43, R44, R45, R46- late, not signed **146.245(d) wrong form/late/not completed/not individualized** R1, R35- wrong form; no resident signature/initials for choosing to receive SLP waiver services or for receiving a copy of the resident rights. R2, R13, R15 wrong form R5, R23, R43- ISP signed prior to RAI R9, R21, R26, R32, R36, R42, R45- No ISP/ISS R10- ISP not signed/initialed by resident or designated representative(remediated) R11, R12, R19, R27- ISP late		

R30- not individualized. Remediate R38- wrong form; no resident goals, no resident signature, Resident Rights, selection of services (Remediated 11.30.23); Service Plan does not address personal hygiene or bathing. Service Plan states resident has assistance of POA/Family to assist with finances/transportation-verified resident does NOT have a POA or Family/Emergency Contact for any type of assistance. Remediate R46- no RN signature; Goals section blank Remediate **146.245 (e) late/not completed/not signed-** R6, R10, R11, R14, R15, R16, R21, R22, R23, R24, R25, R26, R30, R36, R37, R39, R40, R41, R46, R47, R48 **146.245(h) no MD/designated representative notification-** R1, R31, R38, R40 **146.295(e) No documentation resident was oriented to the emergency plan-** R1, R2, R3, R4, R5, R6, R7, R8, R9 (readmit), R10, R13, R14, R15, R16, R17, R25, R26, R28, R29, R30, R31, R32, R33, R34, R35, R36 (readmit), R37, R38, R41, R47. Remediate all if not already done		

Signature of SLP Provider Representative_____Date_____

PRINTED: 08/22/2023
FORM APPROVED

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	014002	A. BUILDING: _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN VILLAGE AT BLOOMINGTON	3607 SOUTH HEIRLOOM DRIVE BLOOMINGTON, IN 47401

(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) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 15 and 16, 2023 Facility number: 014002 Residential Census: 115 Evergreen Village At Bloomington was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed August 21, 2023.	R 000		

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

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00403915 and Complaint IN00403984. Complaint IN00403915 - No deficiencies related to the allegations are cited. Complaint IN00403984 - No deficiencies related to the allegations are cited. Survey dates: March 29 and 30, 2023. Facility number: 014512 Residential Census: 125 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 31, 2023	R 0000	April 14, 2023 RE: Survey Event ID VFUP11 To Whom It May Concern: On March 30, 2023, a State Residential Licensure with Complaint (IN00403915, IN00403984) was conducted at our community Evergreen Village at Fort Wayne by the Division of Long Term Care, Indiana Department of Health, to determine if the facility was in compliance with state requirements for health facilities found at 410 IAC 16.2. Complaint IN00403915 and IN00403984 did not have deficiencies related to the allegation cited. State Residential Licensure survey resulted in findings that were cited. Please see attached Plan of Correction related to those findings attached. We have also attached documents related to the Plan of Correction. Evergreen Village at Fort Wayne is asking for a desk review on this Plan of Correction. If you have any questions I can be reached at 260-637-2830 or emailed at execdir@evergreenvillage-fortwayne.com	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	Executive Director	04/14/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 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.

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
			Sincerely, [redacted] Executive Director	
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. (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			

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	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 a health screen and tuberculosis skin testing were performed for 1 of 5 employee files reviewed. Finding include: During a record review conducted at 8:45 AM on 3/30/23, Certified Nurse Aide (CNA) 2's employee file was reviewed. According to the employee file, CNA 2 was hired on 10/13/22. Neither an employee health screen nor Mantoux testing records were available for review. During an interview conducted at 8:50 AM on 3/30/23 with the Administrator, she indicated CNA 2 had a health screen and Mantoux skin testing performed by a previous employer. The Administrator indicated upon her review of the file, the records were not present and had not been collected. The Administrator indicated all staff members should have a health screen and Mantoux testing performed upon hire. A form titled Employee Health Screen, undated, was provided by the Administrator at 1:32 PM on 3/30/23 for review. The form indicated a health screen shall be required of all employees prior to resident contact.	R 0121	R121 410 IAC 16.2-5-1.4(f)(1-4) Personnel It is the policy of this community to ensure a health screen and Two-Step TB test using the Mantoux method (5TU,PPD) is obtained and kept in the personnel record for all employees with the health screen and first step TB being completed and read prior to resident contact unless a previously positive reaction can be documented. The results shall be recorded in millimeters of induration with the date given, date read, and by whom administered. Then going forward annually each employee should be screened for tuberculosis. (Attachments A) **What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** No staff were affected by this deficient practice. A health screen was completed for CNA 2 on 3-30-23 (Attachment B) A first step TB test was completed for CNA 2 on 3-30-23 and read	04/28/2023

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	A policy titled Tuberculosis Skin Testing and Follow-Up for Employees and Residents, last revised 9/13/21, indicated the facility must assure that at the time of employment, or within one month prior to employment, employees should be screened for tuberculosis.		with negative results on 4-1-23 (Attachment C) A second step TB test was completed on 4-13-23 with results to be read within 72 hours and documented. (Attachment D) **How will the facility identify other residents (staff) having the potential to be affected by the same deficient practice and what corrective action will be taken?** A full audit of Mantoux testing and health screen documentation for all employees will be completed by 4/15/2023. Employee files found out of compliance will be resolved by gathering the necessary missing information to achieve 100% compliance. (Attachment E) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The management team was educated on 4-13-23 regarding the policy and process of health screens and TB testing prior to employment. (Attachment F) A new hire checklist (Attachment G) was created to ensure all employee files have accurate and appropriate pre-employment forms present to include a health screen, two-step TB testing, and annual signs and symptoms for TB. The administrative assistant will ensure this checklist is completed	

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
			and hand to the business office manager for review prior to filing. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Administrative assistant or designee will audit 25% of employee files monthly for the next 6 months to ensure ongoing compliance. Administrative assistant or designee will forward any areas follow-up to the manager of that employee and the Executive Director for follow up if compliance is not achieved. Any ongoing issue or concerns will be forwarded to the QAPI team for follow up and resolution. (Attachment E) **By what date the systemic changes will be completed.** 4/28/2023	
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, interview, and record review, the facility failed to ensure food items were dated upon opening in the kitchen. 125 of 125 residents residing in the facility ate food prepared in the kitchen. Findings include:	R 0273	R 273 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services It is the policy of this community to ensure all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling	04/28/2023

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	During a kitchen tour with the Dietary Manager (DM) on 3/29/23 beginning at 9:05 AM, a container with a clear lid covering half a cream pie was observed in the walk-in refrigerator. No open date was visible anywhere on the package. A bag of blueberries observed in the walk-in freezer was visibly cut open and tied closed. No open date was visible anywhere on the package. In the dry storage room, a jar of chicken base was observed about 1/3 full and no open date was visible on the jar. 3 bags of cereal and 3 bags of pasta were observed to be about ½ full and wrapped closed with clear plastic wrap. No visible date was noted on any of the bags. A stack of 3 trays of eggs were observed in the reach-in cooler. No date was visible on the eggs. The salad station cooler had containers of shredded cheese and boiled eggs with no dates on the containers. During an interview on 3/29/23 at 9:14 AM, the DM indicated all open items must be dated when opened to prevent accidentally serving expired food. She indicated she became busy at times and forgot to date the packages when opening them. A policy titled Ready-to-Eat Hazardous Food, Date Marking Policy and Procedure, undated, was presented on 3/30/23 at 8:50 AM by the Administrator for review. The policy indicated all ready-to-eat foods shall be clearly marked to indicate the date or day by which the food must be discarded. The policy also indicated the container should be marked at the time of opening.		standards. **What Corrective action will be accomplished for those residents found to have been affected by the deficient practice?** On 3-30-23 all opened items that were found in the freezer, dry storage, and walk in cooler to not have open dates were immediately thrown away. The salad station was completely cleared out and cleaned with fresh items stocked and labels placed on each item identifying them and the date they were put into the salad station. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by this deficient practice. On 3-30-23 a 100% audit was done to ensure that there were not any other food items opened without dates clearly labeled on them in all areas of the kitchen. (Attachment M) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Dietary staff were educated on 3-30-23 policy named Ready to Eat Hazardous Food, Date Marking regarding labeling and dating of opened items.	

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
			(Attachment N) Dietary Manager or designee will audit freezer, dry storage, walk in, and salad station to ensure accuracy of labeling and dating items that are opened for 100% compliance on a weekly basis for the next 6 months. (Attachment O) **How the corrective actions will be monitored to ensure the deficient practice will not recur, ie. What quality assurance program will be put into place and by what date will the systemic changes be completed?** Dietary Manager or designee will audit freezer, dry storage, walk in, and salad station to ensure accuracy of labeling and dating items that are opened for 100% compliance weekly for the next 6 months. Any issues or concerns will be forwarded to the Executive Director and QAPI team for follow up and resolution. **By what date the systematic changes will be complete.** 4-28-23	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of			

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on record review and interview, the facility failed to ensure resident's annual tuberculosis skin test or risk assessment was completed in 5 of 6 residents reviewed. (Resident 2, Resident 3, Resident 4, Resident 6, and Resident 7). Findings include: 1. On 3/29/23 at 2:25 PM, Resident 2's record was reviewed. Diagnoses included osteoporosis, pre-diabetes, coronary artery disease and a history of transient ischemic attack. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 9/20/21. Resident 2's TB Skin Test Screening Record, dated 9/20/21, indicated the resident consented to receive TB testing (a screening method developed to evaluate an individual's status for active TB or Latent TB infection). 2 TB skin tests were administered on 9/20/21 and 10/6/21 and read 3 days later which resulted in 0 millimeter (negative) wheal. Resident 2's Immunization Record was reviewed. The record indicated, on 9/20/21, the resident received 0.1 milliliter Tubersol injection (an injection placed within the skin used to detect TB) into her left forearm which was read on 9/23/21 and resulted in 0 millimeter. The record indicated, on 10/6/21, the resident received 0.1 milliliter Tubersol injection into her right forearm which was read on 10/8/21 and resulted in 0 millimeter wheal.	R 0412	R 412 410 IAC 16.2-5-12(i) Infection Control It is the policy of this community to ensure an annual risk assessment is completed for the development of symptoms suggestive of tuberculosis, including, but not limited to cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. (Attachment A) **What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** No residents were affected by this deficient practice By 4-15-23 TB risk assessment will be completed for resident's 2, 3, 4, 6, and 7 (Attachment I) On 3-30-23 DON identified annual risk assessments that had not been completed for residents in 2022 and initiated an improvement action plan (QAPI) dated March 2023 indicating an audit of charts showing non-compliance. DON assigned 4-26-23 for 100% compliance and April as the designated month for ongoing annual compliance. (Attachment J) Due to non-compliance DON or	04/28/2023

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 2's last TB test was done 10/6/21 and the resident should have had a TB test or risk assessment annually. 2. On 3/30/23 at 9:42 AM, Resident 3's record was reviewed. Diagnoses included anxiety, depression, atrial fibrillation, diabetes mellitus, hypertension, and transient ischemic attack. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 11/4/21. Resident 3's TB Skin Test Screening Record, dated 11/4/21, indicated the resident consented to receive TB testing. 2 TB skin tests were administered on 11/4/21 and 11/19/21 and read 3 days later which resulted in 0 millimeter (negative) wheal. Resident 3's Immunization Record was reviewed. The record indicated, on 11/4/21, the resident received 0.1 milliliter Tubersol injection into her right forearm which was read on 11/7/21 and resulted in 0 millimeter wheal. The record indicated, on 11/19/21, the resident received 0.1 milliliter Tubersol injection into her left forearm which was read on 11/21/21 and resulted in 0 millimeter wheal. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 3's last TB test was done 11/19/21 and the resident should have had a TB test or risk assessment annually.		designee will complete annual risk assessment on all residents residing in community by 4-28-23 for 100% compliance. **How will the facility identify other residents (staff) having the potential to be affected by the same deficient practice and what corrective action will be taken?** A full audit of all residents will be completed by 4-15-23 to identify any resident out of compliance and an annual risk assessment for TB will be completed to achieve 100% compliance by 4-28-23. (Attachment K) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Licensed Nursing Staff were educated on 4-13-23 regarding the policy and process of annual risk assessments on all residents residing in community. (Attachment L) DON or designee will track ongoing compliance of residents receiving annual risk assessments to ensure ongoing compliance of 100%. DON has designated April each year to review and complete ongoing annual risk assessments for TB. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	3. On 3/30/23 at 10:35 AM, Resident 4's record was reviewed. Diagnoses included anxiety, diabetes mellitus, acquired absence of right leg below the knee amputation, hypertension, and phantom pain. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 9/24/21. Resident 4's TB Skin Test Screening Record, dated 9/24/21, indicated the resident consented to receive TB testing. 2 TB skin tests were administered on 9/24/21 and 10/11/21 and read 3 days later which resulted in 0 millimeter (negative) wheal. Resident 4's Immunization Record was reviewed. The record indicated, on 9/24/21, the resident received 0.1 milliliter Tubersol injection into her left forearm which was read on 9/27/21 and indicated a negative result. The record indicated, on 10/11/21, the resident received 0.1 milliliter Tubersol injection into her left forearm which was read on 10/13/21 and indicated a negative result. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 4's last TB test was done 10/12/21 and the resident should have had a TB test or risk assessment annually. 4. On 3/30/21 at 11:48 AM, Resident 6's record was reviewed. Diagnoses included chronic pain, depression, enlarged aortic root, paralysis of both lower limbs, and seizures. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 4/14/21.		**assurance program will be put into place?** DON or designee will audit 25% of resident charts monthly for the next 6 months to ensure ongoing compliance. DON or designee will forward any areas of concern to the Executive Director and to the QAPI team for follow up and resolution. **By what date the systemic changes will be completed.** 4/28/2023	

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	Resident 6's TB Skin Test Screening Record, dated 4/15/21, indicated the resident consented to receive TB testing. 2 TB skin tests were administered on 4/15/21 and 4/29/21 and read 3 days later which resulted in 0 millimeter wheal. Resident 6's Immunization Record was reviewed. The record indicated, on 4/15/21, the resident received 0.1 milliliter Tubersol injection into his right forearm which was read on 4/18/211 and resulted in 0 millimeter wheal. The record indicated, on 4/29/21, the resident received 0.1 milliliter Tubersol injection into his left forearm which was read on 5/1/21 and resulted in 0 millimeter wheal. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 6's last TB test was done 4/29/21 and the resident should have had a TB test or risk assessment annually. 5. On 3/30/21 at 1:52 AM, Resident 7's record was reviewed. Diagnoses included anemia, chronic kidney, coronary artery disease, depression, dysphasia, hypertension, diabetes mellitus, and cognitive communication deficit. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 11/12/21. Resident 7's TB Skin Test Screening Record, dated 11/12/21, indicated the resident consented to receive TB testing. A TB skin test was administered on 11/12/21 and 11/29/21 and read 3 days later which resulted in 0 millimeter wheal. Resident 7's Immunization Record was reviewed. The record indicated, on 11/12/21, the resident			

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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
	received 0.1 milliliter Tubersol injection into her left forearm which was read on 11/15/21 and indicated a negative result. The record indicated, on 11/29/21, the resident received 0.1 milliliter Tubersol injection into his right forearm which was read on 12/1/21 and indicated a negative result. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 7's last TB test was done 11/29/21 and the resident should have had a TB test or risk assessment annually. In an interview on 3/30/23 at 2:52 PM, the Administrator indicated all residents in the facility were required to have annual TB test or risk assessment. She indicated Residents 2, 3, 4, 6, and 7 had not had a TB test or risk assessment done in the last 12 months and should have. On 3/30/23 at 2:25 PM, a Quality Improvement Action Plan (QAPI), dated March 2023, provided by the DON, indicated an audit of charts showed not all annual TB assessments were completed for residents and documented in the resident's chart as an area of concern. The QAPI indicated the facility had set a 100% compliance goal by 4/26/2023 to complete all resident annual sign and symptom surveys, document results in the resident's chart and designate April as "TB Month" for annual TB compliance going forward. On 3/30/22 at 1:32 PM, a current policy titled "Tuberculosis Skin Testing and Follow-Up for Employees and Residents", last approved 9/13/21, provided by the Administrator, indicated a sign and symptom checklist would be completed annually for residents.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

(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

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00404536, IN00404943, IN00405633 and IN00401860. Complaint IN00404536 - State deficiencies related to the allegations are cited at R117. Complaint IN00401860 - State deficiencies related to the allegations are cited at R117, R120, and R121. Complaint IN00405633 - State deficiencies related to the allegations are cited at R117. Complaint IN00404943 - No deficiencies related to the allegations are cited. Survey dates: April 10, 11, 12 and 13, 2023. Facility number: 014148 Residential Census: 133 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 21, 2023.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications,			

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

[redacted] | Executive Director | 05/09/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determin 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 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.

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure the staff on duty met the requirements of first aid training for 4 of 21 shifts reviewed for first aid. Finding includes: The employee work schedule, dated 4/3/2023 through and including 4/9/2023, indicated the facility had 4 out of 21 shifts without a first aid certified staff member in the facility. During an interview, on 4/10/2023 at 4:10 p.m., the Executive Director (ED) indicated first aid trained certified staff members were not on duty at the facility for the 4 shifts on the staffing schedule reviewed for 4/3/2023 through 4/9/2023. A current facility policy, titled "CPR & First Aid Certifications," dated as effective 9/2021 and received from the ED on 4/12/2023 at 11:30 a.m.,	R 0117	1. 1. Personnel records were audited and staff in need of First Aid Certification were identified. 2. 2. All necessary staff will receive First Aid Certification on 5/12/23. 3. 3. DON and/or designee will obtain First Aid Certification cards at time of hire or will get signed up for class to obtain required certification. 4. 4. DON/designee will audit schedule weekly for 4 weeks, then monthly for 5 months. The QA committee will review audits monthly x 6 months and make recommendations as needed.	05/13/2023

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	indicated "...It is the responsibility of the Director of Nursing or designee to ensure at least one on duty employee has a current CPR & First Aid Certification at all times...." This State tag related to complaints IN00401860, IN00404536 and IN00405633.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following:			

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	(A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure staff received dementia training for 1 of 10 staff members reviewed for staff dementia training. (Staff Member 2) Finding includes: The staff record for Staff Member 2 was reviewed, on 4/12/2023 at 2:00 p.m., the employee dementia training for Staff Member 2 was not completed. During an interview, on 4/13/2023 at 2:30 p.m., the Executive Director indicated Staff Member 2 did not have a dementia training record in the file. The current facility policy, titled "Staff Training Policy and Procedure," dated as effective on 6/6/2021 and received from the Executive Director on 4/12/2023 at 11:30 a.m., indicated "...Within 30 days of employment, all staff members will complete orientation and training to the community and their assigned department and area of responsibility...Training topics will include, but not be limited to...Techniques for working with persons with disabilities and the elderly population...." This State tag related to complaint IN00401860.	R 0120	~~1. 1.~~ Staff #2 will complete Dementia training by May 11, 2023. 2. 2. The facility audited personnel records for dementia training completion Dementia training will be completed by all staff May 11, 2023. 3. 3. The Business Office Director will run a report monthly to ensure all new employees have completed dementia training. 4. 4. The administrator and/or designee will audit reports monthly and staff will be removed from the schedule if new employee required training is not complete. Audits will be reviewed at monthly QA meetings and make recommendations. 5.	05/12/2023
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			

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	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. (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 perform employee health screenings for	R 0121	~~1. 1.~~ Employees 2, 3, 4, 5, 6 and 7 will have complete 2-step	05/31/2023

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	Tuberculosis (TB) using the two-step skin test for 3 of 5 employees and a yearly TB screening for 3 of 5 staff reviewed for TB screening. (Dietary Aide 2, CNA 3, LPN 4, QMA 5, QMA 6 and Housekeeper 7) Findings include: 1. During a review of Dietary Aide 2's record, on 4/12/2023 at 2:00 p.m., the record indicated a hire date of 9/13/2022, a first step skin test was completed. No second step skin test was completed. 2. During a review of CNA 3's record, on 4/12/2023 at 2:05 p.m., the record indicated a hire date of 1/26/2022, there was no TB 1st step or 2nd step health screening record completed. 3. During a review of LPN 4's record, on 4/12/2022 at 2:10 p.m., the record indicated a hire date of 5/19/2019, there was no TB yearly health screening record completed. 4. During a review of QMA 5's record, on 4/12/2022 at 2:15 p.m., the record indicated a hire date of 8/23/2018, there was no TB yearly health screening record completed. 5. During a review of QMA 6's record, on 4/12/2022 at 2:20 p.m., the record indicated a hire date of 9/19/2022, there was no TB 1st step or 2nd step health screening record completed. 6. During a review of Housekeeper 7's record, on 4/12/2022 at 2:25 p.m., the record indicated a hire date of 8/20/2018, there was no TB yearly health screening record completed. During an interview, on 4/13/2023 at 2:30 p.m., the		TB tests completed by May 31, 2023 ~~2. 2.~~ Employee records audited; any records found with incomplete 2-Step TB test will be completed. ~~3. 3.~~ New employee TB tests will be added to the monthly calendar to ensure all TB tests are administered correctly. ~~4. 4.~~ DON and/or designee will audit TB compliance weekly to ensure compliance. Audits will be reviewed at monthly QA committee meetings x 6 months and make recommendations as needed.	

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	Executive Director indicated the employees were missing a health screening for TB. The current facility policy, titled "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," dated as effective 9/2021 and received from the Executive Director on 4/13/2023 at 12:05 p.m., indicated "...A health screen is required for each employee prior to resident contact...The facility must assure that at the time of employment, or within one month prior to employment, and at least yearly 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...." This State tag related to complaint IN00401860.			
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian for 1 of 17 resident pets records reviewed. (Resident 21) Findings include: The record review of resident pet vaccinations, on 4/10/2023 at 4:51 p.m., indicated the pet for Resident 21 had no current vaccination record. During an interview, on 4/11/2023 at 5:15 p.m., the Executive Director indicated the current pet vaccination record for Resident 21 could not be	R 0151	1. 1. Cat for resident twenty-one has an updated vaccination record as of 4.17.23. 2. 2. Resident records audit completed; any missing animal documentation will be obtained. 3. 3. Administrator/Designee will inservice Move- In Coordinator on the emotional support and service animal policy. 4. 4. Move-in coordinator/designee will audit resident animal binder for vaccinations records weekly for 4 weeks, then monthly x 5 months.	05/13/2023

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	located. The current facility policy, titled "Pet Policy," dated effective 1/2022 and received from the Executive Director on 4/12/2023 at 11:10 a.m., indicated "...Pets need to be certified by a veterinarian to be in good health an up to date with required immunizations...."		QA committee will review audit x 6 months and make recommendations. 5.	
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, interview and record review, the facility failed to ensure food was labeled and dated in the open kitchen and dry storage area for 1 of 1 kitchen reviewed. This deficiency had the potential to affect 133 of 133 residents who received food from the kitchen. Findings include: During the tour of the kitchen, on 4/11/2023 at 3:30 p.m., the following observations were made: 1.) The dry storage area was observed to have opened and not dated items: Two packages of potato chips were opened and not dated or sealed. Two packages of pasta were opened and not dated or sealed. 2.) The open kitchen area was observed to have open and not sealed items and a scoop was found in the oatmeal storage bin: Three loaves of bread were open and not dated. Two packages of hamburger buns were opened	R 0273	1. 1. No residents were affected by non-labeled/dated food items. Unlabeled food was discarded. 2. 2. All dry food and refrigerator audited; non-labeled/dated food items discarded. 3. 3. Inservice to dietary department staff on labeling and dating food items, not leaving scoop in food container completed on 4.27.2023 4. 4. Culinary Director/designee will audit food areas for labeling and dating daily for 4 weeks, weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 6 months. The culinary director and administrator will review the audit weekly and report findings at monthly quality assurance meeting x 6 months.	05/13/2023

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	and not dated. Two packages of hot dog buns were opened and not dated. During a second tour of the kitchen, on 4/13/2023 at 2:00 p.m., the following observation was made: The dry storage area had three packages of flour opened and not dated or sealed. During an interview, on 4/11/2023 at 3:55 p.m., the Acting Dietary Manager indicated all items should be sealed, labeled, and dated when opened. The oatmeal storage bin should not have contained the scoop. During an interview, on 4/13/2023 at 3:55 p.m., the Executive Director indicated there was no policy or procedure for the dating of opened items stored in the kitchen or the proper utilization of the scoop utensil in the food storage bins.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on interview and record review, the facility failed to ensure the reconciliation of controlled drugs were completed for 1 of 1 medication room reviewed for controlled drugs. Finding includes: During a record review of the controlled drug	R 0304	1. 1. No residents were affected by the deficient practice. 2. 2. Residents have potential to be affected by the deficient practice. 3. 3. Inservice to nursing staff on the proper use of narcotic count sheet completed on 4.12.23	05/13/2023

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	records, on 4/12/2023 at 12:21 p.m., with LPN 8, the Controlled Medication Shift to Shift Change Log (narcotic count record- reconciliation) was incomplete. The narcotic reconciliation sign in and sign out documentation record, for April 2023, was missing the month and year. The narcotic count reconciliation sign in and sign out documentation record, for April 2023, was missing 41 of 66 entries. The narcotic count reconciliation sign in and sign out documentation record, had only one signature listed to identify the initials of the staff signing in and out. The narcotic count reconciliation sign in and sign out documentation record, for March 2023, was missing 106 of 186 entries. The narcotic count reconciliation sign in and sign out documentation record, for March 2023, had only 3 signatures listed to identify the initials of the staff signing in and out. During an interview, on 4/12/2023 at 12:40 p.m., LPN 8 indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for that shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse or QMA and must be accurate or it was reported to the supervisor. During an interview, on 4/12/2023 at 12:43 p.m., LPN 4 indicated the staff were to sign in and out		and 4.13.23. 4. 4. DON/Designee will audit narcotic count sheet weekly for 4 weeks, monthly for 4 months. The QA committee will review audit monthly x 6 months and make recommendations as needed. 5.	

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	each shift when they did a narcotic count to verify the correct narcotic count for that shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse or QMA and must be accurate or it was reported to the supervisor. During an interview, on 4/13/2023 at 1:40 p.m., the Director of Nursing (DON) indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for that shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse or QMA and must be accurate or it was reported to her. The current policy, titled "Medication Management, Administration & Storage," dated as effective 3/23/2022 and received from the Executive Director on 4/14/2023 at 4:18 p.m., indicated "...Storage of Medications...All controlled substances shall be kept in a designated, secured location under double lock...Controlled Substances - Hand Off Procedure 1. At shift change, the oncoming license nurse or QMA responsible for the medication administration will verify the resident medication, dosage and count of all controlled substances by physically counting each medication in the direct presence of an off going licensed nurse or QMA...2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log...."			

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 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 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 screen residents for yearly Tuberculosis (TB) for 6 of 7 resident reviewed for Tuberculin screening. (Residents 2, 4, 5, 6, 12, and 14) Findings include: 1. A Mantoux (Tuberculin skin test) Test record for Resident 2 indicated the yearly TB skin test or screening was not administered in 2022. 2. A Mantoux (Tuberculin skin test) Test record for Resident 4 indicated the yearly TB skin test or screening was not administered in 2022. 3. A Mantoux (Tuberculin skin test) Test record	R 0410	1. 1. Residents 2, 6, 12, and 14 had TB Health screen completed on 5.4.2023, residents # 4 and #5 are no longer in the building. ~~2. 2.~~ The Director of Nursing/Designee will audit all Resident charts, any missing documentation will be completed. ~~3. 3.~~ Annually, in August all residents will have TB screen completed. Nursing staff in-serviced by Director of Nursing and/or designee. ~~4. 4.~~ Director of Nursing and/or designee will audit new resident record monthly and audit yearly in	05/13/2023

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	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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
	for Resident 5 indicated the yearly TB skin test or screening was not administered in 2022. 4. A Mantoux (Tuberculin skin test) Test record for Resident 6 indicated the yearly TB skin test or screening was not administered in 2022. 5. A Mantoux (Tuberculin skin test) Test record for Resident 12 indicated the yearly TB skin test or screening was not administered in 2022. 6. A Mantoux (Tuberculin skin test) Test record for Resident 14 indicated the yearly TB skin test or screening was not administered in 2022. During an interview, on 4/13/2023 at 2:30 p.m., the Executive Director indicated the residents were missing a yearly health screening for TB. The current facility policy, "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," dated as effective 9/2021 and received from the Executive Director on 4/13/2023 at 12:05 p.m., indicated "...A health screen is required for each resident...Tuberculosis screening shall be completed within 3 months prior to admission or upon admission and read at forty-eight to seventy- two hours and annually thereafter...."		August. Audits will be reviewed by the QA committee monthly x 6 months and make recommendations as needed. ~~5~~	

PRINTED: 12/22/2021
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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00365838. Complaint IN00365838 - Substantiated. No State Residential Findings related to the allegations were cited. Survey dates: November 15, 16 and 17, 2021. Facility number: 014410 Residential Census: 116 Glasswater Creek of Plainfield was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00365838. Quality review completed on November 30, 2021.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a resident with a newly identified laceration and puncture wound received first aid, pain medication, and timely emergency medical care for 1 of 1 resident randomly observed with an injury (Resident L).	R 0052	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident L experienced no adverse effects from the alleged deficient practice. Upon notification of laceration, resident	01/16/2022

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

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	Findings include: On 11/15/21 at 12:01 p.m., Resident L was observed in the dining room with a puncture laceration on his left hand between his thumb and fore finger. It was about 0.5 inches long with the skin edges unapproximated. There was wet and dried, crusty blood on the back of his hand and on the palmar surface. The wound was not washed or dressed. He indicated Licensed Practical Nurse (LPN) 12 told him it needed stitches. He was waiting on them to take him for stitches. He was trying to open a beverage between 8:00 or 9:00 a.m. that morning, when he cut his hand with a knife. He pointed to the large bruise on the lower palm of his hand and indicated it hurt "a lot," and the center of his palm was "very tender." The knife went into his hand "pretty deep," and it was painful then and now. During an interview, on 11/15/21 at 12:10 p.m., Cook 17 saw Resident L's left hand injury and indicated she talked with the Director of Nursing (DON). The DON indicated she called Resident L's physician, and they will call her back tomorrow. During an interview, on 11/15/21 at 12:19 p.m., Qualified Medication Aide (QMA) 13 indicated Resident L cut open his hand last night. She saw his injury on 11/15/21 about 9:00 a.m., and there was blood everywhere in his room. She even saw blood in a cup. She indicated the DON knew about Resident L's injury and she did not know why it was not cleaned and dressed. During an interview, on 11/15/21 at 12:35 p.m., Licensed Practical Nurse (LPN) 12 indicated she saw Resident L's left hand puncture injury about 9:00 a.m. (sic). She thought he cut it last night but did not get report from the previous staff of his		was assessed by licensed nurse, DON notified resident's physician of the injury, and resident was transported to St. Vincent urgent care for further evaluation. Upon resident's return, all MD orders regarding treatment of laceration were followed. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents were identified as affected by the alleged deficient practice. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. QMA 13 and LPN 12 were verbally in-serviced regarding timely notification of incidents and policy on first aid treatment. All-staff will be in-serviced no later than January 16th, 2022 on resident rights, types of abuse, incident-reporting policy and first aid policy. All nursing staff to be in-serviced on first aid and will be certified in first aid no later than January 16, 2022.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	injury. There was blood was in his room in several places. She called the DON at 8:22 a.m. because she needed to ask her what to do. She knew about bacteria, but she did not wash it because it looked clean. She did not dress the wound because the facility did not have gauze or dressings. They only had small band-aids that were not big enough to cover his open wound. He did not indicate he was in pain, so she did not offer any pain medication. She was working with the DON to get him sent out to the hospital. He was going by the facility's transport bus to the hospital "very soon." During an interview, 11/15/21 at 3:10 p.m., the DON indicated she was notified of Resident L's open hand laceration at 8:39 a.m. When she arrived at the facility at 8:50 a.m., she tried to reach Resident L's previous physician, by phone but no one answered. She faxed his office and did not get a response until 12:20 p.m. She notified the facility's healthcare providers. They indicated he was not their patient, but they could add him as a patient and see him tomorrow. If he needed help today, she could send him out to an urgent care facility or dispatch health (a group who provides care within 4 hours). The facility bus driver left to take Resident L to the hospital at 12:30 p.m. She indicated the facility had a lot of first aid supplies including gauze, tape, bandages, alcohol, Neosporin, bacitracin, ice packs, and tourniquets. It was a large first aid kit. The staff at the hospital indicated the wound was old and they were unable to stitch it. Her expectations for staff who encountered an injury that required first aid would be for them was to be sure the wound was clean, wash it with soap and water, use gauze it pat it dry, and apply a dressing with tape to cover it to keep anything from entering the wound.		4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. All staff will be in-serviced on resident rights, types of abuse, and reportable incidents upon hire and on an as-needed basis. Director of Nursing or designee will be assigned to ensure first aid certifications are current and that all current and new clinical staff receive in-servicing on first aid policy as it relates to reporting and treatment. Director of Nursing or designee will in-service first aid-certified staff members on location of first aid supplies. Director of Nursing or designee will complete audits regarding knowledge of first aid policy and supply storage a minimum of 2x/week for 8 weeks, then 1x/week for 8 weeks, then every other week for 8 weeks. Results to be discussed at QI meeting for six months and as needed.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 11/16/21 at 8:42 a.m., Resident L was in the dining room waiting for his breakfast. He indicated he went to the hospital yesterday and they said the wound was "too old" to put in stitches. The hospital cleaned it and put a dressing on it. It felt "a lot better" with the dressing on it. During an interview, on 11/16/21 at 9:15 a.m., Nurse Practitioner (NP) 19 for the healthcare providers for the facility indicated the facility had already tried to add Resident L to their patient list, for some reason it didn't go through, so he was added today and to be seen tomorrow. On 11/16/21 at 10:02 a.m., Resident L's paper and electronic medical records were reviewed. He was admitted to the facility on 10/19/21. His diagnoses included, but were not limited to, dyspnea (shortness of breath), diabetes mellitus (disorder of blood sugar), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea (OSA). On 11/16/21 at 10:15 a.m., the Administrator provided documents regarding Resident L's left hand puncture injury. A fax cover sheet, dated 11/15/21 with no time, was sent to Resident L's physician. It indicated, "Urgent - We have a resident ...that has cut his hand between the thumb and forefinger - he will need stitches. Please notify us of orders. ..." A nursing note, written by QMA 13, dated 11/12/21 at 9:08 a.m., indicated Resident L's accu-check was 357 this a.m., he continued without insulin orders and awaiting to see facility healthcare providers. Resident went down to eat			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	breakfast after his accu-check. His room had moldy food, trash, and feces on his bed and floor, and bathroom. Flying insects were noted in his room. The nurse and DON were made aware of his living conditions. Resident was provided trash bags. A nursing note, written by LPN 12, dated 11/15/21 at 8:39 a.m., indicated she was notified by QMA 13 that Resident L had cut himself during the night. She notified the DON. The left hand puncture wound was no longer bleeding, and he did not indicate he was in pain. A nursing note, written by the DON, dated 11/15/21 at 12:21 p.m., indicated she was notified of Resident L's left hand laceration to the webbed area between the thumb and forefinger. The resident's primary care physician was called but the phones were down for lunch. A fax was sent to notify him of the laceration. Resident L had requested to begin services with the facility physician group. The physician group had been sent all of this resident's information and was scheduled to see him as a new patient this week. Staff had educated the resident about good hygiene to keep his hand clean to avoid infection. Arrangements had been made for the resident to be transport to an urgent care center by the Resident Services Director for him to have his hand evaluated and treated. An educational document, provided to Resident L during with his discharge, indicated for puncture wounds, depending on how serious the wound was to control the bleeding, wash it out with a germ-free (sterile) salt-water solution, and close the wound with stitches (sutures) if it continues to bleed. Resident L's patient discharge documentation			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	indicated he was being discharge with a primary diagnosis of puncture wound to the hand. His new prescription based on the ER visit was to take doxycycline hyclate (broad spectrum antibiotic to treat bacterial infections) 100 mg tablet. Take 1 tablet by mouth 2 times a day. A document, titled, "Incident Report," dated 11/15/21 at 8:47 a.m., was provided by the DON on 11/16/21 at 10:24 a.m. It was completed, in part, in advance of events occurring. LPN 12 indicated Resident L was found with blood on several items in his room. She was called to his room and found the resident sitting on his couch with a cut to his left hand. His hand was free of debris and blood. Resident L had appeared to provide his own care to the cut. He did not contact staff at the time of the incident, so the initial time of the incident is unknown. He indicated he was using a knife to cut open a bottle and cut his hand. She contacted the DON. The injury was a laceration, no vital signs were taken, and the resident did not receive first aid. During an interview, on 11/16/21 at 3:03 p.m., the Administrator indicated regarding Resident L's puncture wound of his left hand, he should have received first aid at the facility. LPN 12 was not first aid certified, so she should have called on Certified Nursing Assistant (CNA) 18, who was also in the building, to give the resident first aid and dress the wound. A document titled, "Glasswater Creek of Plainfield Job Description Staff Nurse," with no date, was provided by the Administrator on 11/15/21 at 3:05 p.m. A review of the nurse job description indicated, " ...Essential Position Functions ...Refers resident to appropriate medical care when needed ...."			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	A document titled, "Glasswater Creek of Plainfield First Aid Procedure," dated 02/2022, was provided by the Administrator on 11/16/21 at 1:50 p.m. A review of the document indicated, " ...The purpose of this policy is to ensure residents, staff and visitors, receive the appropriate first aid treatment when incident/accidents occur ...It is the responsibility of the Nursing Staff to provide first aid ...."			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure staff wore a hair covering while preparing and serving food to residents, food in the kitchen was sealed, stored, and labeled properly, and food preparation equipment was kept clean, safe, and free of food and grease build-up for 1 of 1 day of observations of the kitchen that served food to 116 residents. Findings include: On 11/15/21, the facility's kitchen was surveyed. The facility's Assistant Culinary Manager (Assistant Manager) accompanied the surveyor for the duration of the survey. On 11/15/21 at 9:41 a.m., a sign on the doors to the entry of the kitchen was observed that indicated, "Notice - hairnets must be worn in this area." On 11/15/21 at 9:42 a.m., Cook 5 was observed inside the kitchen, without a hair net. He indicated	R 0154	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. All residents had the potential to be affected by the alleged deficient practices. No residents experienced adverse reactions from the alleged deficient practices. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practices. No residents experienced adverse reactions from the alleged deficient	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	he was a cook for the facility. He had arrived at 6:30 a.m. that day and had been cooking and serving food to residents since he arrived. He indicated he should wear a hair net while he was in the kitchen. On 11/15/21 at 9:44 a.m., the dry storage room was observed. Shelving units lined 3 of the 4 walls in the room, with another set of shelving placed in the center of the room. Plastic cups, plastic coffee cup lids, and paper debris was observed under the shelves. On a center shelving unit, two 55 ounce (oz) packages of corn tortillas were observed open to air. Neither package had a label that indicated when the packages were opened. During an interview on 11/15/21 at 9:51 a.m., the Assistant. Manager indicated, the packages of tortillas were both opened and not dated. They would need to be thrown out. On 11/13/21, the facility served chicken fajitas. That was the last time he could think of the tortillas being used. On 11/15/21 at 9:56 a.m., the walk-in refrigerator was observed. The outside handle to the walk-in refrigerator was covered in a dried brownish red substance that extended the length of the door handle. The Assistant. Manager indicated he was not sure what the substance was. Inside the refrigerator was a 128-oz container of French salad dressing. The container was 1/8 full. There was no label that indicated when the salad dressing had been opened or when it would expire. A 128-oz container of honey mustard salad dressing was observed, more than half full. There was no label that indicated when the salad dressing had been opened or when it would expire. A 3.5 L (liter), lidded, clear plastic container was observed to contain an unidentified orange food product. The Assistant. Manager indicated the food was cut		practices 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. The kitchen and all equipment were thoroughly cleaned, and cleaning checklist binder was created and implemented on October 15, 2021. All items in the kitchen were audited for labels and dates. Items without dates were immediately discarded. Current and new dietary staff members will be in-serviced no later than January 16, 2022, on proper practices related to kitchen cleaning schedule, Check list binder and expectations, proper food labelling and food storage practices. All staff will be in-serviced no later than January 16, 2022, on proper usage of hair nets in the kitchen. All dietary staff will be educated on proper practices related to kitchen cleaning schedule and expectations, proper food labelling and food storage practices during general or job-specific orientation moving forward. All staff will be educated on proper usage of hair nets in the kitchen during general or job-specific orientation moving forward. 4. Describe how the corrective actions(s) will be monitored to	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	mandarin oranges. He was not sure when the oranges had last been served. The container lacked a label that indicated what was in the container, when it was prepared, by whom it was prepared, or when it would expire. A clear plastic bag of unidentified meat was observed on a slotted shelf. The bag was not in a container and did not have a pan under it. The Assistant. Manager indicated the bag contained salmon fillets. The bag was tied shut. There was no label on the bag that indicated what food item was in it, when it was prepared, by whom it was prepared, or when the food would expire. A cling-wrapped package of sliced ham and a cling-wrapped package of half a ham, was observed on a slotted shelf. Neither package of ham was placed in a container or had a pan underneath. The Assistant. Manager indicated, all food items should be placed on a sheet pan or in a container so that they did not drain or leak onto food stored in lower shelves. On 11/15/21 at 10:05 a.m., the deep fryer was observed. The sides and front of the deep fryer were coated with dried grease and food debris. The Assistant. Manager indicated, "you could scrub all day and not get that [the grease] off there [the sides and front of the deep fryer]." On 11/15/21 at 10:08 a.m., a white, granulated sugar storage container was observed with the scoop placed in with the sugar. The Assistant. Manager indicated the scoop should not be stored in the sugar, it should be placed in the scoop holder, which was on the container lid. Bacteria from a person's hand could get on the scoop handle, and then into the sugar if the scoop was stored in the sugar and not the scoop holder. On 11/15/21 at 10:09 a.m., a 3-compartment sink		ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Administrator or designee will audit food storage and labels, cleaning practices, and hair net usage 5x/week for 2 weeks, then 2x/week for 10 weeks, then 2x/month for 2 months, then 1x/month for 1 month, then ongoing as needed. Results will be reviewed at monthly QI meeting for six months as needed.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	was observed with running water over sealed bags of chicken that had been placed in one of the sink compartments. A green scouring pad was observed floating in the sink with the bags of chicken. The Assistant Manager indicated the chicken was being thawed for service that day. The scouring pad should not have been placed in the sink with the thawing chicken. The scouring pad could have bacteria on it that could spread to the bags of chicken. If the bags of chicken leaked, E. Coli (Escherichia coli, bacteria found in the environment, foods, and intestines of people and animals) and Salmonella (bacteria that live in animal and human intestines and are shed through feces) could spread from the chicken to the scouring pad. Someone could use the scouring pad, not knowing it was in with the chicken, and spread bacteria around, which could cause people to get sick. During an interview on 11/15/21 at 10:25 a.m., the Assistant. Manager indicated, kitchen cleanliness was a concern because it can affect the food quality and can attract pests. On 11/15/21 at 11:37 a.m., Cook 5 was observed as he exited the kitchen with tray of food, and delivered it to a resident in the dining room. He did not have on a hair net. Cook 5 returned to the kitchen. Inside the kitchen, he stood over open pans of food, on the hot serving line, and retrieved food trays to be served to the residents. He did not wear a hair net while in the kitchen. On 11/16/21 at 1:50 p.m., the Administrator (Admin) provided a document titled, "Daily Dietary Cleaning Schedule". Under "Description of Assignment", "polish all stainless steel" was identified as a task to be completed daily by "PM Servers". Cleaning the sides and front of the deep			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	fryer was not listed as a cleaning task to be completed. On 11/16 21 at 1:50 p.m., the Admin. provided an undated policy titled, "Refrigerated Storage Policy". She indicated this was the current policy in use by the facility at that time. The policy indicated, "Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date, time, discard date, initials of the person who made it." On 11/16 21 at 1:50 p.m., the Admin. provided an undated policy titled, "Dietary Uniform and Dress Code Practices". She indicated this was the current policy in use by the facility at that time. The policy indicated, "Caps/ hats or hairnets must be worn in the kitchen." The Indiana Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24-146, indicated, "Food labels...(b) Label information shall include the following: (1) The common name of the food or, absent a common name, an adequately descriptive identity statement. (2) If made from two (2) or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives if contained in the food. (3) An accurate declaration of the quantity of contents." The Indiana Department of Health, "Retail Food Establishment Sanitation Requirements", 410 IAC 7-24-295, Section 295, indicated, "(a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	equipment shall be kept free of an accumulation of: (1) dust; (2) dirt; (3) food residue; and (4) other debris". The Indiana Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24-138, indicated, "Effectiveness of hair restraint...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles."			
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 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 observation, interview, and record review, the facility failed to ensure residents, who self-administered their medications, monitored their vital signs prior to taking medications, as ordered by a physician (Residents C and P). This affected 2 of 4 residents reviewed for medication self-administration.	R 0216	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents C and P did not experience any adverse effects from the alleged deficient practice. DON verified that both residents owned the proper equipment to	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	Findings include: 1. On 11/15/21 at 10:43 a.m., Resident C was observed and interviewed. He indicated he administered his own medications. Shortly after he moved in to the facility, a nurse went over his medications with him to determine if he could safely administer his own medications, without the assistance of nursing staff. At that time, packages of medications were observed in Resident C's apartment for digoxin (used to treat heart failure and irregular heart rate and rhythm), metformin (used to treat type 2 diabetes), xarelto (used to prevent blood clots), acetaminophen (used to treat pain), diltiazem (used to treat high blood pressure and irregular heart rate and rhythm), ergocalciferol (a vitamin D supplement), trazodone (an antidepressant medication used to treat insomnia), a multivitamin, and atorvastatin (used to treat high cholesterol). The package of diltiazem indicated, Resident C was to take 1 tablet by mouth three times daily, and to not take the scheduled dose if his heart rate was less than 60 or his systolic blood pressure (the measure of the pressure in the arteries when the heart beats) was less than 110. Resident C indicated, he did not have a blood pressure cuff or heart rate monitor to check his blood pressure or heart rate before he took his medication. Resident C indicated, the facility nursing staff did not check his blood pressure, heart rate, or any other vital signs. He indicated the facility used to check his vital signs, but that had stopped about 3 weeks ago. Resident C indicated, he had been admitted to the facility in September 2021, from a local hospital. He was admitted to the hospital in August (of 2021) after he went to his doctor with complaints of dizziness and severe headaches. Tests showed Resident C had swelling on his brain. Resident C indicated, he did not have an accident or any head trauma, and		manage their vitals, provided education on proper procedure for taking vitals, and verified both residents understood this procedure by asking residents to complete a returned demonstration. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. Any resident self-administering medications requiring vitals equipment had the potential to be affected by the alleged deficient practice. No additional residents were identified as affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. Education will be provided to all LPNs completing self-medication assessments no later than January 16, 2022. Education and in-servicing will consist of the following: ensuring residents self-administering medications with parameters for vitals have the proper equipment, understand the parameters of the order, and that LPN must document understanding and competence on	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	that the brain swelling resulted from, "just getting old". Resident C indicated, while he was in the hospital, he had a drain placed in his head to relieve the pressure on his brain. His doctors advised him it was important to keep his blood pressure under control to help prevent any future complications. On 11/16/21 at 10:00 a.m., Resident C's record was comprehensively reviewed. Census information indicated, Resident C admitted to the facility on 9/21/21. He had diagnoses to include, but not limited to, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), diabetes mellitus (type 2 diabetes), hypertension (high blood pressure), hypercholesterolaemia (high cholesterol), and idiopathic normal pressure hydrocephalus (a buildup, of unknown cause, of fluid in the ventricles (cavities) in the brain. The excess fluid increases the size of the ventricles and puts pressure on the brain, which can cause damage to brain tissue and brain function problems). Resident C had a physician's order dated 9/20/21, for Diltiazem 60 mg (milligrams), take 1 tablet by mouth three times daily, hold for HR (heart rate) < (less than) 60 or SBP (systolic blood pressure) <110. Vital signs records indicated, Resident C had his HR checked on: 10/26/21, 10/24/21, 10/23/21, 10/7/21, 10/3/21, 10/2/21, 10/1/21, 9/30/21, 9/24/21, and 9/21/21. He had his blood pressure checked on 9/25/21 and 9/21/21. 2. On 11/15/21 at 3:03 p.m., Resident P was observed and interviewed. He indicated he administered his own medications since he moved to the facility in December of 2019. The facility		self-medication administration assessment. All new LPNs will receive this training during job-specific orientation moving forward. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will audit completed self-medication administration assessments with current resident orders to ensure compliance for education on vitals and equipment required to do so. DON or designee will audit a minimum of 1x/week for 8 weeks, then 1x every other week for 8 weeks, then 1x/month for 2 months. Results to be reviewed and discussed at monthly QI meeting for six months and as needed.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	completed an assessment at least once a year to determine if he was safe to self-administer his own medications. Resident P indicated he took several medications. A review of medications kept in the residents apartment included, but was not limited to, metoprolol (used to lower blood pressure by relaxing blood vessels and slowing heart rate in order to improve blood flow). A review of the medication label at that time indicated Resident P should hold the dose of metoprolol if his heart rate was less than 50. Resident P indicated, he did not check his heart rate before he took the medication. The facility did not check his vital signs regularly. On 11/16/21 at 11:08 a.m., Resident P's record was comprehensively reviewed. He had diagnoses to include, but not limited to, hyperlipidemia (high cholesterol), HTN (high blood pressure), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), and GERD (gastroesophageal reflux disease). Resident P had a physician's order dated 5/26/20, for Metoprolol Suc ER (succinate extended-release) 25 mg, take ½ tablet by mouth daily, hold for HR <50. Vital signs records indicated, Resident P had his heart rate checked on 10/9/21, 10/6/21, 10/5/21, 10/3/21, 10/2/21, 10/1/21, and 9/30/21. During an interview on 11/16/21 at 1:50 p.m., the DON (Director of Nursing) indicated, all residents were given a Self Administration Medication Assessment upon admission to the facility. Residents must be assessed in order to administer their own medications. The DON used the Self Administration Medication Assessment form to assess the resident, and made sure the resident			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	could demonstrate all the assessment criteria. At that time the assessment form was reviewed. The assessment form lacked criteria for monitoring blood pressure or heart rate. The DON indicated, if a resident was self administering blood pressure medications, she would need to know that the resident was checking their blood pressure and make sure they had the equipment to check their blood pressure. Residents should have something that can track their HR to monitor their pulse. If a physician had ordered vital signs parameters to be checked prior to taking a medication, the medication should not be taken until the vital sign was checked. Resident C had a history of swelling on his brain. High blood pressure could affect the pressure in the resident's brain. If resident vital signs were not monitored, it could result in bad effects from the medications. Facility staff should check all the residents' vital signs at least daily. On 11/17/21 at 10:45 a.m., the Administrator provided a policy titled, "Universal Screening Policy", dated last revised 8/2021. She indicated, this was the current policy in use by the facility at that time. The policy indicated, "All residents shall have a Daily Wellness Check completed on a specified schedule ...During the Daily Wellness Check, the following is monitored, including but not limited to: temperature, pulse oximetry [oxygen saturation], pulse [HR], and signs & symptoms of COVID-19 or COVID-19 like illness ...The Daily Temperature & Pulse Ox Log shall also be updated at the time of Daily Wellness Check completion." 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			
R 0217 Bldg. 00				

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 the services to be provided. Based on observation, interview, and record review, the facility failed to ensure resident inclusion in the creation and revision of a service plan, and that service plans were signed by the resident for 1 of 5 residents reviewed for service plans (Resident C). Findings include: On 11/15/21 at 10:43 a.m., Resident C was observed and interviewed. He indicated he had lived at the facility for about two months. He had not been involved in any service or care plan	R 0217	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident C experienced no adverse effects from the alleged deficiency. Resident C's Initial Service Plan and Level of Service Assessment were both reviewed with resident and documented with resident and DON signature. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	meetings. He thought he could probably voice his preference regarding the services he received, but no one had ever met with him about it. On 11/16/21 at 10:00 a.m., Resident C's record was comprehensively reviewed. A document titled, "Initial Service Plan", dated 9/21/21, was signed by the DON (Director of Nursing). The space labeled, "Resident Signature" was blank. The date on the resident signature line was blank. A document titled, "Level of Service Assessment/ Evaluation - Full List of Items" was dated 9/21/21. On the bottom of each page of the document was the label, "Indiana LOC [level of care] Assessment". The document was signed by the DON. It was not signed by the resident. A document titled, "Level of Service Assessment/ Evaluation - Full List of Items" was dated 10/1/21. On the bottom of each page of the document was the label, "Indiana LOC [level of care] Assessment". The document was signed by the DON. It was not signed by the resident. Resident C's nursing and progress notes lacked documentation a service plan or level of care meeting had been completed with the resident. During an interview on 11/16/21 at 2:25 p.m., the DON indicated, the facility's practice was the initial assessment was done prior to move in. The resident signed the initial assessment. The day the resident moved in; the assessment was reviewed again. The resident signed again. The initial service plan was good for the first 6 months after a resident admitted to the facility. The facility used the LOC as the service plan. The LOC		deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficiency. All residents Initial Service Plans and Level of Service Assessments will be audited for resident inclusion no later than January 16, 2022. Any resident with an Initial Service Plan or Level of Service Assessment found out of compliance will be reviewed by DON with resident inclusion. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. DON and current staff LPNs to be in-serviced on resident inclusion and signature form for Initial Service Plan and Level of Service Assessment no later than December 31, 2021. New LPN hires will be in-serviced on this policy and form during job-specific orientation moving forward. DON or designee will be responsible for auditing all completed Initial Service Plans and Level of Service Assessments for resident inclusion and signature moving forward. 4. Describe how the corrective actions(s) will be monitored to	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	assessment assigned points to the different assessment areas, which gave a total, that determined the level of care. The DON completed the LOC assessments. Sometimes the resident was involved, sometimes not. On 11/17/21 at 10:45 a.m., the Administrator provided a policy titled, "Service Plans" dated last revised 4/2016. The Administrator indicated this was the current policy in use by the facility at that time. The policy indicated, "Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs ...A. Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. B. Within seven days of completion of assessment tool (i.e. RAI [resident assessment instrument]), all areas of concern will be addressed via the Service Plan. Licensed nursing will also complete documentation in the resident's progress notes. C. The nursing staff along with the resident and/ or family members will identify resident problems, needs and strengths."		ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Administrator, DON, or designee will audit completed Initial Service Plans and Level of Service Assessments for resident inclusion and signature a minimum of 1x/week for 8 weeks, then 1x every other week for 8 weeks, then 1x/month for 2 months. Results to be reviewed and discussed at monthly QI meeting for six months and as needed.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to use a clean glucometer (instrument to read resident blood sugar) for 4 of 4 resident reviewed for glucometer monitoring	R 0241	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents N, P, Q, R, W, X,	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	(Resident N, P, Q, and R), failed to provide all diabetes mellitus (disorder of blood sugar) medications (oral and injection) for 4 of 7 residents reviewed with scheduled diabetes mellitus medications (Resident Q, R, W, and X), and failed to provide all ordered accu-checks (to monitor resident blood sugar) for 3 of 7 residents reviewed with accu-checks ordered by their physician (Resident Q, R, and L). Findings include: 1a. On 11/15/21 at 11:17 a.m., Qualified Medical Assistant (QMA) 13 indicated the glucometer she was using was for multiple residents. She removed the glucometer from her medication tote and set it on the resident's kitchen counter. She gelled (used hand sanitizer) her hands, put on gloves, and wiped the glucometer with Super Sani Cloth Wipes for 10 seconds. She placed it back on the same place on the resident's kitchen counter. She removed her gloves and did not wash her hands. She put on clean gloves and used the glucometer on Resident N to get her blood sugar (BS), then placed it back into the medical tote without cleaning it. 1b. On 11/16/21 at 10:31 a.m., QMA 16 washed her hands, took the glucometer out of the medication tote, put on gloves, and used Super Sani Cloth Wipes to clean the glucometer and the lancet device (used on the skin to attain one drop of blood) for 5 seconds each. She removed her gloves and did not wash her hands. She put on clean gloves and took Resident P's blood sugar. She wiped the glucometer and the lancet device for 5 seconds each with the Super Sani Cloth Wipes and placed them back in the medical tote. 1c. On 11/16/21 at 10:35 a.m., QMA 16 washed her		and L experienced no adverse effects from the alleged deficiency. MD notified of missed medications. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents with orders for accu-checks and insulin-administration had the potential to be affected by the alleged deficiency. All residents with orders for accu-checks and insulin-administration were audited for missing accu-checks and insulin-administration. Residents identified during this audit were assessed by licensed nurse for adverse effects and resident MD notified. No residents experienced adverse effects from the alleged deficiency. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All current clinical staff will be in-serviced on accu-checks and insulin-administration as it relates to timely completion, proper documentation, and infection-control no later than	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYENG INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hands, took the glucometer out of the medication tote, put on gloves, and used Super Sani Cloth Wipes to clean the glucometer and the lancet device for 5 seconds each. She removed her gloves and did not wash her hands. She put on clean gloves and took Resident Q's blood sugar. She wiped the glucometer and the lancet device for 5 seconds each with the Super Sani Cloth Wipes and placed them back in the medical tote. 1d. On 11/16/21 at 10:46 a.m., QMA 16 washed her hands, took the glucometer out of the medication tote, put on gloves, and used Super Sani Cloth Wipes to clean the glucometer and the lancet device for 5 seconds each. She removed her gloves and did not wash her hands. She put on clean gloves and took Resident R's blood sugar. She wiped the glucometer and the lancet device for 5 seconds each with the Super Sani Cloth Wipes and put them back in the medical tote. 2a. Resident Q's November Medical Administration Record (MAR) was reviewed. Resident Q had a physician's order to receive accu-checks three times a day. Her MAR was missing the documentation for the accu-check on 11/8/21 at 4:00 p.m., and the 8:00 a.m. accu-checks on 11/13/21 and 11/14/21. Resident Q had a physician's order to receive a scheduled dose of Levemir (insulin to treat diabetes mellitus) Flextouch 100 U/mL (units per milliliter) at 8:00 p.m. Her MAR was missing the documentation for the Levemir doses on 11/4/21 and 11/7/21. 2b. On 11/17/21 at 9:28 a.m., Resident R's November MAR was reviewed.		January 16, 2022, and as needed moving forward. All new staff will be educated on accu-checks and insulin-administration as it relates to timely completion, proper documentation, and infection-control during job-specific orientation and as needed. b. Individual Glucometers to be obtained from USMed for residents with ordered Accu-checks. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Director of Nursing or designee will conduct accu-check, insulin-administration, proper documentation, and infection-control audits related to insulin administration three (3) times per week for eight (8) weeks, then two (2) times per week for eight (8) weeks, then weekly for eight (8) weeks, then as needed until next survey to ensure proper insulin administration and infection-control practices. Results will be reviewed at monthly QI meeting and then on an as-needed basis.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	Resident R had a physician's order to receive accu-checks four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 7:00 p.m. Her MAR was missing the documentation for the accu-checks on 11/8/21 at 7:00 p.m., and 11/14/21 at 4:00 p.m. and 7:00 p.m. Resident R had a physician's order to receive a scheduled dose of Basaglar (insulin) 100 U/mL Kwikpen (pen delivery system) subcutaneously (under the skin) every evening at 7:00 p.m. Her MAR was missing the documentation for the Basaglar dose on 11/8/21. 2c. On 11/17/21 at 9:51 a.m., Resident L's November MAR was reviewed. Resident L had a physician's order to receive accu-checks once a day at 8:00 a.m. His MAR was missing the documentation for the accu-check on 11/13/21 and 11/14/21. Resident L had a physician's order to receive a scheduled dose of oral dose of metformin (diabetic medication) 1000 mg twice daily at 8:00 a.m., and 4:00 p.m. His MAR was missing the documentation of the metformin at 4:00 p.m. on 11/2, 11/3, 11/4, 11/9, 11/10, and 11/11/21. During an interview, 11/15/21 at 3:10 p.m., the DON indicated she told the staff to use Cavi-wipes (disinfection wipes) for the resident glucometer and the staff should have been doing accu-checks before the residents go to lunch. 2d. On 11/17/21 at 9:35 a.m., Resident S's November MAR was reviewed. He had a physician's order to receive a scheduled dose of Basaglar (insulin) 100 U/mL Kwikpen (pen delivery system) subcutaneously (under the skin)			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	every evening at 7:00 p.m. Her MAR was missing the documentation for the Basaglar dose on 11/8/21. 2e. On 11/17/21 at 9:42 a.m., Resident W's November MAR was reviewed. He had a physician's order to receive a scheduled dose of Lantus Solostar 100 U/mL, inject 40 units twice daily at 8:00 a.m. and 9:00 p.m. His MAR was missing the documentation for the Lantus doses at 9 :00 p.m. on 11/3/21, 11/5/21, and 11/14/21. 2f. On 11/17/21 at 9:49 p.m., Resident X's November MAR was reviewed. Resident X had a physician's order to receive a scheduled dose of Basaglar (insulin) 100 U/mL Kwikpen subcutaneously every evening at 7:00 p.m. His MAR was missing the documentation for the Basaglar dose on 11/1, 11/2, 11/3 and 11/5. During an interview, on 11/16/21 at 8:48 a.m., QMA 13 indicated the resident accu-checks she missed before lunch on 11/15/21, were Resident W and X. She went to Resident W's room at 11:00 a.m. and Resident X's room at 11:15 a.m. She observed the residents were already in the dining room about 11:20 a.m. During an interview, on 11/17/21 at 10:47 a.m., the Administrator indicated the glucometers used for Resident accu-check should be cleaned according to policy and the manufacturer's wipes. On 11/17/21 at 12:17 p.m., the Administrator provided an undated document, titled, "Technical Data Bulletin, Super Sani-Cloth, Germicidal Disposable Wipe." It indicated, " ...most organisms are killed within two (2) minutes by			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	exposure to the liquid in the wipe ...." A current policy, titled, "Glasswater Creek of Plainfield Cleaning/Disinfecting of Glucometer," with no date, was provided by the Administrator, on 11/17/21 at 11:36 a.m. A review of the policy, indicated, " ...ALL glucometers will be cleaned and disinfected using Clorox Germicidal wipe ...ALL glucometers that will be shared by multiple residents will be thoroughly wiped with disinfectant and allowed to air dry after every used and between every resident ...." A current policy, titled, "Medication Oversight, Administration, Storage," with no date, was provided by the Administrator, on 11/15/21 at 3:05 p.m. A review of the policy, indicated, " ...If a resident is assessed as needing medication administration, it is the responsibility of the licensed nursing personnel or qualified medication aide to administer the medications to the resident. It is the responsibility of the Nursing Supervisor and/or Staff Nurse to administer all injectable medications ...Medication administration shall be provided as ordered by the resident's physician ...The individual administering the medication shall document the administration in the electronic medication (or treatment) administration record ...."			
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on observation, interview and record review, the facility failed to ensure a resident's (Resident D) diet order was reviewed/revised as needed by a physician to accommodate her needs for 1 of 5 residents reviewed for diet orders.	R 0275	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident D experienced no adverse effects from the alleged	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	Findings include: On 11/15/21 at 2:34 p.m., Resident D was observed in her room. She sat in a recliner and during an interview at this time indicated, she had lived at the facility for almost a year and was doing okay. The food was not too bad, but sometimes she preferred to stay in her room and make her own meals. She indicated she had a special diet for her diabetes, and sometimes was given too many carbohydrates on her meal trays. On 11/16/21 at 10:00 a.m., Resident D's medical record was reviewed. She had an admission order sheet dated 1/27/21, where the physician wrote in a special diet order, "low carb, diabetic diet." The order sheet was signed and dated by the physician. Resident D's current Physician order sheet dated 11/1/21, did not indicate her special diet. Neither were, "regular" or "heart healthy" options circled/indicated. During an interview on 11/16/21 at 11:25 a.m., the Director of Nursing (DON) indicated, the facility did not offer special diet plans, and only offered two types of diets, regular, or heart healthy. The DON indicated, whoever completed the admission paperwork for Resident D missed the written special order and did not contact the physician at that time to revise the order. Usually, when the facility faxed the admission order sheet to the physician, they would check one of the boxes for regular or heart healthy, but this physician hand-wrote in a diet order that was not provided by the facility, so they would need to call the physician and have it re-ordered.		deficiency. Following the survey, DON contacted resident's MD to notify that the facility is unable to accommodate a "low carb, diabetic" diet, and requested the order be changed to heart healthy. Resident is currently hospitalized and facility requested diet order to be changed prior to resident return. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficiency. No residents experienced adverse effects from the alleged deficiency. All resident diet orders will be reviewed no later than January 16, 2022. Any diet order found out of compliance with facility policy will be addressed with resident's MD for further direction. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All licensed nursing personnel will be in-serviced on therapeutic diet policy no later than January 16, 2022 and as needed. All new	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	On 11/17/21 at 12:36 p.m., the Administrator (ADM) provided a copy of current, but undated, facility policy titled, "Therapeutic Diets." The policy indicated, "It is the policy of this facility to offer therapeutic diets to residents. The therapeutic diets that will be offered are version of the No Added Salt (NAS), Consistent Carbohydrates (Diabetic), Low Fat/Low Cholesterol Diet.... The menu shall include food choices that allow a resident to choose foods that will meet the requirements of a therapeutic diet as ordered by a resident's physician... The Nursing Supervisor will communicate in writing all physician ordered therapeutic diets to the Dietary Service Manager. the Dietary Service Manager will ensure the therapeutic diet is prepared and served as prescribed...."		licensed nursing personnel will receive in-servicing on therapeutic diet policy during job-specific orientation and as needed moving forward. All new admission diet orders will be reviewed by DON moving forward. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will review all resident diet orders prior to resident admission to the facility. Any orders found out of compliance of current therapeutic diet policy will be reviewed with resident MD prior to resident admission to ensure compliance. DON will monitor any new diet orders as needed. Results to be reviewed at monthly QI meeting for six months and as needed.	
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			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	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 interview and record review, the facility failed to ensure a resident had a correct code status according to the resident's desire for end-of-life choices for 1 of 5 residents reviewed for end-of-life choices (Resident L). Findings include: On 11/16/21 at 10:02 a.m., Resident L's paper and electronic medical records were comprehensively reviewed. He was admitted to the facility on 10/19/21. His diagnoses included, but were not limited to, dyspnea (shortness of breath), diabetes mellitus (disorder of blood sugar), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea (OSA). A doctor's orders page from Resident L's paper chart, dated 10/12/21, signed by Resident L's physician indicated the resident was a full code (to perform cardiopulmonary resuscitation) in the event Resident L's heart stopped. An Indiana Physician Orders for Scope of Treatment (POST) form, dated 10/19/21, indicated Resident L was a do not resuscitate (DNR). It was signed by the resident as his wishes for his end-of-life choices. It was not valid because it was not signed by a physician.	R 0356	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident L experienced no adverse effects from the alleged deficient practice. Resident L's code status was added to EMR and changed to DNR upon receipt of POST form signed by MD that indicated resident wished to change code status to DNR. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficiency. Administrator and DON audited EMR for code status discrepancies and made necessary changes. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident L's electronic medical record (EMR) was reviewed for his end-of-life choices. There was no code information in his EMR. During an interview, on 11/16/21 at 10:56 a.m., the Director of Nursing (DON) indicated Resident L signed his DNR POST form when he admitted on 10/19/21. He indicated the DNR was his choice for end-of-life care. The physician's orders from Resident L indicated he was a full code on 10/12/21. She talked with Resident L, and he indicated to her he did not care what the physician order said, he wanted to be a DNR. His code status had not been changed because his physician was hard to reach, and she had not yet signed him up for the facility healthcare providers, Grace at Home (GAH). Resident L was signed up with GAH on 11/16/21. When she arrived as DON here, she has had a mountain of work to do here. She checked Resident L's EMR and indicated his POST form was not in the computer, but the nurses know to looked in the paper medical chart under tab 1. During an interview, on 11/16/21 at 11:11 a.m., Licensed Practical Nurse (LPN) 12 indicated if she needed a code status for a resident, she looked in the computer. During an interview, on 11/16/21 at 3:16 p.m., the DON indicated she tried to get Resident L's POST form signed by his physician by fax. She received information from the physician's office indicating Resident L was no longer his patient and would not sign the POST form. GAH indicated would not sign his POST form until they saw him as a patient. The first day GAH saw him was 11/16/21. A current policy, titled, "Resident Code Status		deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All clinical personnel will be in-serviced on code status policy and proper documentation of code status no later than January 16, 2022. DON to audit current code status of new admissions for discrepancies, as well as any changes in order for code status of current residents moving forward. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will audit orders for current code status of new admissions. DON or designee will audit EMR for code status discrepancies with current MD orders a minimum of 1x/week for 8 weeks, then 1x every other week for 8 weeks, then 1x/month for 2 months. Results to be reviewed and discussed at monthly QI for six months meeting and as needed.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	Identification System" dated 11/2021, was provided by the Administrator on 11/16/21 at 1:50 p.m. A review of the policy, indicated, " ...The purpose of this policy is to provide guidelines and procedures for the decision to initiate, terminate, or withhold cardiopulmonary resuscitative measures ...It is the responsibility of licensed nursing personnel to identify the current code status for each resident upon admission ...It is the responsibility of the Director of Nursing, or designee, to place the code status on the resident service plan ...."			
R 0379 Bldg. 00	410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on interview and record review, the facility failed to ensure a resident, (Resident K) with a diagnosis of a severe mental illness was comprehensively care planned for any special mental health needs. This deficient practice had the potential to effect 1 of 5 residents reviewed for mental health screening. Findings include:	R 0379	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Resident K experienced no adverse effects from the alleged deficient practice. Resident K was referred to GuideStar psych services following an audit that concluded on November 19, 2021.	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	During the survey entrance conference, on 11/15/21 at 9:30 a.m., the Administrator (ADM) provided a list of residents who had a diagnosis of a major mental illness. Resident K was listed due to her diagnosis of Schizophrenia. On 11/17/21 at 9:30 a.m., Resident K's medical record was reviewed. She was admitted to the facility on 11/28/2020 with an active diagnosis of paranoid schizophrenia (a mental illness characterized by symptoms delusions and hallucinations which blur the line between what is real and what is not). A SLUMS (Saint Louis University Mental Status) Examination, (a method of screening for Alzheimer's disease and other kinds of dementia) was dated 11/3/2020 and indicated Resident K had dementia. She had a physician order for Olanzapine (an antipsychotic medication) 20 mg (milligrams) to be given once a day at bedtime. The record lacked documentation of comprehensive mental health screening. The record lacked documentation of a comprehensive care plan to address the resident's needs related to her paranoid schizophrenia. During an interview on 11/17/21 at 12:20 p.m., the Director of Nursing (DON) indicated, if a resident was admitted with a severe mental illness and received Medicaid, like Resident K, the facility should request at least two years' worth of medical records related to mental health. It was important to complete mental health screens to		2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents diagnosed with major mental illness had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficient practice. GuideStar psych services conducted an audit concluding on November 19, 2021 of all residents for diagnoses of major mental illness and all residents found with a diagnosis of a major mental illness were referred to GuideStar psych services. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All clinical personnel will be in-serviced on policy regarding major mental illness and process for referring those residents with a major mental illness diagnosis to an appropriate provider to develop a comprehensive care plan. DON or designee will audit all new admissions for diagnosis of major mental illness and refer to an	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	determine what potential behaviors the resident might have like, wandering, outbursts, or agitation/aggression, then a care plan should be put in place to address those issues. The DON reviewed Resident K's record and indicated there was not comprehensive mental health screen or care plan. The DON indicated the facility should follow the state rules. A Mental Health Screening and Comprehensive Care Plan Policy was requested on 11/16/21 at 2:55 p.m., 11/17/21 at 10:15 a.m., and 11/17/21 at 12:23 p.m., but not provided. The Indiana Department of Health, Residential Regulations 410 IAC 16.2, dated 2008 indicated, "...If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record...."		appropriate provider as needed upon admission and develop comprehensive care plan related to diagnosis of major mental illness. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON will monitor any new diagnoses a minimum of 1x every other week for 2 months, 1x/month for 4 months, and as needed moving forward. When needed, DON will refer current residents with new major mental health diagnoses to an appropriate provider. Results to be reviewed at monthly QI meeting for six months and as needed.	
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 analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control,			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 interview and record review, the facility failed to follow CDC (Centers for Disease Control) guidance during a pandemic and ensure resident vital signs and COVID-19 signs and symptoms were monitored for 4 of 5 residents reviewed for COVID-19 monitoring (Residents C, E, G, and P). Findings include: 1. On 11/17/21 at 10:15 a.m., Resident E's record was reviewed. A nurses note dated 11/8/21 at 10:00 a.m., indicated Resident E was transferred from the facility to a local hospital due to a dry cough. The resident was admitted to the hospital and had tested positive for COVID-19. A nurses note dated 11/11/21 at 6:02 p.m., indicated, Resident E returned to the facility, from the hospital, and would be placed in isolation due to COVID-19 positive results. A nurses note dated 11/11/21 at 8:58 p.m., indicated, Resident E would remain on isolation for 14-days and her vital signs would be checked every shift (three times a day). A nurses note dated 11/13/21 at 1:07 p.m., indicated, the resident remained in quarantine. Her vital signs were checked, and the residents denies signs and symptoms of COVID-19.	R 0407	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents C, E, G, and P experienced no adverse effects from the alleged deficient practice. Staff to be in-serviced on policy for Daily temperatures, vitals, and pulse Oximetry Log no later than January 16, 2022. Facility will implement daily vitals, temperatures, and Pulse Oximetry log for each resident as required by current CDC guidelines no later than December 16, 2021. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficient practice. Facility will implement daily vitals, temperatures, and Pulse Oximetry log for each resident as required by current CDC guidelines no later than December 16, 2021. 3. Describe the steps or systemic	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	A nurses note dated 11/15/21 at 8:10 p.m., indicated Resident E's vital signs were checked at that time, and the resident was not in any acute distress. A nurses note dated 11/17/21 at 1:05 a.m., indicated facility staff had left a voicemail with the resident's son to update him on his mother's condition. The resident was doing well. No complaints of pain or shortness of breath. Her vitals were monitored regularly, and she had no fever. Meals were delivered to the resident's apartment by staff while the resident remained on a 14-day quarantine after hospitalization with diagnosis of COVID-19 positive. A nurses note dated 11/17/21 at 9:41 a.m., indicated, Resident E remained on quarantine. Her vital signs were checked, and within normal limits. Resident E complained of chest congestion, dizziness, and discomfort related to a hernia. Resident E's vital signs record for 11/11/21 to 11/17/21 was reviewed. The record indicated, Resident E had blood pressure (BP), heart rate/ pulse (HR), temperature, Respiratory rate (RR), and pulse ox (pulse oximetry, oxygen saturation) checked once for the dates reviewed. On 11/16/21, resident E had her vital signs checked twice. On 11/17/21 at 11:37 a.m., the Administrator (Admin) provided a document titled, "Current Quarantine List". The document indicated, Resident E's quarantine period began on 11/10/21 and was scheduled to end on 11/24/21. 2. On 11/17/21 at 9:54 a.m., Resident G's record was reviewed. A nurses note dated 11/11/21 at 11:17 p.m.,		changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. Staff to be in-serviced on policy for Daily Temperatures, Vitals, and Pulse Oximetry Log no later than December 30, 2021. Facility will implement daily vitals, temperatures, and Pulse Oximetry log for each resident as required by current CDC guidelines no later than January 16, 2022. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. Director of Nursing or designee will monitor Daily temperatures, vitals, and pulse Oximetry log a minimum of three (3) times per week for four (4) weeks, two (2) times per week for four (4) weeks, and once (1) per week for four (4) weeks, then as needed. Results will be reviewed at monthly QI meeting for three (3) months and on an as needed basis between monthly meetings.	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	indicated, Resident G arrived at the facility on that date for admission. The note lacked documentation regarding the resident's isolation status, vital signs, or COVID-19 symptom monitoring. A nurses note dated 11/11/21 at 11:24 p.m., indicated Resident G's blood pressure was rechecked due to being elevated on the admission BP check. The resident's vital signs were checked. The resident denied complaint of a headache or any discomfort. The note lacked documentation regarding the resident's isolation status or COVID-19 symptom monitoring. A nurses note dated 11/13/21 at 1:01 p.m., indicated Resident G's vital signs were checked. The resident was afebrile (without fever) and denied shortness of breath or cough. The note lacked documentation regarding the resident's isolation status. A nurses note dated 11/14/21 at 12:32 p.m., indicated Resident G continued on quarantine with meals delivered to the resident's apartment. The resident had no complaints, and her vital signs were within normal limits. A nurses note dated 11/15/21 at 8:09 p.m., indicated, Resident G's vital signs were taken, and no acute distress was observed. The note lacked documentation regarding the resident's isolation status. A nurses note dated 11/16/21 at 1:35 p.m., indicated a PPD (a test to detect the immunity developed against tuberculosis causing bacteria) was placed in the resident's right forearm. The note lacked documentation regarding the resident's isolation status, vital signs, or COVID-19 symptom monitoring.			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	Resident G's vital signs record for 11/11/21 to 11/17/21 was reviewed. The record indicated on: 11/17/21: BP, HR, temperature, RR, Pulse Ox checked once. 11/16/21: BP, HR, temperature, RR checked three times. Pulse ox checked twice. 11/15/21: BP and RR checked once. HR, temperature, and pulse ox checked three times. 11/14/21: BP and RR checked once. HR, temperature, and pulse ox checked three times. 11/13/21: BP and RR checked once. HR, temperature, and pulse ox checked three times. 11/12/21: No documented vital signs 11/11/21: BP, HR, temperature, RR, Pulse Ox checked twice. On 11/17/21 at 11:37 a.m., the Administrator (Admin) provided a document titled, "Current Quarantine List". The document indicated, Resident G's quarantine period began on 11/11/21 and was scheduled to end on 11/25/21. 3. On 11/15/21 at 10:43 a.m., Resident C was observed and interviewed. He indicated the facility used to check his vital signs, but that had stopped about 3 weeks ago. On 11/16/21 at 10:00 a.m., Resident C's record was comprehensively reviewed. Vital signs records indicated, Resident C had his HR, temperature, and pulse ox checked on: 10/26/21, 10/24/21, 10/23/21, 10/7/21, 10/3/21, 10/2/21, 10/1/21, 9/30/21, 9/24/21, and 9/21/21. He had his blood pressure checked on 9/25/21 and 9/21/21. 4. On 11/15/21 at 3:03 p.m., Resident P was observed and interviewed. He indicated the			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	facility did not check his vital signs regularly. On 11/16/21 at 11:08 a.m., Resident P's record was comprehensively reviewed. Vital signs records indicated, Resident P had his HR, temperature, and pulse ox checked on 10/9/21, 10/6/21, 10/5/21, 10/3/21, 10/2/21, 10/1/21, and 9/30/21. On 9/25/21, his BP, temperature, and pulse ox were checked. During an interview on 11/16/21 at 1:50 p.m., the Director of Nursing (DON) indicated, all residents in the facility should have a daily check of HR, temperature, and pulse ox. All residents are also screened for COVID-19 signs and symptoms. People on quarantine get those vital signs and COVID-19 signs and symptoms checked three times a day. That is documented and kept on paper. On 11/17/21 at 12:06 p.m., records for Residents C, E, G, and P were reviewed with the DON. She indicated the records reflected all the documentation available for the residents reviewed. The DON indicated, it was the facility expectation to check vital signs and COVID-19 signs and symptoms for residents in isolation or quarantine at least 3 times a day. Staff should document the vital signs and the symptom monitoring in the resident record. On 11/17/21 at 10:45 a.m., the Administrator provided a policy titled, "Universal Screening Policy", dated last revised 8/2021. She indicated this was the current policy in use by the facility at that time. The policy indicated, "All residents shall have a Daily Wellness Check completed on a specified schedule ...Residents who are suspected, symptomatic, and/ or confirmed to			

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have COVID-19 shall have the Daily Wellness Check completed every three times a day. During the Daily Wellness Check, the following is monitored, including but not limited to: temperature, pulse oximetry [oxygen saturation], pulse [HR], and signs & symptoms of COVID-19 or COVID-19 like illness ...The Daily Temperature & Pulse Ox Log shall also be updated at the time of Daily Wellness Check completion." CDC guidance, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", dated 9/10/21, indicated, "Evaluate Residents at least Daily: Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. Actively monitor all residents upon admission and at least daily for fever (temperature 100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry ... Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection ... Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection." 410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance			
R 0410				

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
Bldg. 00	(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 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 interview and record review, the facility failed to ensure first and second step tuberculous (infectious bacterial disease) screens were complete for 3 of 5 residents reviewed for admission screenings (Resident B, K, and E), and failed to provide second step tuberculous admission screenings for 2 of 5 residents reviewed for second step tuberculous screenings (Resident L and D). Findings include: 1. On 11/17/21 at 12:10 p.m., Resident B's medical record was comrehensively reviewed and the record lacked documentation for her required admission first and second step tuberculous screenings. She was admitted on 5/10/21.	R 0410	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a. Residents B, K, E, L, and D experienced no adverse effects from the alleged deficient practice. Residents B, K, E, D, and L will receive first step TB test on December 17, 2021. Residents B, K, E, D, and L will received their second step TB test 1-3 weeks after the first step per polic. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct	01/16/2022

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(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
	2. On 11/17/21 at 12:13 p.m., Resident L's medical record was comprehensively reviewed and his immunization record indicated on 10/19/21 he received, "step 1 of 2 steps," of the required tuberculous screenings. No second step was found in his paper or EMR. He was admitted on 10/23/21. 3. On 11/17/21 at 9:30 a.m., Resident K's medical record was reviewed. She was admitted to the facility on 11/28/2020. The record lacked documentation that an admission Tuberculosis (TB) skin test had been initiated or completed. 4. On 11/16/21 at 10:00 a.m., Resident D's medical record was reviewed. Resident D was admitted on 2/1/21. An initial TB skin test was placed on 2/2/21, but the record lacked documentation the two-step TB test had been completed. TB skin test documentation was requested on 11/16/21 at 2:55 p.m., 11/17/21 at 10:15 a.m., and 11/17/21 at 12:23 p.m., but not provided. On 11/16/21 at 1:50 p.m., the Administrator (ADM) provided a copy of current facility policy titled, "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," dated, 9/21. The policy indicated, "Residents and employees of health care communities have been identified as a high-risk group for re-activation of laten TB infection, acquisition of TB infection and potential spread of TB within the community... a health screen is required for each resident: the screen will include a Mantoux tuberculin test unless a		the deficient practice for any client the facility identified as being affected. a. All residents had the potential to be affected by the alleged deficient practice. No residents experienced adverse effects from the alleged deficient practice. DON will complete first step TB tests on all residents currently in the facility by date of December 20, 2021. All residents currently in the facility will receive second step TB tests 1-3 weeks after first step per policy. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. All licensed nursing personnel will be in-serviced on TB administration policy no later than January 16, 2022. DON or designee will be responsible for ensuring all new residents receive two-step TB test appropriately, and that all current residents receive annual TB tests appropriately. 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. DON or designee will be responsible for ensuring	

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	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYENG INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	previously positive reaction can be documented. Tuberculosis screening shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours an annually thereafter. The result step in 7-21 days...."		compliance on all current and new resident TB tests. DON will monitor all new admissions within 3 days of admission to ensure completion of first step TB test, then again 1-3 weeks later to ensure completion of second-step of TB test. DON will be responsible for monitoring annual TB tests for current residents annually. Results to be reviewed at monthly QI meeting for six months. and as needed.	

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __1__ OF __9___**

PROVIDER NAME: _Grand Prairie of Macomb_WY23__ REFERRAL DATE: __04.11.2023-04.13.2023_____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing **m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** **Facility did not meet this criterion as evidenced by:** Multiple staff members that did not receive a 2 step TB testing at time of hire, did not receive the second step testing, or did not receive/have chest x-ray done due to history of positive Mantoux skin testing: E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, E15, E16, E17, E18, E19, E20, E21, E22, E23 (**Please see additional chart below).**		

Signature of SLP Provider Representative_____Date_____

PROVIDER NAME: ____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
Section 146.220 Resident Participation Requirements **d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** **Facility did not meet this criterion as evidenced by:** Multiple resident were missing TB test, read results, 2nd step, and/or S/S checklist: R1, R2, R3, R4, R5, R6, R7, R8, R9, R10 (**Please see chart below).**		

Signature of SLP Provider Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __3__ OF ___9__**

PROVIDER NAME: _____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements **a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting:** 4) **Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting.**		

Signature of SLP Provider Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __4__ OF __9___**

PROVIDER NAME: _____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220(a)(4) Resident Participation Requirements continued…. **Facility did not meet this criterion as evidenced by:** Several residents had missing dates on Department of Corrections Parolee/Illinois State Police/Dru Sjodin sex offender site checks: R2, R11, R4, R12, R5, R6, R7, R13, R8, R9, R10 **(Checks with missing dates were remediated/re-run at time of on-site review).**		

5669

Signature of SLP Provider Representative_____Date_____

PROVIDER NAME: ____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** **Facility did not meet this criterion as evidenced by:** Residents have untimely/incomplete/missing signatures on RAIs: R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R15, R16, R17, R18, R19, R20.		

Signature of SLP Provider Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __6__ OF __9___**

PROVIDER NAME: _____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident.**		

Signature of SLP Provider Representative_____Date_____

571

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __7__ OF __9___**

PROVIDER NAME: _____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245(d) continued… **The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** **Facility did not meet this criterion as evidenced by:** Resident charts were without completed ISP/ISS, untimely, incomplete sections, inaccurate, missing signatures, selection of choosing services and/or acknowledgement of receiving copy of resident's rights: R1, R2, R3, R22, R14, R23, R24, R25, R12, R4, R5, R26, R6, R7, R13, R9, R15, R27, R28, R16, R17, R29, R30, R31, R18, R19, R20, R21		

Signature of SLP Provider Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __8__ OF __9___**

PROVIDER NAME: _____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Comments: • During the tour portion of the review, it was noticed that there was no Department complaint hotline poster displayed on the second floor of the facility. Remediated on-site. Facility promptly replaced the missing poster on the second floor at time of discovery on 04.11.2023. • One employee HCWR check was performed after start date in facility (no pre-date check noted). E16. • One employee had finder printing done >10 days after authorization signed prior to first shift. E4		

Signature of SLP Provider Representative_____Date_____

573

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE __9__ OF ___9__**

PROVIDER NAME: _____Grand Prairie of Macomb WY23_____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
• E2, E24, E14, E20, E23, E13 do not have current CPR certification. This is not required, but it is imperative that staff do not work alone without another CPR certified staff on shift. • R1, R8-misisng standardized interview • R1, R14, R5, R8, R21-missing/late initial assessment/service plan at time of admission • R24, R4, R18, R19-late/missing quarterly assessments		

Signature of SLP Provider Representative [redacted] _____Date_____

Section 146.235 Staffing

m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

Employee	Start Date	2 Step TB testing Date
E1	11.07.2022	**NONE** *Step 1 initiated 04.11.2023
E2	07.11.2022	**NONE** (hx of pos. skin test) *facility did not have chest x-ray performed at time of hire
E3	02.08.2023	**NONE**
E4	05.24.2022	06.09.22-06.12.22 NEG **LATE** 06.24.22-06.27.22 **No results recorded**
E5	11.23.2022	**NONE**

E6	07.26.2022	07.22.2022-07.25.22 NEG **PRE-Start DATE** 08.05.22-08.08.22 NEG
E7	11.23.2022	**NONE**
E8	08.31.2022	**NONE**
E9	02.02.2023	**NONE**
E10	09.28.2022	**NONE**
E11	06.18.2022	**NONE**
E12	12.07.2022	**NONE**
E13	11.22.2022	**NONE** *Step 1 initiated 04.11.2023
E14	12.08.2022	**NONE**
E15	10.17.2022	**NONE** *Step 1 initiated 04.11.2023
E16	11.14.2022	**NONE**
E17	01.04.2023	**NONE**
E18	01.25.2023	**NONE**
E19	01.31.2023	**NONE**
E20	03.23.2023	**NONE**
E21	04.05.2023	**NONE**
E22	04.07.2023	**NONE**
E23	03.28.2023	03.28.23-03.30.23 NEG ****Waiting on 2nd step testing**

Section 146.220 Resident Participation Requirements

d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

Resident	Admission Date	2 Step TB Testing	S/Sx Check List	Remediation
R1	11.21.2022	**NONE**	04.07.2023-**LATE**	Step 1: initiated 04.11.2023
R2	01.31.2023	**NONE**	**NONE**	Step 1: initiated 04.11.2023 S/Sx: 04.11.2023
R3	10.24.2022	Step 1: 04.10.2023 **Late/No read date or result** Step 2: **Not done**		Step 1: re-initiated 04.11.2023
R4	01.12.2023	Step 1: 01.31.23-02.2.23 NEG Step 2: **Not done**	04.07.2023-**LATE**	Step 1: re-initiated 04.11.23
R5	09.23.2022	Step 1: 09.28.22-09.30.22 NEG Step 2: **Not done**		Step 1: re-initiated 04.11.23
R6	12.30.2022	Step1: 01.01.23-01.04.23 NEG Step 2: **Not done**		Step 1: re-initiated 04.13.23
R7	10.25.2022	**NONE**		Step 1: initiated 04.13.2023

R8	08.12.2022	**NONE**	**NONE**	Step 1: initiated 04.12.2023 S/SX: 04.12.2023
R9	12.22.2022	Step1: 12.22.22-12.26.22 NEG Step 2: **Not done**		Step 1: re-initiated 04.12.23
R10	11.18.2022	Step 1: 11.18.22-11.21.22 NEG Step 2: **Not done**		Step 1: re-initiated 04.12.2023

Grand Victorian of Rockford

Annual Survey – December 18th, 2023

Plan of Correction

Type 2 Violation:

Section 295.3000 Personnel Requirements, Qualifications and Training

b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR.

- Grand Victorian of Rockford has scheduled at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specifically for adults in the building for all scheduled shifts.

- An in-service has been completed by the Regional Director of Wellness Illinois Administrative code 295.3000 Personnel Requirement, Qualifications and Training with the Executive Director and the Wellness Supervisor on 12/20/2023

- An in-service will be completed by the Regional Director of Wellness reviewing the Gardant Management Policy associated with Personnel Requirement to the Executive Director and the Wellness Supervisor.

- A Quality Assurance Study will be conducted for 90 days to assure that all Personnel requirements and qualifications are being met per scheduled shift. The QA will be completed by the Wellness Supervisor and reviewed monthly.

Grand Victorian of Rockford

Annual Survey – December 18th, 2023

Plan of Correction

Type 2 Violation

Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees

a) Each direct care and food service employee shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that would pose undue risk of infection to themselves, other employees, residents, or visitors.

b) The initial health evaluation shall be conducted not more than 30 days prior to and no later than 30 days after the employee's initial employment in the establishment.

c) The initial health evaluation shall include the employee's immunization status.

d) The initial health evaluation shall include a physical examination. The examination shall include a determination that the employee appears to be physically able to perform the job functions that the establishment intends to assign to the employee.

- An in-service will be completed by the Regional Director of Human Resources Business Office Manager on Illinois Administrative code 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees and the Executive Director.

- An in-service will be given by the Regional Director of Wellness reviewing the Gardant Management Policy associated with Health Evaluation being completed 30days prior to and no later than 30days after the employee's initial employment in the establishment.

- A Quality Assurance Study will be conducted for 90days to assure that all new employees receive their Initial Health Evaluation either 30days prior to or no later than 30days after the employee's initial employment in the community.

Grand Victorian of Rockford

Annual Survey – December 18th, 2023

Plan of Correction

Type 2 Violation

Section 295.3040 Health Care Worker Background Check

Section 955.165 Fingerprint-Based Criminal History Records Check

a) Educational entities, other than secondary schools, and health care employers are required to check the Health Care Worker Registry before allowing a student to enter a training program or hiring an employee to determine:

c) Educational entities and health care employers shall conduct *Internet searches on certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted Fugitives Search Engine, the National Sex Offender Public Registry, and the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud,* or shall conduct *similar searches* as provided by the web-based application. (Section 15 of the Act)

- An in-service will be completed by the Regional Director of Human Resources Illinois Administrative Code 295.3040 Health Care Worker Background check with the Executive Director and Business office Manager.

- An in-service will be completed by the Regional Director of Human Resources reviewing the Gardant Management Policy associated with health Care Worker Background check.

- A Quality Assurance Study will be conducted for 90 days to assure that all Health care workers background checks and Fingerprint-based criminal history records check are completed prior to hire.

Grand Victorian of Rockford

Annual Survey – December 18th, 2023

Plan of Correction

Type 3 Violation

Section 295.4010 Service Plan

b) The service plan shall be developed by:

1. **The resident, resident's representative or any individual requested by the resident.**
2. **The manager or manager designee; and**
3. **A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care.**

c) The service plan shall be signed and dated by all individuals involved in its development

d) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000)

- An in-service has been completed by the Regional Director of Wellness pertaining to Illinois Administrative Code 295.4010 on 12/20/2023 with Director of Nursing, Staff Nurses, and Executive Director

- An in-service has been completed by [illegible]

- An in-service will be conducted by the Wellness supervisor to the community nurses pertaining to the frequency of updating resident service plans.

- A quality Assurance Study will be conducted for 90 days to ensure that all Service Plans are signed by the resident / resident and are updated appropriately. The QA will be completed by the Wellness Supervisor and Executive Director and reviewed monthly.

Grand Victorian of Rockford

Annual Survey – December 18th, 2023

Plan of Correction

Type 2 Violation

Section 295.4050 Tuberculin Skin Test Procedures

Section 696.140 Screening for Latent Tuberculosis Infection (LTBI) and Active Tuberculosis (TB) Disease

a) Screening for latent TB Infection

1. Workers and clients at health care settings serving high-risk groups shall be screened in accordance with this subsection and the following CDC guidelines:
2. All clients in non-acute care residential health care settings serving high-risk groups shall obtain a TB screening test within seven days after admission

- An in-service has been completed by the Regional Director of Nursing pertaining to Illinois Administrative code 295.4050 TB Skin Test Procedures with the Executive Director and the Wellness Supervisor on 12/20/2023.

- An in-service has been completed by the Regional Director of Nursing reviewing the Gardant Management Policy associated with Tuberculin Skin Test Procedures.

- A Quality Assurance Study will be conducted for 90 days to assure that all Tuberculin Skin Test Procedures are completed with 7 days of admission. The QA will be completed by the Wellness Supervisor and reviewed monthly.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
245 West Roosevelt Road • West Chicago, Illinois 60185-3739 • www.dph.illinois.gov

8/16/23

Grand Victorian of Sycamore

1440 Somonauk Street

Sycamore, IL 60178

Re: Annual Licensure Survey:

Survey Date: 8/1/23

Dear Executive Director,

On 8/1/23, staff from the Illinois Department of Public Health (IDPH) conducted an annual licensure survey at your establishment. Upon review of the records and on-site analysis, it was determined your establishment was in general compliance with the requirements of the Assisted Living and Shared Housing Establishment Code. Your license will be issued.

If you have any questions regarding this correspondence, please contact my office at 630-520-9331. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

Sincerely,

[redacted]

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Office of Health Care Quality
7120 Samuel Morse Drive
Second Floor
Columbia, MD 21046-3422

1/8/2024

Sent via email to: [redacted]

[redacted]
Assisted Living Manager
Gull Creek Senior Living Community
1 Meadow Street
Berlin, MD 21811

RE: Plan of Correction Accepted

[redacted]

The Office of Health Care Quality (OHCQ) has reviewed and accepted the Plan of Correction you submitted on 1/5/24 in response to a survey conducted on 11/20/23 – 11/22/23, Survey Event ID Number IL1R11.

The assisted living program is required to fully implement the actions described in the Plan of Correction. OHCQ may conduct an unannounced follow-up survey to determine if the plan was fully implemented.

If you have any questions regarding the survey process, please contac[redacted]

Sincerely,

[redacted]
Health Facilities Survey Coordinator II
Office of Health Care Quality

[redacted]

From: [redacted]
Sent: Monday, January 8, 2024 3:15 PM
To: [redacted]
Cc:
Subject: OHCQ - Plan of Correction Accepted - Gull Creek
Attachments: IL1R11 POC ACCEPTANCE LETTER signed.pdf

Good Afternoon -

Attached please find a letter stating that the Plan of Correction for Gull Creek has been accepted.

Respectfully -

[redacted]

--

[redacted]
7120 Samuel Morse Drive
Second Floor
Columbia, MD 21046-3422

Phone: (667) 210-9670
Fax: (410) 402-8056
[redacted]
http://health.maryland.gov/ohcq/Pages/Home.aspx

Maryland MOLST

maryland.molst@maryland.gov

http://marylandmolst.org

Maryland Department of Health is committed to customer service. Click here to take the Customer Satisfaction Survey.

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Office of Health Care Quality
7120 Samuel Morse Drive
Second Floor
Columbia, MD 21046-3422

12/26/2023

Sent via email to: [redacted]

[redacted]
Assisted Living Manager
Gull Creek Senior Living Community
1 Meadow Street
Berlin, MD 21811

RE: Notice of Deficiencies

[redacted]

On 11/20/2023 - 11/22/2023, the Office of Health Care Quality (OHCQ) completed a survey at your assisted living program to determine compliance with the requirements contained in COMAR 10.07.14 and other applicable federal, State, and local requirements. The attached Statement of Deficiencies for Survey Event ID Number IL1R11 explains each deficiency, including the State Tag number, the citation, and the findings.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies identified in the attached Statement of Deficiencies must be submitted within 10 calendar days of your receipt of this notice. Attached is a Plan of Correction form that you must complete. The PoC and any attachments are public documents, so do not use the names of residents. Refer to residents by the Resident Number assigned to them on the Resident Roster that was provided to you during the survey. For each State tag, answer the following questions:

1. How are you going to correct the deficiency?
2. What is the date when you will have each deficient practice corrected?
3. How are you going to prevent the deficient practice from reoccurring?
4. Who will be responsible for ensuring the deficiency does not reoccur?

Failure to submit an acceptable PoC in 10 days may result in the imposition of enforcement remedies.

Informal Dispute Resolution Conference

In accordance with COMAR 10.07.14.11E, you will be given an opportunity to dispute the deficiencies cited through an informal dispute resolution conference (IDR). You have 10 calendar days to submit a written request for an IDR to [redacted] or [redacted]

The written request for an IDR must fully describe the disagreement with the statement of deficiencies and must be accompanied by any supporting documentation. At the discretion of the Office of Health Care Quality, the IDR may be held in-person, by telephone, or in writing. IDRs are informal in nature and are not attended by counsel.

When a licensee requests an IDR, the licensee shall file a plan of correction within the required time, except to the extent that the licensee contests specific findings, in which case absent OHCQ's specific directive, a licensee may delay submitting its plan of correction with respect to those specific findings until 5 days after the licensee is provided oral or written notice of the outcome of the IDR.

A request for an IDR will not delay the effective date of any enforcement action.

Questions

If you have any questions or need additional information, please contact [redacted]

Sincerely,

[redacted]
Health Facilities Survey Coordinator II
Office of Health Care Quality

Attachment: Statement of Deficiencies
Plan of Correction

PRINTED: 12/19/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E 000	Initial Comments On 11/20/23 - 11/22/2023 an unannounced Inspection of Care Survey was conducted by representatives of the Office of Health Care Quality for the purpose of determining the facility's compliance with the requirements of COMAR 10.07.14, for Assisted Living Programs. Survey activities included observations during a tour of the facility, interviews with staff and residents, and a review of records. Based on survey findings, the following deficiencies were identified on the dates of the investigation. The facility's census was 74 residents. Acronyms which appear in this report are defined as follows: ALM - Assisted Living Manager DN - Delegating Nurse RAT - Resident Assessment Tool	E 000		
E3330	.26 B1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually. This Requirement is not met as evidenced by:	E3330		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE ALM (X6) DATE 1.5.24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E3330	Continued From Page 1 Based on resident record review and staff interview, the ALM or designee failed to ensure that when the resident's assessments of condition / RATs are completed by anyone other than the DN, the DN must document their assessment on a separate form. This was true of 5 out of 7 resident records reviewed. Findings include: A review of resident records on 11/20/23, failed to reveal comprehensive nursing assessments by the DN to accompany RATs that were completed by another medical professional. 1. There was no initial comprehensive nursing assessment documented by the DN which corresponded to the admission of Resident #1 and a RAT signed on 4/14/2023 by a physician. 2. There was no initial comprehensive nursing assessment documented by the DN which corresponded to the admission of Resident #2 and a RAT signed on 6/9/23 by a physician. 3. There was no initial comprehensive nursing assessment documented by the DN which corresponded to the admission of Resident #3 and a RAT signed on 4/14/2023 by a physician. 4. There was no initial comprehensive nursing assessment documented by the DN which corresponded to the admission of Resident #5 and a RAT signed on 4/10/23 by a physician. 5. There was no initial comprehensive nursing assessment documented by the DN which corresponded to the admission of Resident #7 and a RAT signed on 7/24/23 by a physician's	E3330	1. Chart audits were completed for all residents. The residents without a comprehensive nursing assessment were identified. The DON completed an updated RAT on those residents. 2. The deficient practice was corrected and completed on 1/4/24. 3. The DON will ensure all new admissions will receive a comprehensive nursing assessment completed by her on admission. All new admission charts will be audited x3 months to ensure the deficient practice is corrected. Findings will be reported in the monthly QAPI meeting. 4. The DON will be responsible for ensuring the deficient practice does not reoccur.	

PRINTED: 12/19/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E3330	Continued From Page 2 assistant. In an interview with the ALM on 11/21/23, the ALM stated that she was unaware that the previous DN had not completed initial comprehensive nursing assessments of residents when their RAT was completed by another medical professional.	E3330		
E3350	.26 B4,5 .26 Service Plan (4) A review of the assessment shall be conducted every 6 months for residents who do not have a change in condition. Further evaluation by a health care practitioner is required and changes shall be made to the resident's service plan, if there is a score change in any of the following areas: (a) Cognitive and behavioral status; (b) Ability to self-administer medications; and (c) Behaviors and communication. (5) If the resident's previous assessment did not indicate the need for awake overnight staff, each full assessment or review of the full assessment shall include documentation as to whether awake overnight staff is required due to a change in the resident's condition. This Requirement is not met as evidenced by: Based on resident record review and staff interview, the ALM or designee failed to ensure that the resident's assessments of condition / RATs are reviewed at least every 6 months. This was true of 4 out of 7 resident records reviewed. Findings include: A review of resident records on 11/20/23, failed to reveal that 6-month reviews of the resident's	E3350	1. Chart audits for all residents was completed. Residents without a 6 month service plan review were identified. A review of their service plans was completed and documented. 2. The deficient practice was corrected by 1/4/24. 3. The DON created a spreadsheet/master calendar for upcoming review dates. Chart audits will be conducted x3 months to ensure 6 month reviews are up to date and current. Findings will be reported through the monthly QAPI meeting. 4. The DON is responsible for ensuring the deficient practice does not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E3350	Continued From Page 3 assessments of condition / RATs were completed and or documented. 1. The RAT for Resident #1 was signed on 4/14/2023, with no 6-month review documentation. 2. The RAT for Resident #3 was signed on 4/14/2023, with no 6-month review documentation. 3. The RAT for Resident #5 was signed on 4/10/2023, with no 6-month review documentation. 4. The RAT for Resident #6 was signed on 2/1/2023, with no 6-month review documentation. In an interview with the ALM on 11/21/23, the ALM stated that she was unaware that the previous DN had not completed and or documented 6-month reviews of resident assessments.	E3350		
E3370	.26 C2 .26 Service Plan (2) The service plan is developed within 30 days of admission to the assisted living program; and This Requirement is not met as evidenced by: Based on resident record review and staff interview, the ALM or designee failed to ensure that resident service plans are in place to direct care for the resident within 30 days of admission. This was true of 2 out of 7 resident records reviewed. Findings include: A review of resident records on 11/20/23, revealed that service plans created by the DN did not include the date that they were created, and that the date that they were signed by the DN was	E3370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E3370	Continued From Page 4 more than 30 days from the date that the residents were admitted. 1. The service plan for Resident #1 was signed on 6/30/23, 38 days after the resident was admitted. 2. The service plan for Resident #3 was signed on 10/16/23, 188 days after the resident was admitted. In an interview with the ALM on 11/21/23, the ALM stated that the date that the service plans were signed was most likely the date that they were created by the previous DN.	E3370	1. Chart audits were completed for all resident service plans. Those residents without service plans were identified and service plans completed. 2. The deficient practice was completed by 1/4/24. 3. The DON will complete service plans within 30 days of a resident admsiion. Audits for all new admissions x3 months will be completed. Findings will be reported through the monthly QAPI meeting. 4. The DON will be responsible for ensuring the deficient practice does not reoccur.	
E3650	.29 L .29 Medication Management and Administration .29 Medication Management and Administration. L. If a resident requires that staff administer medications as defined in Regulation .02B(3) of this chapter, and the administration of medications has been delegated to an unlicensed staff person pursuant to COMAR 10.27.11, the assisted living manager shall comply with COMAR 10.27.11 by arranging for an on-site review by the delegating registered nurse at least every 45 days. The delegating nurse shall make appropriate recommendations to the appropriate authorized prescriber, and the assisted living manager or designee. This Requirement is not met as evidenced by: Based on resident record review and staff interview, the ALM failed to ensure that residents requiring the administration of medications by staff members received an on-site review by the	E3650		

PRINTED: 12/19/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E3650	Continued From Page 5 Delegating Nurse at least every 45 days. This was true of 7 out of 7 resident records reviewed. Findings include: A review of resident records on 11/20/23, failed to reveal that 45-day assessments were being performed as required. 1. Resident #1 had 1 45-day assessment documented on 10/5/23, since admission in May of 2023. 2. Resident #2 had 1 45-day assessment documented on 10/23/23, since admission in June of 2023. 3. Resident #3 had 2 45-day assessments documented on 6/21/23 and 10/16/23, since admission in April of 2023. 4. Resident #4 had 1 45-day assessment documented on 10/24/23, since admission in June of 2023. 5. Resident #5 had 2 45-day assessments documented on 6/21/23 and 10/24/23, since admission in April of 2023. 6. Resident #6 had 4 45-day assessments documented on 4/15/23, 6/21/23, 8/11/23 and 10/16/23, for the year of 2023. 7. Resident #7 had 1 45-day assessment documented on 10/10/23, since admission in July of 2023. In an interview with the ALM on 11/21/23, the ALM stated that the previous DN had fallen behind on	E3650	1. Chart audits were completed for all residents residents without a current 45 day assessment were identified. Those residents received a completed 45 days assessment. 2. The deficient practice was corrected by 1/4/24. 3. Chart audits of 45 day assessments will be completed x3 months. A schedule of 45 day assessments due dates wil l be reviewed daily, Monday thru Friday, in the EMR. Findings will be reported through the monthly QAPI meeting. 4. The DON will be responsible for ensuring the deficient practice does not reoccur.	

PRINTED: 12/19/2023
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001438	A. BUILDING _____ B. WING _____	11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULL CREEK SENIOR LIVING COMMUNITY	ONE MEADOW STREET BERLIN, MD 21811

(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) COMPLETE DATE
E3650	Continued From Page 6 45-day reviews.	E3650		
E4610	.40 A .40 Approval of Burial Arrangements .40 Approval of Burial Arrangements for Unclaimed Deceased Residents. A. An assisted living program shall ascertain and document on admission of the resident, or within 14 days of admission any arrangements the resident has made, or wishes to make, with regard to burial, including but not limited to: (1) Financial; (2) Religious; (3) Name of preferred funeral director, if any; and (4) The name, address, and relationship of any person who has agreed to claim the body of the resident or who has agreed to assume funeral or burial responsibility. This Requirement is not met as evidenced by: Based on resident record review and staff interview, the facility failed to obtain and document in the resident's records, resident burial arrangements. Findings include: A review of resident records on 11/21/23, failed to reveal documented burial arrangements for Resident #2. In an interview with the ALM on 11/21/23, they stated that they were unable to locate documented burial arrangements for Resident #2.	E4610	1.An audit of resident charts was competed and residents without a documented funeral home were identified. Residents/ families were notified and funeral homes of choice for those identified residents were obtained. Documentation updated in the chart and EMR. 2. The deficient practice was corrected and completed on 1/4/24. 3. The Marketing Director received education regarding the importance of obtaining the preferred funeral home of choice during the admission process. The director will ensure the information is completed on the resident emergency form which is completed prior to move in. The Marketing Director will place the form in the chart and the Director of Nursing will enter the information in the 'preferred locations' section of the EMR. Audits for new admissions will be conducted x3 months. Findings will be reported in the monthly QAPI meeting. 4. The Marketing Director will be responsible for ensuring the deficiency does not reoccur.	

ILLINOIS DEPARTMENT OF
fHF:S Healthcare and
Family Services

[redacted]

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0545
Toll Free: (844) 528-8444
TTY: (800) 526-5812

FAX

rro: [redacted]	From: [redacted]
Fax: 815 787 6560	**Date:** 1-8-24
!Re: 2023 Annual review findings	**Pages:** 11

O **Urgent** ☐ **For Review** O **Please Comment** ☐ **Please Reply** O **Please**

CONFIDENTIAL

A plan of correction is due within 14 days and must be completed within 30 days. Please sign page 2 of 2 and page 11 of 14 and return. Thank you.

Please call if questions

[redacted]

[redacted] **Internet:** http://www.hfs.illinois.gov/

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of_2_**

SLP NAME: _HW Dekalb

CHECKONE:

( ) **INTERIM CERTIFICATION REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXITDATE:

( ) **FINAL CERTIFICATION REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXITDATE:

(X) ANNUAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: 1-24-23 EXIT DATE: 1-8-24

( ) **CHANGE OF OWNERSHIP REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE:• EXIT DATE:

() **INCIDENTFOLLOWUP REVIBWFINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findlngs noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residen.ts and/or staff.

BEGINDATE: EXITDATE:

()**COMPLAINT REVIEW** **DATE OF COMPLAINT:_____**

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES O NO O

BEGINDATE: ENDDATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st)**BEGINDATE:** _____ **ENDDATE:** _____

FINDINGS CORRECTED: YES ☐ NO☐

(2nd)**BEGINDATE:** _____ **ENDDATE:** _____

FINDINGS CORRECTED: YES ☐ NO☐

RESPONSE TO ON-SITE REVIEW FINDINGS Page2of_2_

For non-compllance found durlng an interim revlew or interim/final completed simultaneously-

The Response to On-Site Review Findings fonn must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the fonn to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or tenminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings fonn must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the dale that the fmdings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 1O working days of the notification or take other appropriate steps to detennine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative [redacted] — Date 1/8/24

Date

1-8-24
Date

Signature ofBureau of Long Term Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS

RRAL DATE: _1-_::_9-=-2""'"4
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing f) The SLF shall employ certified nursing assistants (CNAs) as follows: 1) Qualifications: Must be 18 years of age or older and have successfully completed no later than 120 days after employment a nursing assistant training course or a Department of Public Health approved equivalent training and competency evaluation.	1.The Regional Director of Operations will provide education related to staffing requirements, background checks, and qualifications to the Executive Director 2. The Executive Director will in-service all hiring directors on background check requirements per regulation and policy. 3. Quality Assurance audits will be conducted by the Executive Director 4. Results of QA audits and results reported and monthly QAPI meeting	

Section 146.235 Staffing f) The SLF shall employ certified nursing assistants (CNAs) as follows: I) Qualifications: **This requirement has not been met.** El. DOH 8/4/21. Per HCWR CNA class was completed 3/6/87. No competency on file. E3 was notified, El was taken off the schedule 1/25/23 to 1/27/23 until E3 was told by IDPH that El's competency was "grandfathered" and that the website would be updated. IDPH was not contacted until it was brought to the SLFs attention by HFS Staff. E2. DOH **5/4/22.** Per the Healthcare Worker Registry (HCWR), there was no CNA course completion or competency on file. E3 supplied documentation that E2 completed a CNA course through Quality CNA Training on 10/2/20 and that CNA certification exam was completed on 10/24/20 in Wisconsin. E3 said E2 was given a form to fill outto have the certification transferred to Illinois. Form was not given to E2 until it was brought to the SLPs attention by HFS staff.	5. Remediation of Employees sited have been corrected	

86

6/4/18

93531586.2

Section 146.235 Staffing l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that confonns to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Departrnent of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal bistory record check. **This requirement has not been met.** E3. DOH 03/16/20. HCWR verified O 3/10/20, no 30-day verify completed. No annual HCWR check in 2021. Last annual check was 11/30/22. E4. DOH 1/9/19. Authorization and Disclosure (A&D) signed on 1/7/19, Fee App 2/4/19, greater than 10 days. Per E3, E4 was allowed to work until fingerprints were completed. No annual HCWR check in 2020 or 2021. Last check was 11/3/22.		

6/4/18 8 6

Section 146.23S Staffing 1) continued ES. DOH 04/21/20. HCWR verified 04/09/20, no 30-day verify completed. No annual HCWR check in in 2021, last checked 11/30/22. E6. DOH 10/10/22. HCWR verified 10/07/22, no 30-day verify completed. E7. DOH 08/10/22. HCWR verified 07/06/22, no 30-day verify completed. ES. DOH 06/30/22. HCWR verified 06/30/22, no 30-day verify completed. E9. DOH 11/02/22. HCWR verified 10/25/22, no 30-day verify completed. **EIO.** DOH 08/24/22. HCWR verified 08/23/22, no 30-day verify completed. **Ell.** DOH 12/23/19. HCWR verified 11/16/19, no 30-day verify completed. No annual HCWR check in 2020, 2021. Last annual check was 11/3/22. **E12.** DOH 11/27/22. HCWR verified 11/21/22, no 30-day verify completed. **E13.** DOH 11/23/22. HCWR verified 11/17/22, no 30-day verify completed.		

93531586.2

607

Section 146.235 Staff I) continued E14. DOH 10/19/22. HCWR verified 10/19/22, no 30-day verify completed. **E16.** DOH 11/26/19. No annual HCWR check in 2020, 2021. Last annual check was 11/03/22. E17. DOH 11/14/17. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E20.** DOH 05/17/19. No annual HCWR check in 2020, 2021. Last annual check was 11/03/22. **E22.** DOH 04/21/20. No annual HCWR check in 2021. Last annual check was 11/03/22. **E25.** DOH 01/16/14. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E28.** DOH 02/08/19. No annual HCWR check in 2020, 2021. Last annual check was 11/03/22. **E32.** DOH 07/01/08. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E33.** DOH 07/10/17. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E34.** DOH 02/25/19. No annual HCWR check in 2020, 2021. Last annual check was 11/03/22.		

86

6/4/18

Section 146.235 **Staff"mg** 1) continued **E35.** OOH 10/19/15. No annual HCWR check in 2019, 2020 and 2021. Last annual check was 11/03/22. **E36.** DOH 04/14/17. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E37.** DOH 11/11/19. No annual HCWR check in 2020, 2021. last annual check was 11/03/22. **E39.** OOH 01/14/19. No annual HCWR check in 2020, 2021. Last annual check was 11/03/22. **E42.** DOH 07/14/20. No annual HCWR check in 2021. Last annual check was 11/03/22. E44. OOH 10/11/17. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E45.** DOH 09/24/18. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. **E46.** OOH 09/28/20. No annual HCWR check in 2021. Last annual check was 11/03/22. **E47.** DOH 07/16/18. No annual HCWR check in 2019, 2020, 2021. Last annual check was 11/03/22. E48. DOH 09/14/20. No annual HCWR check in 2021. Last annual check was 11/03/22.		

86

6/4/18

Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control ofTuberculosis Code (77 Ili. Adm. Code 696). **This requirement was not met.** ES. DOH 06/30/22. QuantiFERON lab drawn 07/21/22. Greater than 7 days from DOH. **E27.** DOH 01/03/22. 1st step given 01/05/23, read neg on 01/07/23. 2nd step was never started. E27 was on sick leave from 01/08/23 to 1/30/23. E18 states E18 plans to restart the two-step testing when E18 returns to work. **E40.** DOH 2/17/22. pt step given 03/04/22, read neg. on 03/07/22. 2nd step given 03/11/22, read neg. on 03/14/22. 1st step given greater than 7 days from DOH. E12. DOH 11/27/22. 1st step given 12/07/22, read neg. on 12/09/22. 2nd step given 12/21/22, read neg. on 12/23/22. pt step given greater than 7 days from DOH. **E13.** DOH 11/23/22. pt step given 12/13/22, read neg. on 12/16/22. 2nd step given 12/20/22, read neg. 12/22/22. 1st step given greater than 7 days from DOH.	1. The Regional Director of Clinical Services will provide in-servicing to the Executive Director and Director of Nursing related to employee tuberculin skin tests following the Control of Tuberculosis Code (77 Ili. Adm. Code 696). 2. Director of Nursing or designee will provide education and process direction to all hiring directors. 3. Director of Nursing or designee will conduct monthly QA audits and tracking 4. QA results will be reported at monthly QAPI meeting	

86

6/4/18

93531586.2

Section 146.230 Services m) Emergency Call System 2) The SLF shall have electronic devices available in each common area, each public restroom, each common bathing room and each resident laundry room to enable residents to secure help in an emergency. **This requirement was not met.** • The following common areas did not have working call lights during building tour with E3 and E49 on 01/24/23. 2nd floor laundry, two 2nd floor common areas. E3 and E49 report getting new call light system in the last month and most likely those areas were overlooked. E49 put working call lights in those area by the end of the workday on 01/24/23.	1. In-service provided to Executive Director and Maintenance Director on requirements of Emergency Call Systems 2. Staff to be in service on reporting call lights not designated areas or malfunctioning. 3. Weekly rounding and QA will be performed. 4. Results reported at the community monthly QAPI meeting. 5. The community has remediated all noted areas of difficulty have been remediated and new call system in place	

86

6/4/18

93531586.2

935311586.2

Section 146.240 Resident Contract a) The SLF shall have a signed contract with each resident, which specifies the terms of his or her agreement. **This requirement was not met:** **R13.** Admit 7/21/22. Greater than 30 day readmit. There was not a new contract signed at readmission.	1. In-service provided to the Executive Director and management team. 2. All residents who are out more than 30 days will be provided an updated contract 3. 30 day absences monitored and reported and monthly QAPI	

6/4/18 886

935315862

Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 lll. Adm. Code 696). **This requirement was not met:** R3. Admit 2/18/22. No two-step TB done on admit. Last two-step TB documentation is from previous admission in 2020. S&S TB checklist was completed 6/6/22-late. **R6.** Admit 3/11/22. No two-step TB was done on admit.. S&S were completed 3/14/22. **RIO.** Admit 2/21/22. No TB documentation. S&S was done 8/12/22, late. **RII.** Admit 6/3/21. 1st step TB given 11/14/22, read neg 11/16/22. 2nd step given 11/21/22, read neg on 11/23/22. S&S dated 11/14/22. TB testing and S&S were both late.	5. The Regional Director of Clinical Services will provide in-servicing to the Executive Director and Director of Nursing regarding resident participation requirements oftuberculin skin tests following the Control of Tuberculosis Code (77 Ili. Adm. Code 696). 6. Director of Nursing or designee will provide education and process direction to all hiring directors. 7. Director of Nursing or designee will conduct monthly QA audits and tracking QA results will be reported at monthly QAPI meeting	

86

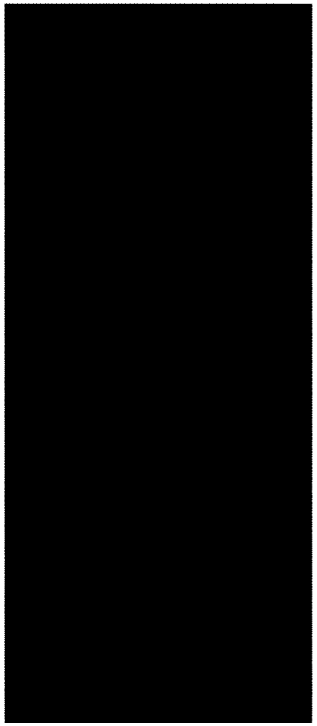
6/4/18

93531586.2

Section 146.220 Resident Participation Requirements a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met pńor to admission to the SLF: 2) Be screened by the Department or other State agency screening entity and found to be in need of nursing facility level of care and that SLF placement is appropńate to meet the needs of the individual. A new screen is not needed for a resident who is transferring between SLFs or comes from a nursing facility with no break in service. It is the admitting SLF's responsibility to ensure that a screening document is received from the transferńng SLF or nursing facility. Pńvate pay individuals may choose to be admitted into the SLF when the screening assessment does not justify nursing facility level of care; and **R4.** Admit 1/19/16 per facility. Per sample list admit date is 10/8/19. E35 reports a conversion was done on 3/8/18 but was denied because resident stili had money. Another conversion was never dane and it wasn't entered into medi until 10/8/19 when R4s resources were exhausted.		

Signature of SLP Provider Representative_____Date_____
6/4/18 86

Resident and Employee Key:



CNA	
CNA	
Administrator	
Dietary Aide	
CNA	
Dietary Aide	
Dietary Aide	
CNA	
CNA	
Dietary Aide	
CNA	
Dietary Aide	
CNA	
Dietary Aide	
CNA	
CNA	
CNA	
CNA	

86

E49. [redacted] Maintenance Supervisor

6/4/18

8
6

627

HW ofDekalb Annual Review 1/24/23

[redacted]

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods of Batavia
REFERRAL DATE: 12/11/23
First Follow-up ( ) Second Follow-up ( )
SURVEY DATES: 6/12/23-6/22/23

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. R-10 was admitted to the SLP on 12/23/22. The SLP completed the three required sex offender websites on 3/13/23, not before admission as required.		

R-23 was admitted to the SLP on 12/1/22. The SLP checked R-23 against the three required sex offender websites on 12/14/22, not before the admission as required. R-34 was admitted to the SLP on 11/16/22. The SLP completed the three required sex offender websites on 3/13/23, not prior to admission as required. **Section 146.220 Resident Participation Requirements** d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R-2 was admitted to the SLP on 8/30/22. The TB screening was completed late, with the first step done on 4/12/23 and the second step done on 4/21/23. R-8 was admitted to the SLP on 1/22/23. The TB screening was completed late, with the first step done on 5/17/23 and the second step done on 5/26/23. R-10 was admitted to SLP on 12/23/22. The TB screening was completed late, with the first step done on 4/12/23 and the second step done on 4/21/23. R-10's signs and symptoms of TB Disease was completed on 3/23/23, not within the required 7 days of admission. R-11 was admitted to the SLP on 9/22/22. The TB screening was completed late, with the first step done on 5/17/23 and the second step done on 5/26/23. R-11's signs and symptoms of TB Disease was completed on 5/17/23, not within the required 7 days of admission.		

R-14 was admitted to the SLP on 2/22/22. The TB screening was completed late, with the first step done on 6/9/22 and the second step done on 6/22/22. R-18 was admitted to the SLP on 8/30/22. The TB screening was completed late, with the first step done on 5/17/2 and the second step done on 5/26/23. R-18's signs and symptoms of TB Disease was completed on 5/17/23, not within the required 7 days of admission. R-19 was admitted to the SLP on 12/21/22. The SLP completed the signs and symptoms of TB Disease on 3/23/23, not within 7 days of admission. R-21 was admitted to the SLP on 8/8/22. The TB screening was completed late, with the first step done on 4/12/23 and the second step done on 4/21/23. R-23 was admitted to the SLP on 12/1/22. The TB screening was completed late, with the first step done on 4/17/23/12/23 and the second step done on 4/26/23. R-24 was admitted to the SLP on 10/2/22. The TB signs and symptoms date is unknown as the date is not documented on the form. R-25 was admitted to the SLP on 2/28/23. The SLP completed the signs and symptoms of TB Disease on 3/14/23, not within 7 days of admission as required. R-26 was admitted to the SLP on 3/3/23. The TB screening was completed late, with the first step done on 3/27/23 and the second step done on 4/5/23. The SLP completed the signs and symptoms of TB Disease on 3/15/23, not the required 7 days after admission.		

R-27 was admitted to the SLP on 12/27/22. The TB screening was completed late, with the first step done on 5/17/23 and the second step done on 5/26/23. The SLP completed the signs and symptoms of TB Disease on 5/17/23, not within 7 days of admission. R-28 was admitted to the SLP on 3/6/23. The TB screening was completed late, with the first step done on 5/22/23 and the second step done on 6/2/23. R-29 was admitted to the SLP on 8/25/22. The TB screening was completed late, with the first step done on 5/22/23 and the second step done on 6/2/23. **Section 146.235 Staffing** e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) The SLP setting shall provide staff and subcontractors who provide direct care with: A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment; E-34 was hired on 9/27/22. E-34 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/23/23, not within the required 30 days of hire.		

E-11 was hired on 1/17/23. E-11 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/24/23, not within the required 30 days of hire. E-13 was hired on 1/18/23. E-13 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-1 was hired on 1/18/23. E-1 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-14 was hired on 1/26/23. E-14 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-15 was hired on 1/30/23. E-15 completed training that covers infection control; crisis intervention, prevention of abuse, neglect		

and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/18/23, not within the required 30 days of hire. E-2 was hired on 2/9/23. E-2 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-18 was hired on 4/17/23. E-18 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/24/23, not within the required 30 days of hire. E-4 was hired on 3/6/23. E-4 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-16 was hired on 3/13/23. E-16 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry		

and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-5 was hired on 3/15/23. E-5 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-6 was hired on 3/17/23. E-6 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/19/23, not within the required 30 days of hire. E-7 was hired on 3/27/23. E-7 completed training that covers infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/18/23, not within the required 30 days of hire. E-28 was hired on 10/31/22. E-28 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/17/23, not within the required 30 days of hire.		

E-8 was hired on 11/4/22. E-8 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-9 was hired on 12/4/22. E-9 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-10 was hired on 12/4/22. E-10 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-30 was hired on 11/21/22. E-30 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. E-12 was hired on 1/17/23. E-12 completed training that covers resident rights; infection control; crisis intervention, prevention of abuse, neglect and financial exploitation; behavioral		

intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy on 5/16/23, not within the required 30 days of hire. **Section 146.235 Staffing** l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. E-1 was hired on 1/18/23. The registry employment verification was completed late on 6/12/23, not within 30 days of the hire date. E-2 was hired on 2/9/23. The registry employment verification was completed late on 2/17/23, not within 30 days of the hire date. The six required registries have been checked late on 2/17/23, not prior to starting the first shift. E-3 was hired on 2/16/23. The registry employment verification was completed late on 4/18/23, not within 30 days of the hire		

date. The six required registries have been checked late on 3/16/23, not prior to starting the first shift. E-5 was hired on 3/15/23. The Registry Employment verification completed late on 5/19/23, not within 30 days of hire. E-6 was hired on 3/17/23. The registry employment verification was completed late on 5/19/23, not within 30 days of the hire date. The healthcare worker registry was completed late on 5/19/23, not prior to first start date. E-7 was hired on 3/27/23. The registry employment verification was completed late on 5/5/23, not within 30 days of the hire date. E-8 was hired on 11/4/23. The registry employment verification was completed late on 5/19/23, not within 30 days of the hire date. The six required registries have been checked late on 4/18/23, not prior to starting the first shift. The Healthcare Worker Registry was completed late on 4/18/23, not within 30 days of hire. E-9 was hired on 12/4/22. The Healthcare Worker Registry was completed late on 3/31/23, not prior to the start date. The six required registries have been checked late on 3/31/23, not prior to starting the first shift. The fingerprint authorization was completed on 3/24/23, not prior to the first shift. E-10 was hired on 12/4/22. The Healthcare Worker Registry was completed late on 3/31/23, not prior to the start date. The six required registries have been checked late on 3/31/23, not prior to starting the first shift. The fingerprint authorization was completed on 3/24/23, not prior to the first shift. The registry		

employment verification was completed late on 5/19/23, not within 30 days of the hire date. **Section 146.235 Staffing** m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). E-1 was hired on 1/18/23. TB signs and symptoms have been completed late on 5/31/23. The TB screening was completed late, with the first step done on 5/31/23 and the second step done on 6/23/23. E-11 was hired on 1/17/23. TB signs and symptoms and TB screenings have not been completed. E-11 was terminated on 6/22/23. E-12 was hired on 1/17/23. TB signs and symptoms have been completed late on 5/30/23, not within 7 days of hire. The TB screening was completed late, with the first step done on 5/30/23 and the second step done on 6/8/23 E-13 was hired on 1/18/23. TB signs and symptoms have been completed late on 5/31/23. The TB screening was completed late, with the first step done on 5/3/23 and the second step done on 6/2/23. E-14 was hired on 1/26/23. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/24/23 and the second step done on 6/28/23. E-15 was hired on 1/30/23. TB signs and symptoms have been completed late on 5/23/23. The TB screening was completed		

late, with the first step done on 5/23/23 and the second step done on 6/7/23. E-2 was hired on 2/9/23. TB signs and symptoms have been completed late on 5/29/23. E-3 was hired on 2/16/23. TB signs and symptoms have been completed late on 5/23/23. The TB screening was completed late, with the first step done on 5/23/23. E-4 was hired on 3/16/23. TB signs and symptoms have been completed late on 6/8/23. The TB screening was completed late, with the first step done on 6/8/23 and the second step done on 6/16/23. E-16 was hired on 3/13/23. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/24/23. E-5 was hired on 3/15/23. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/22/23. E-6 was hired on 3/17/23. TB signs and symptoms have been completed late on 6/4/23. The TB screening was completed late, with the first step done on 6/7/23. E-7 was hired on 3/27/23. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/24/23 and the second step done on 6/8/23. E-17 was hired on 4/12/23. TB signs and symptoms have been completed late on 6/15/23. The TB screening was completed late, with the first step done on 6/15/23.		

E-18 was hired on 4/17/23. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/24/23 and the second step done on 6/7/23. E-19 was hired on 5/1/23. TB signs and symptoms have been completed late on 6/19/23. The TB screening was completed late, with the first step done on 6/19/23. E-20 was hired on 5/2/23. TB signs and symptoms have been completed late on 5/31/23. The TB screening was completed late, with the first step done on 5/31/23. E-21 was hired on 5/4/23. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/23/23. E-22 was hired on 5/9/23. TB signs and symptoms have been completed late on 6/13/23. The TB screening was completed late, with the first step done on 6/13/23. E-23 was hired on 5/9/23. TB signs and symptoms have been completed late on 6/21/23. The TB screening was completed late, with the first step done on 6/21/23. E-24 was hired on 5/15/23. TB signs and symptoms have been completed late on 5/25/23. The TB screening was completed late, with the first step done on 6/7/23. E-25 was hired on 5/17/23. TB signs and symptoms have been completed late on 6/7/23. The TB screening was completed late, with the first step done on 6/7/23.		

E-28 was hired on 10/31/22. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/24/23 and the second step done on 6/8/23. E-8 was hired on 11/4/22. TB signs and symptoms have been completed late on 5/23/23. E-9 was hired on 12/4/22. TB signs and symptoms have been completed late on 5/30/23. The TB screening was completed late, with the first step done on 5/30/23 and the second step done on 6/7/23. E-10 was hired on 12/4/22. TB signs and symptoms have been completed late on 5/30/23. The TB screening was completed late, with the first step done on 5/30/23 and the second step done on 6/7/23. E-29 was hired on 8/22/22. TB signs and symptoms have been completed late on 5/30/23. E-30 was hired on 11/21/22. TB signs and symptoms have been completed late on 5/24/23. The TB screening was completed late, with the first step done on 5/24/23. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** a) Interview: The SLP provider shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy but not before the DON, or successor tool, and other required PAS assessments are completed and determinations provided to the SLP provider.		

R-14 was admitted to the SLP on 2/22/22. The SLP completed the standardized interview on 12/28/22, not at or before admission. R-19 was admitted to the SLP on 12/21/22. The SLP completed the standardized interview on 6/13/23, not at or before the admission as required. R-27 was admitted to the SLP on 12/27/22. The SLP completed the standardized interview on 6/8/23, not at or before the admission as required. R-30 was re-admitted on 12/22/22, the standardized interview was completed late on 6/14/23. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse. R-3 was admitted 6/24/22. The initial assessment was completed on 6/16/22 before the admission and not within 24 hours after admission. R-8 was admitted 1/22/23, the initial assessment completed on late on 2/22/23, not within 24 hours after admission. R-14 was admitted on 2/22/22. The initial assessment and service plan were not signed or dated.		

R-19 was admitted on 12/21/22. The initial assessment and service plan were completed on 6/12/23, not within 24 hours of admission. R-25 was admitted on 2/28/23. The SLP completed the initial assessment and service plan on 3/14/23, not within the required 24 hours of admission. R-26 was admitted on 3/3/23. The SLP completed the initial assessment on 6/13/23, not within the required 24 hours of admission. R-27 was admitted on 12/27/22, The SLP did not complete the initial assessment and service plan within 24 hours after admission, 6/8/23. R-29 was admitted on 8/25/22. The initial assessment and service plan were completed 8/29/23, not within the required 24 hours of admission. R-30 was re-admitted on 12/22/22, initial assessment and service plan completed late on 6/14/23, not within the required 24 hours of admission. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R-1 was admitted 1/5/22, RAI was completed late on 8/15/22.		

R-4 was admitted 6/24/22, RAI was completed late on 8/15/22, not within 7-14 days after admission, R-7 was admitted 8/19/22, RAI was completed late on 9/6/22. R-9 was admitted 1/22/23, RAI done late on 2/25/23. R-12 was admitted on 11/2/22. The RAI was completed late on 11/17/22. R-12's RAI was not thoroughly completed. Remediated onsite, new RAI completed on 6/13/23. R-14 was admitted on 2/22/22. RAI was completed late on 3/24/22, not the required 7-14 days after admission. RAI not signed. R-15 was admitted 3/28/23, RAI was completed late on 5/19/23, not the required 7-14 days after admission. R-16 was admitted 11/14/22, RAI was completed late on 1/6/23, not the required 7-14 days after admission. R-17 was admitted 11/18/22, RAI was completed late on 2/7/23, not the required 7-14 days after admission. R-19 was admitted on 12/21/22. RAI completed on 3/30/23, not within 7-14 days after admission. R-20 was admitted on 11/15/22. The RAI was completed late on 12/22/22, not within the 7-14 days after admission. The RAI was not thoroughly completed. It was remediated onsite and completed 6/14/23. R-23 was admitted on 12/1/22. The RAI was completed on 2/7/23, not within the required 7-14 days after admission.		

R-26 was admitted on 3/3/23. The RAI was completed late on 3/30/23, not the required 7-14 days after admission. R-28 was admitted on 3/6/23. The RAI was completed late on 4/13/23, not the required 7-14 days after admission. R-29 was admitted on 8/25/22. The RAI was completed on 9/12/22, not the required 7-14 days after admission. R-30 was re-admitted on 12/22/22, no RAI completed for 12/22/22 re-admission, the last RAI was completed on 5/19/22. R-31 was admitted 1/16/23. The RAI was completed late on 2/10/23, not the required 7-14 days after admission. R-33 was admitted 2/10/23, the RAI was completed late on 3/13/23, not within 7-14 days as required. R-34 was admitted on 11/16/22. The RAI was completed on 1/6/23, not within the required 7-14 days after admission. R-37 was admitted 7/1/15, the last two RAIs were completed on 5/2/21 and 6/16/22, not within 366 days of the previous assessment. R-39 was admitted 6/24/22, the RAI was completed late on 8/15/22, not as required in 7-14 days after admission. R-40 was admitted 2/22/23. The RAI was completed on 3/21/23, greater than 7-14 days after admission. R-42 was admitted 5/16/23. The RAI was completed 6/2/23, greater than 7-14 days after admission.		

R-43 was admitted 9/2/20, the RAI was completed on 6/19/22, greater than 366 days from the previous RAI was completed on 6/7/21. R-44 was admitted 10/1/16, the RAI is not accurate as the RAI has the medication assistance scored "2," the care plan states no physical assistance needed. R-47 was admitted 6/3/20, the RAI was completed 6/19/22, greater than 366 days from the previous RAI was completed 6/9/21. R-48 has no RAI for 2022. The RAIs present are dated 3/26/23 and 9/6/21, greater than 366 days apart. R-51 was admitted 8/22/21, the RAI, completed on 9/26/22, scored "2" for medication administration, ISS indicates that R-51 receives assistance with order and set up only. Resident interview confirmed that R-51 is independent with medication administration. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency, and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by		

the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. R-1's ISP completed late 3/27/23 for the RAI completed on 8/15/22. R-2, no ISP for 22. RAI completed on 9/14/22. R-5 has an ISS completed on 11/13/22, instead of an ISP. R-6 has an ISS completed on 11/13/22 instead of an ISP. R-12 was admitted on 11/2/22. R-12 had an ISS completed on 11/17/22, not the required ISP. R-10 was admitted on 12/23/22. The RAI was completed on 1/6/23 with the ISP completed on 3/30/23; not within the required 7 days of completed the comprehensive assessment. R-11 has an ISS completed instead of an ISP on 9/28/22. R-13 has an ISS completed instead of an ISP on 9/6/22. R-14 was admitted 2/22/22. R-14 did not have an ISP completed in 22. The only ISP was completed on 4/18/23. R-20 was admitted to the SLP on 11/15/22. The SLP completed the ISP on 6/14/23 not within the required 7 days of completing the RAI. R-22 has an ISS instead of an ISP completed on 11/11/22.		

R-23 was admitted to the SLP on 12/1/22. The SLP completed the ISP on 2/17/23, not within 7 days of completing the RAI. R-24 has an ISS completed on 10/3/22 instead of an ISP. R-31 has an ISP completed on 2/17/23 instead of ISS, as required. R-32 does not have an ISS completed in 2022, and RSP was completed on 7/16/22. R-33 has an ISP completed on 3/13/23 instead of an ISS, as required. R-34 was admitted on 11/16/22. The SLP completed the ISS on 3/27/23, not within 7 days of completing the RAI. R-39 was admitted 6/24/22. An RSP was completed on 8/21/22 instead of ISP. R-43 has an ISP completed on 6/19/22 instead of ISS, as required. R-46 No ISS was completed for 2022. R-47 has an ISP completed on 6/19/22, instead of an ISS, as required. R-50 was admitted to the SLP on 7/30/19. The ISS was completed 1/10/23, while the RAI was completed on 11/17/22. The ISSs were not completed within 7 days of completing the RAIs.		

R-52 was admitted on 4/17/21. The ISP was completed 8/31/21, while the RAI was completed on 5/14/21, not within 7 days of completing the RAI. **Section 146.245 Assessment and Service Plan and Quarterly Evaluation** e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R-1. Missing Quarterly evaluation around 11/14/22. R-3. Missing quarterly evaluation around 12/14/22. R-6 Quarterly evaluation completed late, greater than 92 days after RAI. RAI dated 11/13/22, quarterly evaluation dated 2/13/23. R-10 was admitted to the SLP on 12/23/22. The SLP did not complete the required quarterly assessment. R-10 was enrolled in Managed Care Organization on 7/1/23. R-12 was admitted to the SLP on 11/2/22. R-12 had a quarterly evaluation completed on 2/22/23, not every 92 days (2/17/23) as required R-13 was admitted to the SLP on 8/23/22. The SLP completed a quarterly assessment on 3/26/23, not within the required 92 days. R-14 was admitted to the SLP on 2/22/22. The SLP completed quarterly evaluations on 8/5/22 and 5/26/23, not every 92 days as required.		

R-23 was admitted to the SLP on 12/1/22. The SLP completed the RAI on 2/17/23 and the quarterly evaluation on 5/26/23, not the required every 92 days. R-35 was admitted 5/6/22, last quarterly evaluations completed 8/5/22 and 11/1/22, not every 92 days. R-36 was admitted 7/20/18, RAI completed on 7/26/22, Quarterly evaluations missing 1/2/23 and 4/3/23. R-38 Quarterly evaluation missing 12/16/23. R-39 12/15/22 Quarterly evaluation missing. R-41 was admitted 5/6/22, quarterly not done every 92 days, only available for 3/26/22 and 6/3/23. **Section 146.295 Emergency Contingency Plan** For the purpose of this Section, "emergency" means an event, as a result of a mechanical failure or natural force such as water, wind, fire or loss of electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the SLF. e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. R-9 was admitted on 1/25/23 and oriented to the emergency plan late on 6/3/23.		

R-10 was admitted to the SLP on 12/23/22. No evidence that R-10 was oriented to the emergency plan within ten days after admission. R-14 was admitted to the SLP on 2/22/22. No evidence that R-14 was oriented to the emergency plan within ten days after admission. R-19 was re-admitted to the SLP on 12/21/22. No evidence that R-19 was re-oriented to the emergency plan within ten days after re-admission. R-20 was admitted to the SLP on 11/15/22. No evidence that R-20 was oriented to the emergency plan within ten days after admission. R-24 was admitted on 10/2/22, R-24 was oriented to emergency plans on 9/30/22, not within 10 days after admission. R-30 was re-admitted on 12/22/22, emergency plans orientation not done for re-admission on 12/22/22.		

Signature of SLP Provider Representative_____Date_____

Resident/Employee Key

Residents

R-1 [redacted]

R-2

R-3

R-4

R-5

R-6

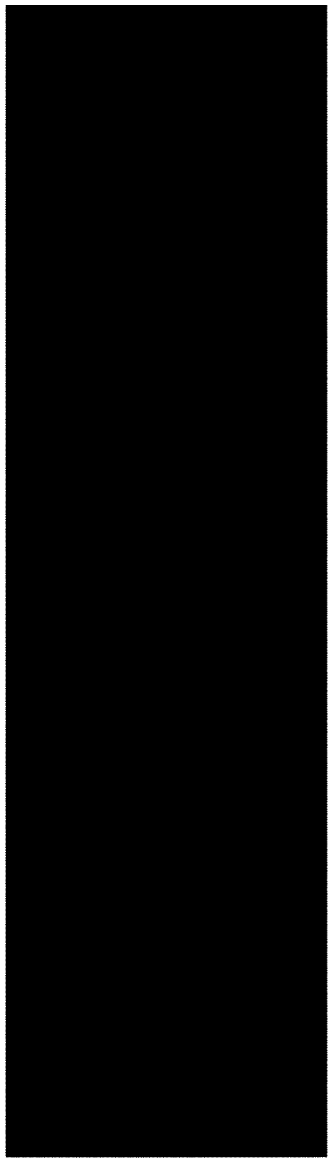
R-7

R-8

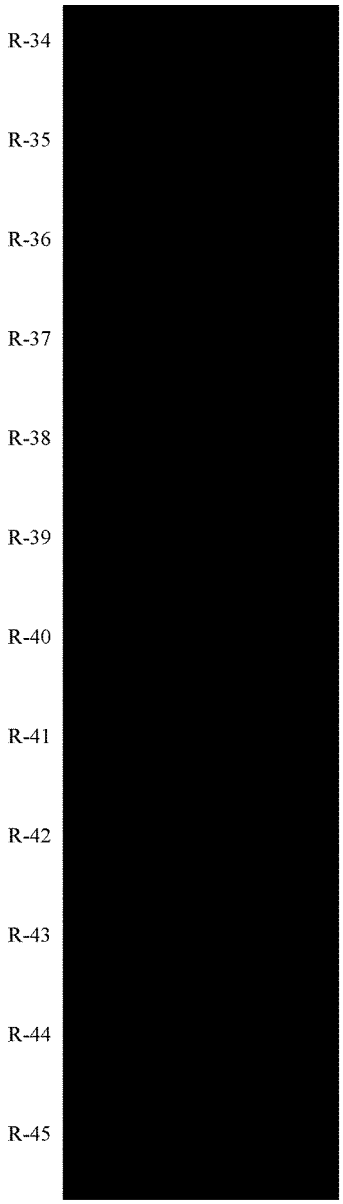
R-9

R-10

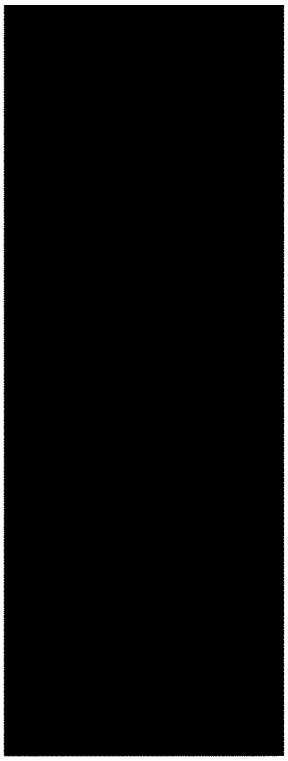
R-11


R-12
R-13
R-14
R-15
R-16
R-17
R-18
R-19
R-20
R-21
R-22


R-23
R-24
R-25
R-26
R-27
R-28
R-29
R-30
R-31
R-32
R-33



93531577.2



Employees

E-1 Name: [redacted]
Position: Housekeeper

E-2 Name: [redacted]
Position: CNA

E-3 Name: [redacted]
Position: CNA

E-4 Name: [redacted]
Position: Receptionist

E-5 Name: [redacted]
Position: CNA

E-6 Name: [redacted]
Position: Dietary Aide

E-7 Name: [redacted]
Position: Business Office Manager

E-8 Name: [redacted]
Position: CNA

E-9 Name: [redacted]
Position: Dietary Aide

E-10 Name: [redacted]
Position: Dietary Aide

E-11 Name: [redacted]
Position: CNA

E-12 Name: [redacted]
Position: CNA

E-13 Name: [redacted]
Position: Housekeeper

E-14 Name: [redacted]
Position: CNA

E-15 Name: [redacted]
Position: Administrator

E-16 Name: [redacted]
Position: Maintenance Director

E-17 Name: [redacted]
Position: Dietary Aide

E-18 Name: [redacted]
Position: Maintenance Assistant

E-19 Name: [redacted]
Position: CNA

E-20 Name: [redacted]
Position: Personal Care Attendant

E-21 Name: [redacted]
Position: DON

E-22 Name: [redacted]
Position: Dietary Aide

E-23 Name: [redacted]
Position: CNA

E-24 Name: [redacted]
Position: CNA

E-25 Name: [redacted]
Position: Personal Care Attendant

E-26 Name: [redacted]
Position: CNA

E-27 Name: [redacted]
Position: CNA

E-28 Name: [redacted]
Position: Move-in Coordinator

E-29 Name: [redacted]
Position: LPN

E-30 Name: [redacted]
Position: CNA

E-34 Name: [redacted]
Position: Dietary Aide

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 9**

SLP NAME: Heritage Woods of Benton

CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES **X** NO ☐

ENTRANCE DATE: 07-31-23 EXIT DATE: 08-31-23

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) INCIDENT FOLLOW UP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

_____	08-31-23
Signature of SLP Provider Representative	Date
_____	08-31-23
Signature of Bureau of Long-Term Care HFSN	Date
_____	_____
Signature of Bureau of Long-Term Care Regional Supervisor	Date
_____	_____
Signature of Bureau of Long-Term Care Area Manager	Date

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
146.220 (a)(4) Resident Participation Requirements: **a) The SLF may admit or retain residents whose needs can be met through the services described in section 146.230. The following criteria shall be met prior to admission to the SLF:** **4) Have named checked against the United States Department of Justice Dru Sjodin National Offender Public Website at** www.nsopr.gov**, the Illinois Sex Offender registration website at** www.isp.state.il.us **and the Illinois Department of Corrections registered sex offender database at** www.idoc.state.il.us Finding R-1 Admission date 11-28-22. Illinois State Police sex offender website and National Sex offender website dated 12-7-22 completed after admission. Illinois Department of Corrections website was checked and was not dated. R-3 No documentation that the Illinois Department of Correction sex offender website was checked. Remediated 8-9-23. R-4 The National Sex Offender website was checked but is not dated.		

R-7 Illinois Department of Corrections sex offender website checked yet the form is not dated. R-12 Illinois Department of Corrections sex offender website checks were done but the form is not dated. The Illinois State Police sex offender website check was not done. Illinois State Police sex offender website check was remediated on-site on 7-31-23. R-15 Admission date 11-30-22. Illinois State Police sex offender website checked and dated 12-7-22, The National Sex Offender website was also checked and dated 12-7-22 both checked after admission date. The Illinois Department of Corrections sex offender website was checked, the form is not dated. **R-17** Illinois Department of Corrections sex offender website was checked, the form is not dated. Illinois State Police sex offender website checked and dated 3-28-23. National Sex Offender website checked and dated 3-28-23, both done timely. **R-21** National Sex Offender website and Illinois State Police sex offender website both checked and dated 2-20-23. Illinois Department of Correction website checked the form is not dated. **R-23** National Sex Offender website checked 9-30-22, Illinois State Police sex offender website checked and dated 9-30-22. Illinois Department of Correction website checked form is not dated. **R-24** National Sex Offender website checked 8-8-22, Illinois State Police sex offender website checked and dated 8-8-22. Illinois Department of Correction website checked form is not dated. **R-25** National Sex Offender website checked 8-15-22, Illinois State Police sex offender website checked and dated 8-15-22. Illinois Department of Correction website checked form is not dated. **R-26** Illinois State Police sex offender website and the National Sex Offender websites checked and dated 2-23-23 prior to		

admission date of 3-3-23. Illinois Department of Correction website checked and is not dated. **R-29** Illinois State Police sex offender website and the National Sex Offender websites checked and dated 3-31-23 prior to admission date of 4-26-23. Illinois Department of Correction website checked and is not dated.		

Signature of SLP Provider Representative: _____ Date: _____

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements, **b) Private pay residents seeking to convert to Medicaid while residing in an SLF shall be screened by the Department using the DON prior to the point of conversion and must be found to be in need of nursing facility level of care before Medicaid payment may be authorized.** **Finding** **R-13** SLF failed to request a screen (DON) from the department (HFS) prior to the point of conversion to verify resident was in need of nursing facility level of care. Facility admit date 8-30-2019. DON date 8-12-2019 score of 42. Medicaid start date 6-1-2022. DON requested by the SLF, and a DON was completed on 8-1-23 and the score was 50. **R-14** Date of application to Medicaid 7-28-23. Previous DON completed prior to admission on 4-5-22 with a DON score of 43. DON is greater than 90days from the date of Medicaid application. SLF admit date 5-5-22 HFS Central office date of admission 8-1-22. A conversion screen was not requested until		

7-31-23. The DON was completed on 8-2-23 and the score was 42. **R-19** Medicaid application date 12-29-22. Medicaid approval back dated to 10-1-22. DON screening prior to the 6-30-22 SLP admission date was 6-20-22 with a DON score of 56. A conversion screen was not requested/completed. SLF requested a conversion screen on 08-03-23. The conversion screen was completed on 08-25-23 and the score was 51.		

Signature of SLP Provider Representative: _____ Date: _____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 5 OF 9**

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements c) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). **Comment with remediation** **R-7** The 2nd TB skin test was read on 5-8-23 which is greater than 48-72 hours from administration date of 5-4-23.	No POC required, repeat the 2 step TB testing for R-7.	

Signature of SLP Provider Representative: _____ Date: _____

93531578.2

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 l) Staffing: **l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical, or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check.**		

Finding **E-3** Hire date 2-6-23, Disclosure and Authorization form signed and dated 2-1-23. Fingerprint obtained by a Livescan vendor 3-23-23 more than 10 working days after form signature. The employee was not suspended or terminated. **E-4** Hire date 6-20-23. Disclosure and Authorization form signed and dated 6-13-23. Fingerprint obtained by a Livescan vendor 7-25-23 more than 10 working days after form signature. The employee was not suspended or terminated. **E-5** Hire date 6-12-23. Disclosure and Authorization form signed and dated 6-8-23. Fingerprints obtained by a livescan vendor 7-24-23 more than 10 working days after form signature. The employee was not suspended or terminated.		

Signature of SLP Provider Representative: _____ Date: _____

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed** by, a registered nurse. Finding with remediation for R-6, R-9, R-10, R-11, and 12 **R-6** On the RAI dated 07-14-23 Section O.1 Participation in Assessment is blank for a- resident, b-family, and c-significant other. **R-9** RAI dated 4-25-23 Section O.1.c. Participation in Assessment "significant other" was left blank. **R-10** RAI dated 8-15-22 Section AA.6. b. "Medicare number" was left blank. **R-11** RAI dated 12-12-22 Section AA6. b. "Medicare number" was left blank. **R-12** RAI dated 8-9-22 Section O.1 "Participation in Assessment" is blank for, a-resident, b-family, c-significant other. **R-28** RAI dated 5-24-23 was completed greater than 14 days from admission date of 4-26-23.		

R-29 RAI dated 5-25-23 was completed more than 14 days from admission date of 4-26-23.		

Signature of SLP Provider Representative: _____ Date: _____

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency, and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** **Finding with remediation for R-3, R-4, R-5, R-15, R-16, R-20, R-23, R-24, R-25, and R-26 ("What is important to me")** **R-3** ISP dated 3-7-23 "What is important to me" is blank.		

R-4 ISP dated 7-13-23 "What is important to me" is blank. **R-5** ISP dated 6-9-23 "What is important to me" is blank. **R-7** The admission ISS is signed by the RN on 7-25-23 which is more than 7 days from the RAI dated 4-25-23. **R-8** ISS dated 1-3-23 completed greater than 7 days from RAI dated 12-19-22. **R-15** ISP dated 12-15-22 "What is important to me" is blank. The ISP dated 12-15-22 is not individualized to address home health services as identified in the care notes, physician orders and as identified in the RAI dated 12-9-22 section N "Special treatment N1f Home care is checked (a) OT is checked and (b) PT is checked. **R-16** ISP dated 12-1-22 "What is important to me" is blank. ISP dated 12-1-22 is not individualized as resident smokes, possibly in apartment and in front of the building, to use the designated smoking area, also set microwave on fire 3-1-23. **R-17** ISP dated 4-27-23 is more than 7 days from the RAI dated 4-18-23. **R-18** ISP dated 3-30-23 was completed greater than 7 days from the RAI dated 3-22-23. **R-20** ISP dated 2-1-23 "What is important to me" is blank. **R-23** ISP dated 11-18-22 "What is important to me" is blank. **R-24** ISP dated 9-9-22 "What is important to me" is blank. **R-25** ISP dated 8-26-22 "What is important to me" is blank. **R-26** ISP dated 3-30-23 is more than 7 days from the RAI dated 3-35-23. "What is important to me" is blank. **R-28** ISP dated 6-2-23 was completed greater than 7 days from RAI dated 5-24-23.		

Signature of SLP Provider Representative: _____ Date: _____

PROVIDER NAME: Heritage Woods of Benton REFERRAL DATE: 08-31-23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.** **Finding** **R-1** Quarterly evaluation dated 6-7-23 is more than 92 days from the quarterly evaluation dated 3-3-23. **R-2** Quarterly evaluation dated 5-18-23 is more than 92 days from the quarterly evaluation dated 2-10-23. **R-3** Quarterly evaluation dated 6-8-23 is more than 92 days from the quarterly evaluation dated 3-2-23. **R-16** Quarterly evaluation dated 5-23-23 is more than 92 days from previous quarterly evaluation dated 2-17-23 **R-17** Quarterly evaluation dated 7-20-23 is more than 92 days from the RAI dated 4-18-23. **R-18** Quarterly evaluation dated 6-22-23 is more than 92 days from the RAI dated 3-22-23.		

R-20 Quarterly evaluation dated 4-29-23 is more than 92 days from the RAI dated 1-27-23. **R-21** Quarterly evaluation dated 7-17-23 is more than 92 days from the RAI dated 3-31-23. **R-22** Quarterly evaluation dated 8-1-23 is more than 92 days from Quarterly evaluation 5-1-23. **R-24** Quarterly evaluation dated 5-25-23 is more than 92 days from Quarterly evaluation dated 2-20-23. **R-25** Quarterly evaluation dated 5-19-23 is more than 92 days from the Quarterly evaluation dated 2-13-23. **R-26** Quarterly evaluation dated 6-16-23 is more than 93 days from the RAI dated 3-15-23. **R-27** Quarterly evaluation dated 6-16-23 is more than 92 days from the RAI dated 3-14-23.		

Signature of SLP Provider Representative_____Date_____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: Heritage Woods of Bolingbrook
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES (X) NO ☐
ENTRANCE DATE: 3-27-19 EXIT DATE: 6-28-21 29 LW

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.
BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____
REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐
BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**
(1st) BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐
(2nd)BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 6/29/21
Date

Signature of Bureau of Long Term Care HFSN Date

29[redacted]

[redacted] 6-28-21
Date

Signature of Bureau of Long Term Care Area Manager Date

Heritage Woods of Coleybrook 3-27-19 Annual

Heritage Woods of Bolingbrook ID Key for 2019 AR
Exit 6-28-21

HERITAGE WOODS OF BOLINGBROOK AR RESIDENT/STAFF IDENTIFIER KEY
March 27, 2019 – June 28, 2019

Resident Key

[redacted]

Heritage Woods of Bolingbrook ID Key for 2019 AR
Exit 6-28-21

Resident Key Continued

[redacted]

STAFF IDENTIFIER KEY

[redacted]

Heritage Woods of Bolingbrook ID Key for 2019 AR
Exit 6-28-21

Staff Key continued

[redacted]

[redacted]

MON -
TUES -

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods of Bolingbrook Annual 3-27-19 REFERRAL DATE: 6-28-21 [redacted]
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services b) Nursing Services 3) Nursing services shall include medication set-up (such as preparing weekly pill caddies with that week's medication) and follow-up care, and shall be conducted by a licensed nurse. This requirement is not met: R2 has order dated 2/1/19 for Lidocaine patch 5% to be applied to the left hip q 12 off and on 12 hours for pain. The med reminder sheet for February 2019 was reviewed. There is no documentation for 2/1/19 through		

2/4/19 to indicate if R2 received the Lidocaine 5% patch as ordered. The nurse's notes were reviewed. A late entry dated 3/29/19 documents that the order was not faxed to the pharmacy until Monday 2/4/19. R2 did not receive the Lidocaine 5% patch until 2/6/19.		

Signature of SLP Provider Representative: [redacted] Date 6/29/21

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods of Bolingbrook Annual 3-27-19 REFERRAL DATE: 6-28-21 [redacted]
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. This requirement is not met: ~~-R8: the RAI dated 11/2/18 was not co-signed by an RN~~ -R11: the RAI dated 1/21/19 has a RN signature but no		

6/4/18

2020 signed + dated.

date. Unable to determine when RAI was signed and completed by an RN. ~~R12; the RAI dated 10/16/18 not dated when it was signed by RN.~~ ~~R13 was admitted 10/29/18, RAI dated 11/11/18 no~~ date to ~~indicate~~ when RN signed it and completed it.		

Signature of SLP Provider Representative [redacted] Date 6/29/21

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods of Bolingbrook Annual 3-27-19 REFERRAL DATE: 6-28-21 [redacted]
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act		

Heritage Woods of Bolingbrook 3-27-19 annual

unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check. This requirement is not met E2 hired 6/19/18, no documentation of 30 day employment verification E3 hired 9/6/18, HCW Registry dated 9/7/18 is 1 day late. No 30 day employment verification E4 hired 1/18/19, no 30 day employment verification E5 hired 2/6/19, no 30 day employment verification E6 hired 7/20/18, no 30 day employment verification E7 hired 8/16/18, no 30 day employment verification E8 hired 10/15/18, no 30 day employment verification E9 hired 10/21/18 fingerprint check 11/3/2018, no 30 day employment verification E10 hire 12/28/18, no 30 day employment verification E11 hired 3/25/19, no 30 day employment verification E12 hired 3/18/19, fingerprint dated 3/20/19, no 30 employment verification		

Heritage Woods of Bolingbrook 3-27-19

E13 hired 12/31/18, no 30 day employment verification **Disclosure and Authorization forms were not completed and signed by all employees prior to beginning work.** E9 hired 10/21/18 did not sign fingerprint authorization forms until 11/3/2018. E12 hired 3/18/19 did not sign fingerprint authorization forms until 3/20/19.		

Signature of SLP Provider Representative [redacted] Date 6/29/21

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods of Bolingbrook Annual 3-27-19 REFERRAL DATE: 06-28-21
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior		

-~~R13: the ISP dated 11/11/18 not signed by R13 or~~ designated representative.

Not all ISPs individualized to each resident's needs.

~~-R2: the RAI dated 9/25/18 codes shopping as 3,~~ transportation and managed finances as 3, ~~manages cash coded as 3, pain coded as 1. All these are not~~ addressed on the ISP.

-R11: ISP dated 1/21/19 does not address how staff communicates with the resident. R11's primary language is Lithuanian.
E20 was interviewed and stated, "R11 uses a phone app that translates Lithuanian to English."
This is not addressed on the ISP.

-R1: the RAI dated 12/21/18 has meds coded as 1, manages finances coded as 2, managed cash coded as 2, laundry coded as 2. All of this is not addressed on the ISP dated 12/21/18.

~~-R4: the ISP is not individualized. The RAI dated~~ 11/13/18 has shopping coded as 2, transportation ~~coded as 2,~~ managing finances coded as 1, manages ~~cash coded as 1. All of this is not addressed~~ on the ISP ~~dated 11/13/18~~.

~~-R3: the RAI~~ dated 8/12/18 has shopping coded as 2, ~~transportation coded as 2, managing~~ finances coded as 2, managing money coded 2, incontinence 1. All of this ~~is not addressed~~ on the ISP dated ~~8/12/19~~.

~~-R8: the ISP~~ dated 11/2/18 ~~does not address the ostomy supplies that the daughter brings on Saturday~~

~~and Sunday. The ISP is~~ not individualized for the ~~resident assessed need for ostomy supplies.~~ -R9: the ISP dated 7/2/18 under medication ~~management~~ indicates R9 needs assistance with medication related to decreased vision. The RAI dated 7/2/18 under Vision coded vision as adequate, no glasses or contacts. ~~-R13: the ISP dated 1/21/19 does not~~ address that R13's primary language is Lithuanian. E20 was interviewed and stated, "Lithuanian ~~is~~ R13's primary language. R13 ~~uses an~~ app on her cell phone to ~~assist~~ with communicating with staff." This is not addressed on the ISP. **ISPs do include coordination and inclusion of services who receive services delivered by an outside entity.** ~~-R5: ISP not individualized. R5 receives~~ Home Health Nursing care for BLE stasis changes, ~~ordered on~~ 12/6/18. This is not address on the ISP dated 12/21/18. -R14: the physician's order dated 3/13/18 are for PT/OT ~~eval~~ and treat, diagnosis OA. Follow up left hip OA with gait disturbance. The physician's orders dated 5/16/19 are for OT eval ~~and treat~~, diagnosis Carpal Tunnel. R14 home health care notes dated 6/28/19 were ~~reviewed~~. R14 receives wound care at the facility for a surgical wound due to hip replacement surgery. Wound care is not addressed on the ISP dated 10/12/18. All of these services are not addressed on the ISP.		

~~R15: the RAI dated 2/22/19~~ indicates R15 is receiving PT/OT. This is not addressed on the ISP dated 2/22/19.		

Signature of SLP Provider Representative [redacted] Date 6/29/21

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods of Bolingbrook Annual 3-27-19 REFERRAL DATE: 6-28-21 [redacted]
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.265 Records and Reporting Requirements c) Medication Error Report: The SLF shall record, and retain in a facility record, all medication errors identified and reported by staff. Errors shall be recorded on a Department designated form. Any medication error resulting in a hospitalization shall be reported to the resident's physician and to the Department within 24 hours after discovery. R2's medication error occurred 2/1/19 – 2/6/19. The medication error report was not done until 3/29/19 after HFS asked if one had been completed.		

R11: Review of the nurse's notes dated 5/16/19 indicate ~~E22~~ informed E21 that she realized she handed R11 her 8pm medications with the 8am medications this morning and R11 took all of them. Physician was notified. Voicemail message was left for POA, but not personally reached. Med error report not complete until 6/29/19 after HFS asked if one had been completed. The facility presented an incident report that does not include what medications were mistakenly given.		

Signature of SLP Provider Representative [redacted] Date 6/29/21

693

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of _2_**

SLP NAME: _Heritage Woods of Centralia_____

Check One:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES X ☐ NO ☐

ENTRANCE DATE: 1/31/23 EXIT DATE: 3/01/23

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: ..... EXIT DATE: .....

COMPLAINT REVIEW **DATE OF COMPLAINT:_____**

REFERRAL DATE:_____REVIEW FINDINGS: YES☐ NO ☐

BEGIN DATE: END DATE:

(X) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(15t) BEGIN DATE: _4/13/23___ END DATE: _4/28/23____

FINDINGS CORRECTED: YES XO NO ☐
(2nd)BEGIN DATE: _____END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page2of_2_**

For non-compliance round during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings fonn to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or tenninate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the fonn to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to detennine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

Date

Signature of Bureau of Long Tenn Care HFSN — Date

Signature of Bureau of Long Tenn Care Regional Supervisor — Date

Signature of Bureau of Long Tenn Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE OF**

PROVIDER NAME: _Heritage Woods of Centralia_____ REFERRAL DATE: _3/01/23_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the correspondin2 identifier key with this form.

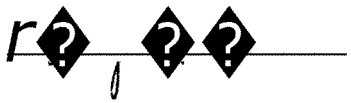
COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
#1 Finding: **Section 146.235 Staffmg f) The SLP provider shall employ certified nursing assistants (CNAs) as follows: 1) Qualifications: Must be 18 years of age or older and have successfully completed no later than 120 days after employment a nursing assistant training course or a Department of Public Health approved equivalent training and competency evaluation.** E-1: Start Date: 12/J5/22. No record of passing the competency exam for a CNA certification on file nor on the IDPH Healthcare Worker website. E-2: Start Date: 10/13/22. No record of passing the competency exam for a CNA certification on file nor on the IDPH Healthcare Worker website.	This plan of correction does not constitute an admission of liability on the part of the provider and such liabi Jity is hereby denied. The submission of this plan does not constitute agreement by the provider that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. (Finding #I: E-1 & E-2) The Regional Director of Health Services will educate and provide an in-service with the Director of Nursing, Staff Nurse, Business Office Manager, and Administrator to review the Certified Nursing Assistant job description and the process of checking and verifying the passing the competency exam for a C.N.A. certification on file and on the IDPH Healthcare Worker website.	On or before 3/3 I /23

#2 Finding: Section 146.245 Assessment and Service Plan and Quarterly Evaluation, c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the **resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** R-5 - RAI dated 8/29/22 was completed greater than 14 days from the admission date of 717122. R-7 - RAI dated 12/1/22 was completed greater than 366 days from the RAJ dated 11/23/21. R-8 - RAI dated 7/29/22 was completed greater than 366 days from the RAI dated 7/15/21. R-9 - RAI dated 7131/22 was completed greater than 366 days from the RAI dated 7/20/21. R-10 RAI dated 6/30/22 was completed greater than 366 days from the RAI dated 6/28/21. R-11 RAI dated 12/1/22 was completed greater than 366 days from the RAI dated 11/ I6/21. R-12- RAI dated 8/27/22 was completed greater than 14 days from the admission date of 6/29/22. R-13 RAJ dated 10/27122 was completed greater than 14 days from the admission date of 10/13/22. R-17 RAJ dated 9/19/22 was completed greater than 14 days from the admission date of7/29/22. R-19 RAI dated 9/9/22 was completed greater than 14 days from the admission date of7/28/22.	(Finding#2: R-5, R-7, R-8, R-9, R-10, R-11, R-12, R-13, R-17, R-19, R-20) The Regional Director of Health Services will educate and provide an in-service with the Administrator and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the Service Plan Policy and Procedure. The Administrator shall complete a quality assurance audit of all RAIs to ensure that they are completed within the appropriate timeframe and co-signed by an RN no less than annually.	 On or before 3/31/23 Immediate and Ongoing

R-20 RAI dated 12/1/22 was completed greater than 14 days from the admission date of 11/4/22. **#3 Finding:** **Section 146.245 Assessment and Sen-ice Plan and Quarterly Evaluation, d) Sen-ice Plan: Within seven days after completion of the RAI, a written sen-ice plan shall be developed** by, **or co-signed by, a registered professional nurse, with input from the resident and his** or **her designated representative. This includes coordination and inclusion of sen-ices being delivered to a resident by an outside entity. The sen-ice plan shall include a description of expected outcomes, approaches, frequency and duration of sen-ices provided and whether the sen-ices will be provided by** licensed or unlicensed staff. The sen-ice **plan** must be **individualized** to **address the health and behavior needs of each resident. The sen-ice plan shall document any sen-ices recommended** by **the SLP provider that are refused by the resident. The sen-ice plan shall be reviewed and updated in conjunction with the quarterly evaluation** or **as dictated by changes in resident needs or preferences.** R-5 ISP dated 9/6/22 was completed greater than 7 days from the RAI dated 8/29/22. R-8 ISP dated 8/6/22 was completed greater than 7 days from the RAI dated 7/29/22. R-14 - ISP dated 10/19/22 was completed greater than 7 days from the RAI dated 10/10/22. R-16 ISP dated 10/19/22 was completed greater than 7 days from the RAI dated 10/11/22. **R-18** ISP dated 12/11/22 was completed greater than 7 days from the RAI dated 11/10/22.	(Finding#3: R-5, **R-8,** R-14, R-16, R-18) Heritage Woods of Centralia shall complete a personalized Residents Service Plan within 7 days of the RAI. The Residents Service Plan shall include coordination of outside services, services with expected outcomes, approaches, frequency, and duration of services. In addition, resident service plans will be individualized to address both health and behavior needs. The Administrator will audit 10% of resident charts monthly to ensure full compliance.	On or before 3/31/23 Immediate and Ongoing

#4 Finding: Section 146.245 Assessment and Sen-ice Plan and Quarterly Evaluation, e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a **Department** designated form shall be completed by, or co-**signed by, a registered professional nurse.** R-1 - Quarterly Evaluation dated 11/28/22 was completed greater than 92 days from the Quarterly Evaluation dated 8/22/22. R-2 -Quarterly Evaluation dated 5/2/22 was completed greater than 92 days from the RAJ dated \/31i22. Quarterly Evaluation dated 8/5/22 was completed greater than 92 days from the Quarterly Evaluation dated 5/2/22. Quarterly Evaluation dated 11/9/22 was completed greater than 92 days from the Quarterly Evaluation dated 8/5/22. R-3 -Quarterly Evaluation dated 9/6/22 was completed greater than 92 days from the RAJ dated 6/1/22. Quarterly Evaluation dated 12/7/22 was completed greater than 92 days from the Quarterly Evaluation dated 9/6/22. R-4 - Quarterly Evaluation dated 12/22/22 was completed greater than 92 days from the Quarterly Evaluation dated 9/16/22. R-6 -Quarterly Evaluation dated 7/11/22 was completed greater than 92 days from the RAI dated 3/30/22. R-13 Quarterly Evaluation dated 2/1/23 was completed greater than 92 days from the RAJ dated 10/27/22. R-14 Quarterly Evaluation dated 1/19/23 was completed greater than 92 days from the RAI dated 10/10/22. R-15 Quarterly Evaluation dated 8/2/22 was completed greater than 92 days from the Quarterly Evaluation dated 4/24/22. R-16 - Quarterly Evaluation dated 1/20/23 was completed greater than 92 days from the RAJ dated 10/11/22.	(Finding #4: R-1, R-2, R-3, R-4, R-6, R-13, R-14, R-15, R-16) The Regional Director of Health Services will conduct an in-service with the Administrator and Licensed Nursing Staff (Director of Nursing and Staff Nurse) on the completion of Quarterly Assessments. The Administrator will audit 10% of resident charts monthly to ensure full compliance.	On or Before 3/31/23 Immediate and Ongoing

700

Signature of SLP Provider Representative:- 

Date 3/11/2013

93531583.2

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider Heritage Woods of Charleston ID # 263678425001

Address 480 W. Polk Ave. Freestanding (X) ~~Rehab NF ( )~~

City Charleston Zip Code 61920

Phone # 217-345-4900 Fax # 217-345-4904

Occupancy Information

# of Single Occupancy Apts.	28	Current Medicaid Census	53
# of Double Occupancy Apts.	40	Current Private Pay Census	8
Total # of Apts.	68	**Total** Current Census	61
Maximum Potential Occupancy	108	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes (X) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (X) No ( )

Type of Certification Review (complete only one)	Entrance Date	Exit Date
Final		
Annual	12/4/23	1/29/24

REVIEW FINDINGS: YES (X) NO ( )

Ombudsman was notified on 12/4/23 about the date of the review.
Ombudsman participated in review: Yes ( ) No (X)

Provider Manager/Designee Signature/Date [redacted]

Review Team's Signature/Date [redacted]

Regional Supervisor Signature/Date _____

Area Manager Signature/Date _____

Bureau Chief Signature/Date _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

1. **Required Certifications/License**
Does the SLP provider have documentation to verify compliance with the following during the past year?

Certification/License	Yes	No	N/A	Comment
Fire 146.210(a)(1)	X			
Local Health and Food Preparation 146.215(c)(5)	X			
Elevator (freestanding 2 or more levels = 1 for 75 or < apartments/2 for 76 or >apartments 146.210(a)(4)	X			
Other (list)				

General Policies 146.230 and 146.310	Yes	No	Comments
2. Is there a policy addressing potential resident inquiry and application for admission? 146.215(c)(4)(S)	[X]	[ ]	[ ]
3. Is there a Non-Discrimination policy? 146.215(c)(4)(T)	[X]	[ ]	[ ]
4. Is there a policy addressing resident rights? 146.215(c)(4)(H)	[X]	[ ]	[ ]
5. Is there a policy(ies) that supports residents' choice of services that meet their needs and preferences? **NOTE:** Examples include residents rights, involvement in assessment and service planning.	[X]	[ ]	[ ]
6. Does the resident discharge policy include relocation assistance? 146.215(c)(4)(I) and 146.255(i)	[X]	[ ]	[ ]
7. If the SLP provider manages residents' funds, is there a surety bond equal to or more than the amount of funds managed? 146.310(b) **NOTE:** Mark N/A if SLP provider is not providing this service. [X] NOT APPLICABLE	[ ]	[ ]	[ ]
8. If the SLP provider manages resident funds, are they kept in an account that is separate from SLP provider funds? **NOTE:** resident funds may ONLY be maintained in an account with other residents' funds. This applies to managed resident funds and direct-deposit of resident income. 146.310(a)(7) and 146.310(c) **NOTE:** Mark N/A if SLP provider is not providing this service. [X] NOT APPLICABLE	[ ]	[ ]	[ ]

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of _11____**

SLP NAME: _Heritage Woods of Charleston_____
CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES X NO ☐

ENTRANCE DATE: 12/4/23 EXIT DATE: 1/29/24

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) INCIDENT FOLLOW UP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of __11___**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted] 1/30/24
Date

Signature of Bureau of Long Term Care HFSN — Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _3___ OF __11___**

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements, a), 2) Be screened by the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON), or successor tool, screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. R-3 was readmitted on 2/27/23 after a greater than 30-day nursing facility stay and a new SLP Initial Screen was not completed.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements, d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R-3 was readmitted on 2/27/23 after a greater than 30-day nursing facility stay. TB testing was not completed within 90 days or initiated within 7 days of admission. R-3's TB testing provided for review was from R-3's previous admission in 2018.		

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _5__ OF __11___**

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing, m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). **Employee Testing not provided for review:** E-2 – Hire date 11/27/23. E-3 – Hire date 11/3/23. E-4 – Hire date 2/3/23. **Employee Testing not initiated within 7 days of hire:** E-5 – Hire date 6/5/23. TB testing initiated 6/14/23. E-6 – Hire date 6/5/23. TB testing initiated 6/14/23. E-8 – Hire date 10/25/23. TB testing initiated 11/6/23.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse. R-4 – The Initial Assessment dated 10/10/23 was completed greater than 24 hours from admission on 9/26/23.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R-3 – RAI dated 3/8/23 documents a 2018 date however R-3 was readmitted after a greater than 30-day nursing facility stay indicating the new admission date of 2/27/23 should be recorded. R-4 – RAI dated 10/17/23 was completed greater than 14 days from admission on 9/26/23. This same RAI contains blanks under Section A.A.4. Race/Ethnicity.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 d) continued: R-5 – ISS dated 11/7/23 was completed greater than 7 days from the RAI dated 9/11/23. R-6 – ISS dated 11/30/23 was completed greater than 7 days from the RAI dated 8/18/23. R-15 – ISP dated 11/8/23 was completed greater than 7 days from the RAI dated 9/11/23. R-17 – ISP due by 7/26/23 was not provided for review. R-17's RAI was dated 7/19/23.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R-7 – QE dated 11/2/23 was completed greater than 92 days from the RAI dated 5/15/23. R-8 – QE dated 8/4/23 was not completed or co-signed by a RN. R-9 – QE dated 4/6/23 and 7/19/23 were not completed or co-signed by a RN. R-10 – QE dated 3/17/23 was not completed or co-signed by a RN. QE dated 12/1/23 was completed greater than 92 days from the RAI dated 6/5/23. R-11 – QE dated 7/19/23 was not completed or co-signed by a RN. QE dated 10/23/23 was completed greater than 92 days from the QE dated 7/19/23. R-12 – QE dated 4/26/23 and 7/19/23 were not completed or co-signed by a RN. QE dated 10/24/23 was completed greater than 92 days from the QE dated 7/19/23.		

PROVIDER NAME: Heritage Woods of Charleston_____ REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 e) Continued: R-13 – QE dated 11/9/23 was completed greater than 92 days from the RAI dated 5/11/23. R-14 – QE dated 12/7/22, 2/13/23 and 4/19/23 were not completed or co-signed by a RN. R-15 – QE dated 2/27/23 and 5/3/23 were not completed or co-signed by a RN. R-16 – QE due by 5/15/23 was not provided for review. R-17 – QE dated 10/24/23 was completed greater than 92 days from the RAI dated 7/19/23. R-19 – QE dated 7/19/23 was completed greater than 92 days from the RAI dated 4/12/23. QE dated 10/25/23 was completed greater than 92 days from the QE dated 7/19/23.		

Signature of SLP Provider Representative_____Date_____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING FACILITY (SLF)
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 4**

SLF NAME: Heritage Woods at Chicago
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

(x) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES X☐ NO ☐

ENTRANCE DATE: 9/13/21 EXIT DATE: 4/11/22

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLF)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of facility residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS Page 2 of 4

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLF within ten working days after the conclusion of the on-site review. The SLF must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLF's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLF within five working days after the conclusion of the on-site review. The SLF should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLF has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate the SLF's provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLF within ten working days after the conclusion of the on-site review. The SLF should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLF unless there is justification documented by the SLF. Within those 30 days, the SLF is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLF within 10 working days of the SLF's notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the facility is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

4-12-2022
Date

4/11/22
Date

4/11/22
Date

Signature of Bureau of Long Term Care Area Manager

Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 3 OF 4**

SLF NAME: HERITAGE WOODS REFERRAL DATE: 9/13/21
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section: 146.235(I) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or financial, medical, or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act(225ILCS 46) . This requirement has not been met as evidenced by: E1 start date was 5/7/20, HWC Registry was completed late on 11/24/20.	Correct start date for E1 was 12-1-2020.	4/12/2022

Signature of SLF Representative [redacted] Date 4/12/2022

716

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING FACILITY (SLF)
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 4**

SLF NAME: Heritage Woods at Chicago

CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

(x) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES X☐ NO ☐

ENTRANCE DATE: 9/13/21 _____ EXIT DATE: 4/11/22_____

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLF)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of facility residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:**_____

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLF within ten working days after the conclusion of the on-site review. The SLF must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLF's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLF within five working days after the conclusion of the on-site review. The SLF should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLF has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate the SLF's provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLF within ten working days after the conclusion of the on-site review. The SLF should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLF unless there is justification documented by the SLF. Within those 30 days, the SLF is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLF within 10 working days of the SLF's notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the facility is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

4-12-2022
Date

4/11/22
Date

4/11/22
Date

Signature of Bureau of Long Term Care Area Manager

Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 3 OF 4**

SLF NAME: HERITAGE WOODS REFERRAL DATE: 9/13/21
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section: 146.235(I) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or financial, medical, or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act(225ILCS 46) . This requirement has not been met as evidenced by: E1 start date was 5/7/20, HWC Registry was completed late on 11/24/20.	Correct start date for E1 was 12-1-2020.	4/12/2022

Signature of SLF Representative [redacted] Date 4/12/2022

719

HERITAGE WOODS OF DWIGHT	701 E. Mazon Dwight, IL 60420 Phone: 815-584-9280 Fax: 815-584-9283

FAX

To: [redacted] From: [redacted]

Fax: 815-939-8187 Pages: 25

Phone: 815-584-9280 Date: 6/8/23

Re: CC:

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply

Heritage Woods of Dwight
Plan of Correction
from 10/24/22 Annual Survey

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 3 OF 16

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.220 Resident Participation Requirements a) 4) Have name checked against the United State Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.ua and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears in either registry is admitted to an SLF. Late/untimely DOC parolee search for: R4, R7, R8, R9, R16, R17, R20, R22, R23, R24, and R32. R7-late State Police and Dept of Justice offender checks. R30-late background checks.	See attached for response	6/25/23

[redacted] 6/8/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.220 Resident Participation Requirements

4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following SLF Regulations and applicable Gardant Management Solutions policies.

The Marking Director will be in service by the Administrator to ensure all residents' background checks are done completely and in a timely manner. All background checks performed will be printed with the time and date stamps on them and put into the resident office file.

A QA Study will be conducted to monitor compliance for all move-ins from 06/2023 through 09/2023 with any necessary follow up actions taken to ensure compliance. The Administrator will assure compliance.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R1 admitted 3/3/21. 1st step was administered 4/27/21 and read 4/30/21. 2nd step administered 5/7/21 and read 5/10/21. R1 also did not have a signs/symptoms checklist completed within 7 days after admission. R4 was admitted 3/11/21. 1st step was given 3/31/21 and read 4/3/21. 2nd step given 4/12/21 and read 4/15/21. 2nd step was read late. R17 was admitted 12/14/21. 1st step not completed timely. R17 tested positive for Covid-19 and was in quarantine beginning 12/16/21. 2nd step not initiated until 3/12/22 and read 3/21/22. Signs/symptoms checklist not completed within 7 days after admission. [redacted]	See attached for response 6/8/23	6/25/23

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.220 Resident Participation Requirements d) Continued R22's sign/symptoms checklist completed 5 days prior to admission. R23's 1st and 2nd steps were administered timely, but neither have documented read dates/results. R24's 2nd step was not completed. R32 was admitted 1/16/22. R32's 1st step results did not include the date read. 2nd step was not completed. Signs/symptoms checklist completed on 10/24/22.		

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Section 146.220 Resident Participation Requirements
146.220 (d)Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Il. Adm. Code 696).

Correction Date: 6/25/2023

There were no ill effects suffered by residents because of this finding. Heritage Woods of Dwight is committed to following the SLF Regulations and applicable Gardant Management Solutions policies.

Director of Nursing, Staff Nurse will be in-serviced by Administrator on the TB Skin Test and Follow Up for all new residents in accordance with the Control of Tuberculosis Code. The in-service will emphasize the importance of timely completion of 2-step Testing/Follow-Up or documentation of previous 2-step Testing/Follow-Up within 90 days prior to move-in. All cited residents will be reviewed as appropriate to ensure proper follow up and documentation of the Tuberculin skin tests in accordance with the Control of Tuberculosis Code.

A QA Study will be conducted to monitor compliance for all move-ins from 6/2023 through 06/2024. QA Study will include ensuring that timely completion and documentation is maintained regarding receipt of 2-step Testing/Follow-Up for all new residents. The Administrator will monitor all of the above for completion.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.230 Services n) Daily Check: The SLF shall implement a system to check on the welfare of each resident daily. Daily checks were not documented on multiples dates in April and May 2022 for the following residents: R8, R12, R14, R15, R17, R18, R27, R18 and R31.	See attached for response	6/25/23

[redacted] 6/8/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.230 Services
n) Daily Check the SLF shall implement a system to check the welfare of each resident daily.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following the SLF Regulations and applicable Gardant Management Solutions policies.

The Director of Nursing and staff Nurse will be in-serviced by the Executive Director on Daily Check Regulation/Policy to check on the welfare of each resident daily. The Director of Nursing shall check the Daily Wellness records on a routine basis to assure accurate and timely completion, taking any necessary corrective actions based upon the review.

A QA Study will be conducted through 09/2023 to ensure compliance that Daily Check Records are completed and recorded with no blank spots. The Administrator will monitor all of the above for completion.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.235 Staffing e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLF shall make changes in training materials. **1) The SLF shall provide staff and subcontractors who provide direct care with:** **A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment.** E13, E16, E17, E18, and E19 did not have training related to their employment documented within 30 days of hire. E14, E15, E20, and E21 did not have documentation of semi-annual training related to their employment. [redacted]	See attached for response 6/8/23	6/25/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.235 Staffing

Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials.

1) The SLP setting shall provide staff and subcontractors who provide direct care with:

A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following SLF Regulations and applicable Gardant Management Solutions policies.

The Department Managers will be in service by the Administrator to ensure all employees' new training is done completely and in a timely manner. As well as all employees having documented proof of semi-annual training related to their department.

A QA Study will be conducted to monitor compliance for all employees training to be completed timely and accurately from 06/2023 through 12/2023 with any necessary follow up actions taken to ensure compliance. The Administrator will ensure compliance.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.235 Staffing l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check. E1, E3, E4, E5, E6, E7, E9 and E11 did not have their employment verified within 30 days of their start date. The HCW Registry was not checked for E10 prior to their start date.	See Attached for response	6/25/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.235 Staffing

l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical, or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following SLF Regulations and applicable Gardant Management Solutions policies.

The Business Office will be in service by the Administrator to ensure all employees' employment verifications are done completely and in a timely manner. As well as ensuring the HCW registry is checked in a timely manner.

A QA Study will be conducted to monitor compliance for all new employees from 06/2023 through 09/2023 with any necessary follow up actions taken to ensure compliance. The Administrator will ensure compliance.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). E1, E2, E5, E8, E10, E11, E13: TB test administered or read late.	See attached for response [redacted] 6/8/23	6/25/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.235 Staffing
m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

There were no ill effects suffered by residents or staff as a result of this finding. Heritage Woods of Dwight is committed to following the SLF Regulations and applicable Gardant Management Solutions Policies.

Director of Nursing, Staff Nurse and all Department Managers will be in-serviced by Administrator on the TB Skin Test and Follow Up for all new employees in accordance with the Control of Tuberculosis Code. The in-service will emphasize the importance of timely completion of 2-step Testing/Follow-Up or documentation of previous 2-step Testing/Follow-Up within 90 days prior to hire. All cited and new employee files shall be checked to ensure accurate documentation of the Tuberculin skin tests.

A QA Study will be conducted to monitor compliance for all new hires from 06/2023 thru 06/2024. QA Study will include ensuring that timely completion and documentation is maintained regarding receipt of 2-step Testing/Follow-Up for all new hires. The Administrator will monitor all of the above for completion.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by a registered nurse.** R2--RAI dated 3/1/22 completed greater than 366 days from the previous assessment done on 1/19/21. R6—Admitted 2/18/22. RAI dated 4/11/22 was not timely. Section AA.4 was blank. R7--Admitted 3/30/22. RAI dated 5/25/22 was not timely. Section E (mood/behavior) was blank. R8—Admitted 4/1/22. RAI dated 5/25/22 was not timely. Sections AA.4, A.3, A.5 and E were blank. [redacted]	See attached for response 6/8/23	6/25/23

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment Continued** R9—Admitted 6/4/22. RAI dated 9/2/22 was not timely. Section AA.4 was blank. R19—RAI dated 10/28/22 was >366 days from the previous assessment done on 10/12/21. R19—RAI dated 10/28/22 was >366 days from the previous assessment done on 10/12/21.		

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.245 Assessment and Service Plan and Quarterly Evaluation146.245(c)
c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following the SLF Regulations and applicable Gardant Management Solutions policies.

The Director of Nursing and Staff Nurse will be in-serviced by Regional Director of Clinical Services of Gardant Management Solutions on timely completion of RAI for all residents (new residents within 7-14 days after admission and current residents within 366 days of previous RAI). The in-service will also emphasize that all areas are completed thoroughly. The cited residents shall be checked with any necessary corrective actions where appropriate.

A QA Study will be completed thru 09/2023 by DON and Staff Nurse to ensure compliance taking any necessary corrective actions based upon review. Administrator will monitor compliance ongoing.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/22/23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** R6—2022 ISP does not address personal goals.	See attached for response	6/25/23

[redacted] 6/8/23

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/22/23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Continued** R7—2022 ISP does not address personal goals. R7 did not initial that they received a copy of resident rights. R8—2022 ISP, R8 did not initial that they received a copy of residents rights. R17—2021 ISP, R17 did not mark if they chose/did not choose to receive services from the SLP provider. R17 did not initial that they received a copy of residents rights. R18—Admitted 9/27/21. An ISP was not completed. R23—Admitted 10/7/21. ISP was not completed. An ISS was completed on 10/29/21, but R23 was not enrolled in managed care. R24--ISP did not include personal goals.		

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/22/23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Continued** R25--ISP had both boxes checked for "I do wish to receive services", and I do not wish to receive services". R27---R27 signed their ISP 2/7/22. The RN did not sign until 9/1/22. R29--ISP had both boxes checked for "I do wish to receive services", and "I do not wish to receive services". R30-- ISS completed late on 10/12/22. RAI completed 8/25/22. R32--ISP had both boxes checked for "I do wish to receive services", and "I do not wish to receive services.		

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.245 Assessment and Service Plan and Quarterly Evaluation
d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following the SLF Regulations and applicable Gardant Management Solutions policies.

The Director of Nursing and Staff Nurse will be in-service by the Regional Director of Clinical Services of Gardant Management Solutions on appropriate and timely completion of ISPs for all residents. The in-service will emphasize thorough completion including individualized service plans for every resident including areas important to the resident. The in-service will also emphasize the importance of appropriate signatures and with required dates as well as ensuring the resident has received the resident's right information and understands what they are checking and signing.

R-18 ISP is completed.
R23 is enrolled into straight Medicaid, no managed care therefore the ISP was completed.

A QA Study will be completed thru 09/2023 by DON and Staff Nurse to ensure compliance taking any necessary corrective actions based upon the review. Administrator will monitor compliance ongoing.

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/22/23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: a quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse. This requirement is not met as evidenced by: missing/untimely quarterlies for R5, R6, R7, R8, R19, R23 and R26.	See attached for response	6/25/23

[redacted] 6/8/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/2023

Section 146.245 Assessment and Service Plan and Quarterly Evaluation
146.245(e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following the SLF Regulations and applicable Gardant Management Solutions policies.

The Director of Nursing and Staff Nurse will be in-serviced by Regional Director of Clinical Services of Gardant Management Solutions on appropriate and timely completion of Quarterly Evaluations for all residents. The Director of Nursing shall review cited residents for the necessary updates where indicated.

A QA Study will be completed through 09/2023 by DON and Staff Nurse to ensure compliance. The DON will take any necessary corrective actions based upon outcomes of the review. Administrator will monitor compliance ongoing.

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 16 OF 16

SLF NAME: Heritage Woods of Dwight REFERRAL DATE: 10/24/22

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.295 Emergency Contingency Plan e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. R1, R17, R20, R23, R24, and R30 did not have documentation of orientation within ten days of admission to the emergency plan.	See attached for response	6/25/23

Signature of SLF Representativ [redacted] Date 6/8/23

Heritage Woods of Dwight

SLF Response to Findings from 10/24/22

Correction Date: 6/25/23

Section 146.295 Emergency Contingency Plan
e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.

There were no ill effects suffered by the residents as a result of this finding. Heritage Woods of Dwight is committed to following SLF Regulations and applicable Gardant Management Solutions policies.

The Marketing Director will be in service by the Administrator to ensure all residents are provided with information on Emergency Plans including identifying and using emergency exits. This information will be provided to new residents upon move-in. Acknowledgement of receipt of information will be documented on Resident Orientation Checklist.

Residents noted in finding as not having received information upon move-in will receive information on Emergency Plan. A QA Study will be conducted to monitor compliance for all move-ins from 06/2023 through 09/2023 with any necessary follow up actions taken to ensure compliance. QA Study will include ensuring that documentation is maintained regarding receipt of information by residents. The Administrator will assure compliance.

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

ProviderJ-\1.ir; e. WoOl)l hDt4 ID #d. fq'1').fj l.JObl

Address /003 W.a.fh:f' Freestanding (A_) Rehab NF ( )

city Fro."tt Zip Code LJ()\9-J'Gf

Phone # /:/?- :.- L/--\qJ Fax# LJ./?-1/lJ) • - ?1

Occupancy Information

# of Sin	2-	Current Medicaid Census	37
# of Double Occupancy Aots.	/ I)	Current Private Pay Census	14
Total # of Ants.	52	**Total Current Census**	51
Maximum Potential Occupancy	62		

Is the private pay rate higher than the Medicaid rate? Yes (() No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (;(.) No ( )

Type of Certification Review , complete only one	**Entrance Date**	**Exit Date**
Final		
Annual	5/16/23	5/18/23

REVIEW FINDINGS: YES ( ) NO <X)

Ombudsman was notified on S/n.lo:3 _about the date of the review.
Ombudsman participated in review: Ye_(•) No ( )

Provider Manager/Designee Signatu [redacted]

Review Team's Signature/Date

Regional Supervisor Signature/Date

Area Manager Signature/Date _____

Bureau Chief Signature/Date _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
SPONS TO ON-S_!,.TE REVIEW FINDINGS **Page 1 of -3,__**

SLP NAME: .1 JI'.0
CHECK ON

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

9(**ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO **pt'**

ENTRANCE DATE: _ _ffiii,,-_J_ EXIT DATE: .5/;,g/d-?

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: ..... EXIT DATE: .....

()**COMPLAINT REVIEW** **DATE OF COMPLAINT:_____**

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES☐ NO☐

BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

(2nd)BEGINDATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

DEPT OF HEALTHCARE AND
FAMILY SERVICES
BUREAU OF LONG TERM CARE
200 S WYMAN ST #307C
ROCKFORD, IL 61101
815-987-7731 Direct OFFICE
Fax: (217) 557-5061

facsimile transmittal

To: [redacted]HW Freeport Fax: 815/801-3901 Manager

From: HFS BLTC ROCKFORD REG Date: 2-1-24

Re: 23 Annual REview Pages: 10 pages to Follow

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

CONFIDENTIAL

Please sign page 2 of 2 and page 8 of 10 and return to me. A plan of correction is due within 14 days and must be completed within 30 days. Call if questions.

Lori Wojciechowski 815 987 7731

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: HW Freeport Annual review 7-2-23
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐ ENTRANCE DATE: 7-2-23 EXIT DATE: 2-1-24
( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)** Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff. BEGIN DATE: _____ EXIT DATE: _____
( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____ **REFERRAL DATE:** _____ **REVIEW FINDINGS:** YES ☐ NO ☐ BEGIN DATE: END DATE:
( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW** (1st) BEGIN DATE: _____ END DATE: _____ FINDINGS CORRECTED: YES ☐ NO ☐ (2nd)BEGIN DATE: _____ END DATE: _____ FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative	Date
Signature of Bureau of Long Term Care HFSN	Date
[redacted]	2/1/24 Date
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: HW Freeport AR REFERRAL DATE: 2-1-24
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. R1 admit 12/12/22. RAI 12/27/22 >14 days. R2 admit 8/31/22. RAI date 9/21/22. >14 days.	1. In Service provided by Regional Director of Health Services to review Assessment and Service plan protocol 2. QA audit tool and reporting to maximize compliance in timeliness and accuracy for a 3 month period. 3. DON and ED to perform weekly audits and ensure each RAI has been completed w/in 14 days of admission, annually and upon a significant change in the residents's mental and physical status. Audit will include dates are accurate and signatures are present as required. A QA/QI Report of findings and action plan at monthly Quality meeting.	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) R3 admit 6/15/22 RAI date 7/30/22. Late R3 admit 2/1/22. RAI date 3/2/22. Late R4 admit 7/18/22. RAI 8/25/22. RAI > 14 days. R7 admit 11/11/22. RAI date 12/5/22. >14 days. R9 admit 7/27/22. RAI 8/25/22. Late >14 days. R10 admit 2/28/23. RAI date 3/15/23. >14 days. R11 admit 3/22/23. RAI 4/18/23. >14 days. R13 admit 6/7/22. RAI date 7/12/22. >14 days. R14 admit 12/2/22, RAI 12/18/22. Late >14 days. R15 admit 2/1/22, RAI date 2/22/22. >14 days. R 17 admit 1/14/22. RAI 2/22/22 and 2/20/23. >14 days. R19 admit 11/16/22. RAI date 12/5/22. >14 days. R20 admit 1/17/22. RAI 2/2/22. >14 days. R21 admit 12/28/21. RAI 2/4/22. Late. R22 admit 12/14/22. RAI 12/30/22. >14 days. R23 admit 6/20/22. RAI 8/15/22. > 14 days. R24 admit 7/8/19. RAI date 7/22/21 and 8/12/22. RAI annual longer than 366 days.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. **ISP/ISS:** R7 admit 11/11/22. ISP date 1/19/23. Late R9 admit 7/27/22. RAI date 8/25/22. ISP 9/26/22. Late. R10 admit 2/28/23. ISP done 4/5/23. Late R27 admit 2/14/23. RAI 2/28/23. ISP date 3/30/23. Late.	1. In Service provided by Regional Director of Health Services to review Assessment and Service plan protocol 2. QA audit tool and reporting to maximize compliance in timeliness and accuracy for a 3 month period. 3. DON and ED to perform weekly audits and ensure each Service Plan has been completed w/in 7days of RAI, and includes coordination and inclusion of services being delivered toa resident by an outside entity. Audit will include dates are accurate and signatures are present as required. A QA/QI Report of findings and action plan at monthly Quality meeting.	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: R28 admit 10/19/22. ISP date 1/18/23. Went MCO 12/1/22. R29 admit 11/1/21. Went MCO on 4/1/22. ISS dated of 5/15/23. Late R30 admit 10/5/22. RAI 10/19/22. ISS done 12/21/22. Late. R1 admit 12/12/22. ISS date 4/4/23. Late R19 admit 11/16/22. ISS date 1/10/23. Late R21 Admit 12/28/21, RAI 2/4/21, ISS 2/28/22. Late R31 admit 9/1/17. RAI date 3/14/22 and 2/22/23. ISP date 3/13/23. ISP done > then 7 days past RAI. R32 admit 3/7/19. RAI date 3/19/22 and 3/2 23. ISP date 6/29/23. > 7 days.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse. R3 admit 6/15/22, RAI date 7/30/22, Quarterly dates 10/20/22, 3/8/23, and 6/1/23. Quarterly done > then 92 days. R3 admit 2/1/22. RAI 3/2/22. Quarterly dates 10/20/22, 3/8/23, and 6/1/23. Quarterly late. R7 admit 11/11/22. RAI 12/5/22. Quarterly date 3/7/23. Late R8 admit 2/17/20. RAI 3/3/20, Quarterly dates 6/14/22, 8/2/22, and 12/23/22. Late. R9 admit 7/27/22. RAI 8/25/22. Quarterly dates 12/5/22. Late. R11 admit 3/22/23. RAI 4/18/22. Quarterly dates 8/8/22, 11/5/22, and 7/3/23. Late. R17 admit 1/14/22. MCO on 7/20/22. No quarterlies found. R26 admit 1/17/19. RAI date 2/15/22, 2/15/23. Quarterly dates 6/1/22, 9/1/22, and 12/1/22. 1st Quarterly is late.	1. In Service provided by Regional Director of Health Services to review Assessment and Service plan protocol 2. QA audit tool and reporting to maximize compliance in timeliness and accuracy for a 3 month period. 3. DON and ED to perform weekly audits and ensure each Quarterly Evaluation has been completed using department designated form by or co-signed by a registered nurse and and signatures are present as required. A QA/QI Report of findings and action plan at monthly Quality meeting.	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse. **Initial Assessment:** R3 admit 2/1/22. Assessment not done. R15 admit 2/1/22, no date or signature. R23 admit 6/20/22. Initial Assessment done on 6/22/22. 2 days late.	1. In Service provided by Regional Director of Health Services to review Assessment and Service plan protocol 2. QA audit tool and reporting to maximize compliance in timeliness and accuracy for a 3 month period. 3. DON and ED to perform weekly audits and ensure each initial assessment and service plan within 24 hours after admission identifying needs and potential immediate problems by or co-signed by a registered nurse and and signatures are present as required. A QA/QI Report of findings and action plan at monthly Quality meeting.	

Signature of SLP Provider Representative_____Date_____

86

HW Freeport 7/3/23

Employee and Resident Key.

6/4/18

86

HW Freeport 7/3/23

6/4/18

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0545
Toll Free: (844) 528-8444
TTY: (800) 526-5812

FAX

To: [redacted] HW Gurnee Manager	**From:** Lori Wojciechowksi PSA HFS
Fax: [redacted]	**Date:** 1-27-23
Re: Findings for 9-17-20 complaint	**Pages:** 30 following

X **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please**

A plan of correction is due within 14 days and must be completed within 30 days. Please sign page 21 of 28 and page 107 and return to me.

Fax# is **(217) 557-5061**

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: [redacted]
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐

ENTRANCE DATE: 9-12-22 EXIT DATE: 1-27-23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS Page 2 of 2

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative	Date
Signature of Bureau of Long Term Care HESN [redacted]	Date
	01-27-23 Date
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: HW of Gurnee AR 09-2022 REFERRAL DATE: 1-27-23
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing **m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** E1: hire 12/2/21. TB 1st step 7/18/22-7/20/22, 2nd step 7/26/22-7/28/22 Neg results. E2: hire 12/10/20. TB 1st step 7/18/22-7/20/22 2nd step 7/25/22-7/27/22, neg results. E3: hire 7/27/20. TB 1st step 11/11/20-11/14/20 2nd step 11/30/20-12/8/20 neg results.	1. **Regional Director Health Services In-Service Nursing Staff on TB compliance program for employees** 2. **Monthly audit completed by Director of Nursing or designee monthly** 3. **Audit results shared at monthly QA Meeting for at least 6 months**	

Section 146.235 Staffing e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) A) and B) Continued: **The following employees did not have all of the required orientation training.** E22: E23: E15: E24: E14: E25: E26: E17: E8: E10: E28: E29:		

Section 146.235 Staffing e) 1) A and B) Staff Training E30: E31: E13: E4: E32: E1: **The following employees did not have all of the required annual training:** E34: E35: E36: E37: E38: E39: E40: E41:		

Section 146.235 Staffing e) 1) A and B) Staff Training **Staff that have not had semi-annual training in areas related to their employment;** E29, E30, E23, E37, and E42		

Section 146.295 Emergency Contingency Plan			
e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. The following residents were not oriented to the emergency plans within 10 days of admission. R1: R2: R3: R4: R5: R6: R7: R8: R9: R10: R11: R12: R13: R14:			

Section 146.295 Emergency Contingency Plan e) Continued: R15: R16: R17: R18: R19: R20: R21: R22: R23: R24: R25: R26: R27: R28: R29: R30: R31: R32:		

Section 146.295 Emergency Contingency Plan e) Continued		
R33:		
R34:		
R35:		
R36:		
R37:		
R38:		
R39:		
R40:		
R41:		
R42:		
R43:		
R44:		
R45:		
R46:		
R47:		
R48:		
R49:		
R50:		

6/4/18 86

Section 146.295 Emergency Contingency Plan e) continued		
R51:		
R52:		
R53:		
R54:		
R55:		
R56:		
R57:		
R58:		
R59:		
R61:		
R62:		
R63:		
R64:		
R65:		
R66:		
R67:		
R68:		
R69:		

Section 146.220 Resident Participation Requirements **d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** **The following residents did not have a TB test completed or it was not timely:** R12: admit 8/23/21. TB 1st step started on 7/6/21. The TB test was not completed. R18: admit 7/29/19 No TB was completed. R15: admit 7/18/19 1st step TB 8/3/19-8/6/1 2nd step 8/6/19-8/10/19 late R10: admit 11/8/20 No TB completed. R61: admit 12/28/20 No TB test was completed. R3: admit 9/20/21. No TB was completed. R72: admit 10/31/20. No TB was completed. R46 admit 2/4/21. No TB was completed. R51: admit 4/1/21. TB started 1/26/21. TB test was not completed. R48: admit 2/1/19. TB 1st step given 1/19/19-1/21/19. No 2nd step started.		

Section 146.220 Resident Participation Requirements **d) continued** R41: admit 10/9/20. TB test not completed. R65: admit 10/1/21. TB 1st step started 8/15/21 but not read. 2nd step given 8/26/21 but not read. R38: admit 2/8/19. TB not completed. R73: admit 2/4/21. TB not completed. **TB Signs and Symptoms Check List:** R10: no signature on TB signs and symptom checklist. R38: admit 2/8/19. Signs and Symptoms checklist not completed. FFS New		

Section 146.220 Resident Participation Requirements 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting **This requirement is not met for the following residents:** R10: admit 11/8/20. Sex Offender check not checked until on 9/15/22. R16: admit 9/2/21. Sex Offender not checked until 9/6/22. R72: admit 10/31/20. Sex Offender not checked until 10/7/22. R51: admit 4/1/21. Sex Offender not checked until 10/5/22.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. **This requirement is not met for the following residents:** ***Fee For service (FFS)** R23: RAI date 11/23/21 Quarterlies dated 2/3/22 and 5/2/22. Missing quarterly for August 2022. FFS. R15: RAI 8/15/19. Quarterly dates 11/12/19, 2/6/20, 5/14/20. 3rd quarterly late. FFS. R11: RAI 11/7/20, Quarterlies dated 2/6/21, 5/11/21 (late), and 8/6/21. FFS. R4: RAI 11/8/19, quarterlies 2/3/20, 5/20/20, and 8/13/20. 2nd is late. FFS. R73: admit 2/4/21, RAI 2/17/21 Quarterlies date 5/11/21 and 10/28/21 late. FFS. R8: admit 2/14/22. RAI dates 2/24/22 and 8/8/22. No Quarterlies done. R8 is a Fee for Service New admit.		

RAI: Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R14 admit 12/16/21, RAI dated 1/3/22. late. R15: admit 7/18/19. RAI date 8/15/19. LATE R11: SLF admit date 10/19/20. RAI date 11/7/20. RAI late R9: admit 3/28/21. RAI 4/14/21 late. R10: admit 11/8/20, RAI 12/15/20, late and has no signature.		

RAI: Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. This requirement is not met: R9: no ISP available. FFS New admit. R10: admit 11/8/20 ISP not done until 11/26/20. FFS New admit. R38: admit 2/8/19 no ISP or ISS completed. R13: admit 12/29/21, no ISP completed only an ISS dated 2/2/22. FFS New admit. R20: admit 12/31/21 no ISP only an ISS dated 2/7/22. FFS New admit. R73: admit 2/4/21. No ISP. ISS dated 2/7/21. FFS New admit.		

RA1: Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan R34: admit 3/12/22. ISS 3/25/22 only, no ISP. FFS New admit. R32: admit 10/23/20. no ISP done. FFS New admit. R31: admit 1/20/22. ISS 2/8/22 only, no ISP done. Fee for Service New admit.		
6/4/18	86	

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 2) Be screened by the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON), or successor tool, screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. If the individual is transferring directly from a nursing facility and has a history of a developmental disability or serious mental illness, as evidenced in the medical history accompanying the individual, the SLP provider must submit a referral for a specialized evaluation to be completed by the DHS Division of Developmental Disabilities (DHS-DDD) Independent Service Coordination (ISC) agency or the Division of Mental Health (DHS-DMH) Preadmission Screening Resident Review (PASRR) agency to evaluate for need for active treatment or the existence of serious functional risks and needs associated with the diagnosis to determine if they exceed the capacity of the SLP setting. Private pay individuals may choose to be admitted into the SLP setting when the screening assessment does not justify nursing facility level of care;		

Section 146.220 Resident Participation Requirements a) 2) continued **DON Screen Issues:** R72: admit 10/31/20. The DON screen for R72 was not in the chart. The SLF had no record of having one done. The SLF called the CCU and they had no record of a DON screen for R72. R33: admit 8/30/21. Resident did not have a DON Screen done until 9/7/21. R33 came from a private home. R22: admit 2/2/22. Front office reported resident was admitted as private pay on 10/27/21. Resident converted on 2/2/22. There was no DON score.		

Signature of SLP Provider Representative_____Date_____

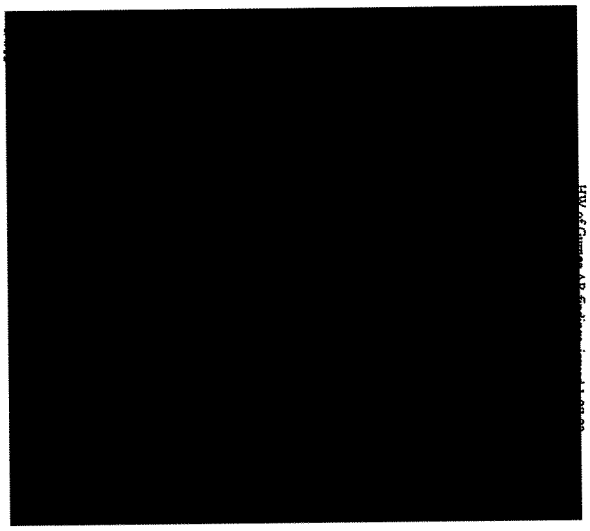
777

HW of Gumee AR findings, issued 1-27-23

Identification Key

Employee ID Key

86



86

[redacted]

[redacted]

86

HW of Grimes AP findings issued 1-27-23

[redacted]

6/4/18

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 1__ OF _17_ _**

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.215 SLF Participation Requirements **(o) The SLF shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests. The SLF shall provide all residents with information about advance directives, including the Durable Power of Attorney for Health Care, Statement of Illinois Law on Advance Directives, Living Will, Declaration for Mental Health Treatment and Do Not Resuscitate Advance Directive. The SLF shall maintain in a resident's file any of these documents authorized by the resident.** This requirement is not met as evidenced by: **R1, R3, R7, R9, R23, R48** No documentation of resident being informed of Advance Directives.		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements **146.220 (c)Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Il. Adm. Code 696).** This requirement is not met as evidenced by: **R1** TB screening not completed in accordance with the Control of Tuberculosis Code – 1st step given 1.30.21 – No 2nd step – Facility found that resident was missing 2nd step and completed a 2 step screening in December 2021. **R3** TB screening not completed/documented in accordance with the Control of Tuberculosis Code – Admit date 12.12.20, TB 2 step dates – G-12.3.21 R-12.6.21 – G-12.14.21 R-12.17.21 **R5** TB screening test not completed or documented in accordance with the Control of Tuberculosis Code - 1st step was given 5.31.21 read 6.2.21 No 2nd step documented – Facility found that resident was missing 2nd step and completed a new 2 step screening in December 2021. **R7** TB screening not performed/documented in accordance with the Control of Tuberculosis Code – 2 step not completed until December 2021 – No documentation of TB from SNF. **R9** TB screening not completed in accordance with the Control of Tuberculosis Code – Not administered until December 2021.		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements CONTINUED **146.220 (c)Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Il. Adm. Code 696).** **R11** TB screening not completed in accordance with the Control of Tuberculosis Code – 1st given 4.29.21 read 5.2.21, no 2nd step documented – Facility found that resident was missing 2nd step and completed a 2 step screening in December 2021. **R13** TB screening not completed in accordance with the Control of Tuberculosis Code – facility found that resident was missing 2 step screening and completed in December 2021. **R14** TB 2 step completed at SLP resident directly transferred from, therefore facility only needed to complete a one step, which they did. **R24-** 1st step given day of admit 11/6/2020 read 11/9/2020. No 2nd step. Reinitiated 12/3/21 read 12/6/21. 2nd step given 12/14/21 read 12/17/21. **R23** TB screening not completed in accordance with the Control of Tuberculosis Code – not completed until almost a year after admission. **R25** admitted 12/26/2020, 1st step given 12/3/21 read 12/6/21. 2nd step give 12/14/21 read 12/17/21. **R26** admitted 12/14/2020, 1st step given 12/3/21 read 12/6/21, 2nd step given 12/14/21 read 12/17/21. **R27** - admitted 3/27/21, 1st step given 3/27/21 read 3/29/21. No 2nd step. Re-given 12/3/21 read 12/6/21, 2nd step given 12/14/21 read 12/17/21 **R49** TB screening and S/S checklist completed one day prior to admission		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 3) D) E) **d) Medication Administration, Oversight and Assistance in Self-Administration 1) The SLF shall provide the following: D) Assisting residents in the removal of the medication from the container and assisting the resident in consuming or applying the medication when requested to do so by the resident (i.e., placing a dose in a container and placing the container to the mouth of the resident). E) Documentation showing that resident has taken, or refused to take, the medication; and** This requirement is not met as evidenced by: several missing initials and blanks on medication reminders **R32**-missing initials for 3/4/21, 3/5/21, 3/6, 3/9-13/21, 3/10, 3/12, 3/13, 3/16, 3/20, 3/24-27/21, 4/2, 4/4, 4/5, 4/6, 4/8, 4/9, 4/13, 4/15, 4/20, 4/23, 4/24, 4/25/21, 5/1, 5/13 & 14/21, 5/20, 5/22 & 23, 5/27-30/21. **R39**-missing initials for, 9/3 &4/21, 9/6/21, 9/13, 9/26/21, 10/1/21, 10/12/21, 10/23/21, 10/30/21, 11/22/21 & 11/30/21. **R36** -missing initials for, 10/2/21, 10/3, 10/8,/10/12, 10/14,10/15, 10/17, 10/23, 10/24,10/29/21, 11/12/21, 11/14, 11/23, 11/29/21, 12/10/21, 12/11-13/21, 12/20 & 12/25/21 **R37** -Meds not given 6/11 & 6/20/22. Med error report completed. Missing initials for, 5/4/22, 5/6, 5/8, 5/10, & 11/22, 5/15, 5/16, 5/18, 5/21, 5/22, 5/29/22, 6/1, 6/4, 6/5, 6/6, 6/8, 6/11, 6/13, 6/15, 6/18, 6/25-27/22, 6/29/22, 7/1, 7/3, 7/4, 7/6, 7/10, 7/15-17/22, 7/22 & 7/29/22		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 3) D) E) CONTINUED This requirement is not met as evidenced by: **R42** Medication reminders missing for several dates in June 2021, July 2021, and August 2021. **R43** Medication reminders missing for several dates in June 2021, July 2021, and August 2021. **R44** Medication reminders missing for several dates in June 2021, July 2021, and August 2021.		

Signature of SLF Representati [redacted] Date 4-18-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.230 Services **n) Daily Check The SLF shall implement a system to check on the welfare of each resident daily.** This requirement is not met as evidenced by: **R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21 R22, R23, R24, R25, R27, R28, R31, R32, R35, R38, R39, R40, R46, R47, R48** Well – being checks have multiple blank spots.		

Signature of SLF Representative [redacted] Date 4-11-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 7__ OF __17_**

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.235 Staffing **m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** missing employee TB screenings and TB S/S checklist **-E3,E5, E7, E8, E9, E10, E11, E12, E13, E14, E15, E17,E18, E19,E20, E21, E22, E23, E24,** **E16-** no 2nd step		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Standardized Interview Section 146.245(a) Assessment and Service Plan and Quarterly Evaluation(a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy. **R11** Standardized Interview not signed or dated. **R14** Standardized Interview not signed or dated. **R24** Admitted 11/6/2020, Initial assessment completed 11/8/2020. **R28** Nurse signed standardized interview but did not date. **R29** No standardized interview for this facility. Resident transferred from HW Watseka. **R30**Transferred from HW Watseka. No standardized interview.		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation146.245(c) **c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.** This requirement is not met as evidenced by: **R1, R2, R3, R5, R8, R9, R11, R13, R14, R20, R23,** RAI not completed within 7-14 days after admission. **R6** RAI not completed within 366 days of previous RAI. **R10** RAI not completed within 366 days of previous assessment. **R22**RAI not signed/co-signed by an RN within 7-14 days after admission – signed 6.28.20 **R24**Admitted 11/6/2020, RAI not signed by RN until 12/4/2020. **R26** admitted 12/14/2020, RAI not completed until 1/6/21 and not completed thoroughly. Section AA. 4 (Race/Ethnicity) was blank. **R27** admitted 3/27/21 per facility's admit date, RAI not completed until 4/19/21. **R28** admitted 10/17/19, RAI not completed and signed until 12/9/19. **R29** No RAI completed within 7-14 days of admit. **R30** admitted 6/3/19, RAI completed 3/5/2020		

Signature of SLF Representativ[redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation146.245(c) CONTINUED This requirement is not met as evidenced by: **R31** RAI of 8/15/22 not signed or co-signed by the RN within 366 days of previous assessment of 6/30/21. **R32**RAI of 8/22/22 not signed by RN within 366 days of previous assessment of 10/19/2020. **R33** RAI of 11/5/21 not signed by RN within 366 days of previous assessment of 10/19/2020. RAI not thoroughly completed due to Section J (1) b (weight) was blank. **R34** RAI of 5/16/22 not signed within 366 days of previous assessment of 5/5/21. **R35** RAI of 8/22/22 not signed by RN within 366 days of the previous assessment of 8/10/21. **R36** RAI of 8/23/22 not signed by RN within 366 days of previous assessment of 8/17/21. **R37** RAI of 8/4/22 not signed within 366 days of previous assessment of 6/29/21. **R42** RAI not completed within 366 days of previous assessment, last two RAI's completed 8/8/22, 5/1/21 **R46** RAI completed late in 4/7/2020 (admitted 2/29/20) **R48** RAI completed 12/20/19, but no RN signature until 1/9/2020 (late) **R49** Section AA(4) Race ethnicity blank		

Signature of SLF Representat[redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** **This not met as evidenced by:** ISP has untimely signatures, is late, incomplete, missing, wrong form, and/or does not have resident choosing services or resident rights- **R2** ISP completed by the LPN and co-signed by the RN 10/8/21, **R3** ISP signed 1/8/2020. RAI completed 12/31/19, **R5** ISP: Not completed within 7 days of completing the RAI. RAI completed 9/17/21, ISP completed 10/7/21, **R6** ISP does not include areas important to the resident,		

Signature of SLF Representativ [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan CONTINUED** **R8** ISS of 2/9/21 not signed within 7 days of completing the RAI dated 1/25/21, **R11** ISS not signed by RN within 7 days of completing the RAI of 5/26/21. Co-signed by RN6/8/21. ISS completed by the LPN 6/6/21. Should have been completed 6/2/21, **R17** ISS not signed by the RN within 7 days of completing the RAI. RAI completed 9/18/21, ISS completed 10/8/21, **R18** ISP completed by RN 9/17/21 but not signed by the resident until 6/9/22, **R19** No ISP completed since admission, **R20** Resident signed ISP but there is no date of signature, **R21** ISP not signed or dated by RN, ISP has no resident signatures. There is a 2022 ISP, completed, corporate nurse remediated signature on 2022 ISP but refused to remediate RN signature on 2021 ISP, **R22** Resident did not sign for reviewing ISP or initial for receiving a copy of the SLP providers resident rights. – remediated onsite, ISP does not include areas important to resident. ISP does not include areas important to resident, **R23** ISP not signed by RN, ISP not signed by resident for reviewing, not initialed by resident for choosing or not choosing SLP provider services, or for receiving a copy of the SLP providers resident rights – remediated onsite. ISP does not include areas important to resident, **R25** ISS completed instead of required ISP **R30** ISP created 7 days after RAI [redacted]		

Signature of SLF Representative [redacted] Date 4-11-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 13__ OF _17_ _**

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **146.245(e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.** This requirement is not met as evidenced by: **R6, R7, R8, R9, R13, R18, R21,** Quarterly evaluations not completed every 92 days. **R14** Quarterly evaluations not completed every 92 days – due 5.18.21 completed 5.19.21, no further quarterlies required as resident switched to MCO on 6.1.21 **R15** Quarterly evaluations not completed every 92 days – Not all signed/co-signed by an RN. **R16** Quarterly evaluations not completed every 92 days – Not all signed/co-signed by an RN. **R17** Quarterly evaluation due 3.29.21 not completed until 4.9.21 – resident switched to MCO on 4.1.21 **R22** No quarterly evaluations required as resident switched to MCO on 8.1.20 prior to any being due. **R23** Quarterly evaluations not completed every 92 days, none due after 5.5.21 quarterly as resident switched to MCO on 6.1.21 **R24** Quarterly eval of 3/7/21 is > 92 days. Should have been completed 3/5/21. 3/7/21 and 6/22/21 quarterlies are > 92 days. June's quarterly should have been completed 6/6/21. 6/22/21 quarterly was completed by the LPN and not co-signed by the RN.		

Signature of SLF Representative [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **146.245(e) Quarterly Evaluation: CONTINUED** **R25**Quarterly eval of 5/5/21 should have been completed 4/9/21, 8/30/21 quarterly should have been completed 8/4/21, 11/30/21 quarterly should have been completed 11/29/21. Quarterlies are > 92 days. **R26** Quarterly of 8/30/21 is > 92 days from the 5/5/21 quarterly. **R27** RAI done 4/19/21, no July quarterly. Quarterly not completed until 9/8/21. Quarterly of 12/15/21 is > 92 days from the 9/8/21 quarterly. **R28**4/9/21 quarterly is > 92 days and not signed by RN or LPN. Quarterly should have been done in March. **R38** Quarterly of 4/27/21, 8/31/21 and 2/17/22 are > 92 days. RAI done between quarterlies 10/11/21. **R29** No quarterlies presented for time frame of admit date 6/3/19. **R30** Quarterly of 10/18/2020 is > 92 days from quarterly of 6/20/2020 Converted to MCO 7/1/19. **R46** Quarterly assessments not completed as required, admitted 2/9/20, no quarterlies completed until 9/21/21		

Signature of SLF Representative [redacted] Date 4-14-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.240 Resident Contract a) The SLF shall have a signed contract with each resident, which specifies the terms of his or her agreement. This requirement is not met as evidenced by: Resident contracts not signed by SLP provider: **R1, R3** Remediated on-site, **R6** Remediated on-site, **R7** Remediated on-site, **R12** Remediated on-site, **R13** Remediated on-site, **R14** Remediated on-site, **R20** Remediated onsite, **R22** Remediated onsite, **R23** Remediated on-site		

Signature of SLF Represent [redacted] Date 4-11-23

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.295 Emergency Contingency Plan **e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative** This requirement is nit met as evidenced by: **R2** admitted 5/12/21, not oriented to the emergency plans within ten days after admit. Orientation checklist dated 3/23/22. **R6** Resident not oriented to the emergency plans within ten days after admit. **R7** No documentation to show resident was oriented to the emergency plans within ten days after admit. **R10** Resident was not oriented to emergency plans with ten days after admit. Orientation checklist noted for 3/23/22. **R11** Not oriented to emergency plans until 3/21/22. **R13** Resident not oriented to the emergency plans. Checklist dated 7/9/22. **R23** Resident not oriented to emergency plan within 10 days after admission – admit date 02.23.22 – Orientation date 3.23.22 **R24** Not oriented to the emergency plans within ten days after admit. Orientation checklist completed 3/23/22 **R29** Admitted 10/16/21, orientated to emergency plans late on 7/1/22		

Signature of SLF Representative [redacted] Date 4-11-23

800

SLF NAME: Heritage Woods Manteno DATE: 8/22/22 AR FY 23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.** This requirement is not met as evidenced by: **R20** Resident sent to ER per 10.4.21 Nurses Notes – No documentation of resident representative/POA notification or resident refusal of notification. **R23** Resident out to hospital overnight three (3) times in less than a month with no documentation of designated representative/POA notification, only one occurrence of resident going to the hospital documented in nursing notes. **R27** Resident sent to hospital 4/12/21, no evidence of designated rep notification. **R29** Two hospitalizations 1/28/22 and 12/22/21, no evidence of designated representative notification		

Signature of SLF Representative [redacted] Date 4-11-23

DEPT OF HEALTHCARE AND
FAMILY SERVICES
BUREAU OF LONG TERM CARE
200 S WYMAN ST #307C
ROCKFORD, IL 61101
815-987-7731 Direct OFFICE
Fax: (217) 557-5061

facsimile transmittal

To: [redacted] HW McHenry **Fax:** 815 344 2691

From: HFS BLTC ROCKFORD REG **Date:** 7-19-23

Re: **Pages:** to Follow

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

CONFIDENTIAL

A plan of correction is due within 14 days and must be completed within 30 days of today. Please sign page 2 of 2 and page 7 of 9

Thank you

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: HW of McHenry
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: 4-26-23 EXIT DATE: 7-19-23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.
BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____
REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐
BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**
(1st) BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐
(2nd)BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative — Date

[redacted] — 7/19/23

Date

7-19-23

Date

Signature of Bureau of Long Term Care Area Manager — Date

PROVIDER NAME: McHenry 4-26-23 Annual REFERRAL DATE: 7-19-23
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services c) Personal Care 2) Personal care services shall be delivered by certified nursing assistants who meet the qualifications described in Section 146.235(f)(1). E5 is a personal care attendant and per interview with E5 and staff, E5 does some personal care duties such as standby assist for showers.		

249

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R25 admit 1/20/22. RAI date 1/28/22. MCO date 6/1/22. No quarterlies completed. Should have had 1. R26 admit 2/26/23. Not an MCO. RAI date 3/10/23. No quarterlies completed.		

Section 146.235 Staffing l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check. **30-Day Checks not completed after hire:** E1 hired 3/12/23. Checked on 3/8/23. E2 hired 1/31/23. Checked on 1/12/23. E3 3/1/23. Checked on 2/27/23. E4 hired 2/23/23. Checked on 2/20/23.		

4 of 9

Section 146.220 Resident Participation Requirements 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. **R1** admit 3/3/22. No date on IDOC or ISP. DOJ was ok. R2 admit 9/1/22 IDOC not checked until 4/26/23. Others were ok. R3 admit 11/14/22. DOJ and ISP ran on 3/29/23. IDOC ran on 4/26/23. R4 admit 11/15/21. IDOC ran on 4/26/23. Others were timely. R5 admit 11/17/22. IDOC ran 4/26/23. Others ran on 11/17/22. R6 admit 1/3/23. IDOC ran on 4/26/23. Others ran on 1/3/23. R7 admit 3/21/22. IDOC ran 4/26/23. Others ran before admit. R8 admit 4/4/22. IDOC ran 4/26/23. Others ran on 4/4/22.		
6/4/18	86	

Section 146.220 Resident Participation Requirements		
4)		
R9 admit 5/25/22. DOJ and ISP ran on 5/27/22. IDOC ran on 4/26/23.		
R10 admit 7/12/22. ISP and DOJ ran before admit on 4/27/22. IDOC ran 4/26/23.		
R11 admit 1/9/23. IDOC ran 4/26/23. ISP and DOJ ran 726//22.		
R12 admit 2/9/22. IDOC ran 4/26/23. ISP and DOJ ran 2/3/22.		
R12 admit 12/1/22. IDOC ran 4/26/23. DOJ and ISP ran before admit.		
R13 admit 8/30/22. IDOC ran 4/26/23. Others ran before admit.		
R14 admit 4/24/22. IDOC ran 4/26/23. DOJ and ISP ran 4/7/22.		
R15 admit 6/15/21. DOJ ran 4/7/21. IDOC ran 9/16/20. ISP had no date.		
R16 admit 10/19/21. DOJ ran 7/28/21. ISP and IDOC had no date.		
R17 admit 9/21/22. DOJ ran 8/31/21. ISP and IDOC had no dates.		

Section 146.220 Resident Participation Requirements 4) R18 admit 3/16/22. ISP and DOJ were ok. IDOC had no date. R19 admit 12/12/22. ISP and IDOT ran on 10/25/22. IDOC ran 4/26/23. R20 admit 4/18/22. ISP and IDOC had no dates. DOJ ran 10/5/21, before admit. R21 admit 11/16/21.DOJ ran 8/31/21. ISP and IDOC had no dates. R22 admit 9/7/22. DOJ and ISP ran 7/19/22. IDOC not checked. R23 admit 1/28/23. IDOC not checked. DOJ and ISP were timely. R24 admit 10/25/22. IDOC checked 4/20/23. ISP and DOJ checked 4/11/22.		

Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). **Resident TB:** R26 admit 2/26/23. TB started on 3/13/23. Signs and symptoms Check list completed on 3/13/23. R27 admit 9/11/19.1st step given in the NF. No read date. 2nd step given 7/29 with no read date.		

Signature of SLP Provider Representative_____Date_____

Exh 2

86

[redacted]

HW of McHenry ID Key for findings

[redacted]

6/4/18

[redacted]

6/4/18

86

DEPT OF HEALTHCARE AND
FAMILY SERVICES
BUREAU OF LONG TERM CARE
200 S WYMAN ST #307C
ROCKFORD, IL 61101
815-987-7731 Direct OFFICE
Fax: (217) 557-5061

facsimile transmittal

To: [redacted] HW Minooka Fax: 815 467 2783

From: HFS BLTC ROCKFORD REG Date: 2-28-22

Re: 2021 Annual Pages: 19 pages to follow

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

CONFIDENTIAL

Plan of correction due within 14 days and must be completed within 30days. Please sign page 107 and page 14 of 14 and return to me. It can be scanned back without any key or identifier.

Also at the time you submit the POC please verify the training for E1 has been remediated and attach documentation. This includes annual training and abuse and neglect training

Thank you!

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: Heritage Woods of Minooka
CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES ☒ NO ☐

ENTRANCE DATE: 09-20-21 EXIT DATE: 02-28-22

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: END DATE:

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office.
BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the

[redacted] 2/28/22
Date

Signature of Bureau of Long Term Care HFSN Date

[redacted] 02-28-22
Date

Signature of Bureau of Long Term Care Area Manager Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: HW Minooka 2021 AR REFERRAL DATE: 02-28-22
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing, l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses		

defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. The requirement is not met: Healthcare Worker Registry not checked prior to beginning work: E-3 – start date 12/28/20 – Healthcare Worker Registry check not available for review – printed on 9/21/21. E-7 – start date 5/14/21 – Healthcare Worker Registry check not available for review – printed on 9/21/21. E-9 – start date 6/11/20 – Healthcare Worker Registry check not available for review – printed on 9/21/21. E-16 – start date 6/7/21 – Healthcare Worker Registry check dated 7/13/21. E-23 – start date 12/1/20 – Healthcare Worker Registry check not available for review – printed on 9/22/21. E-24 – start date 9/2/20 – Healthcare Worker Registry check dated 9/16/20. E-26 – start date 7/26/21 – Healthcare Worker Registry check not available for review – printed on 9/22/21.		

Authorization and Disclosure form signed prior to work: E-9 – start date 6/11/20 – No Authorization and Disclosure form provided for review. Six Registry Sites checked prior to beginning work: E-3 – start date 12/28/20 – six registry sites dated 1/28/21. E-6 – start date 6/10/21 – ISP registry site not provided for review - printed on 9/20/21. E-9 – start date 6/11/20 – six registry sites not provided for review – printed on 9/21/21. E-16 – start date 6/7/21 – six registry site dated 7/13/21. E-18 – start date 8/13/21 – ISP registry site provided however not dated. E-19 – start date 4/8/21 – ISP registry site provided however not dated. E-22 – start date 5/6/21 – ISP registry site provided however not dated. E-23 – start date 12/1/20 – six registry sites provided but not all dated. Healthcare Worker Registry updated within 30 days of beginning employment: E-3 – start date 12/28/20 – updated 7/15/21. E-4 – start date 2/2/21 – updated 9/21/21. E-6 – start date 6/10/21 – updated 9/21/21. E-7 – start date 5/4/21 – updated 7/13/21. E-9 – start date 6/11/20 – updated 9/21/21. E-10 – start date 8/17/21 – updated 9/21/21. E-12 – start date 8/29/18 – updated 7/30/19. E-14 – start date 10/5/18 – updated 9/21/19. E-15 – start date 8/8/18 – updated 1/11/20.		

E-16 – start date 6/7/21 – updated 9/21/21. E-17 – start date 3/13/21 – updated 7/15/21. E-18 – start date 8/13/21 – updated 9/21/21. E-19 – start date 4/8/21 – updated 9/21/21. E-20 – start date 8/13/21 – updated 9/21/21. E-22 – start date 5/6/21 – updated 9/21/21. E-23 – start date 12/1/20 – updated 9/22/21. E-26 – start date 7/26/21 – updated 9/22/21. E-27 – start date 5/10/21 – updated 9/22/21.		

Section 146.235 Staffing, m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). The requirement is not met: E-2 – start date 6/14/20 – TB testing not initiated until 7/15/20 E-3 – start date 12/28/20 – TB testing not initiated until 7/9/21 E-4 – start date 2/2/21 – TB testing not initiated until 7/19/21 E-5 – start date 4/7/20 – TB testing not initiated until 5/26/21 E-6 – start date 6/10/21 – TB testing not initiated until 8/7/21 E-7 – start date 5/4/21 – TB testing not provided for review. E-8 – start date 5/23/19 – TB testing not initiated until 7/8/19 E-9 – start date 6/11/20 – TB testing not initiated until 7/20/21 E-11 – start date 10/28/20 – TB testing not initiated until 7/2/1 E-13 – start date 4/16/20 – TB testing not initiated until 4/28/20 E-16 – start date 6/7/21 – TB testing not initiated until 8/18/21 E-17 – start date 3/13/21 – TB testing not initiated until 5/17/21 E-19 – start date 4/8/21 – TB testing not initiated until 8/24/21 E-20 – start date 8/13/21 – TB testing not initiated until 8/25/21 E-21 – start date 7/27/20 – TB testing not initiated until 8/5/20 and the second step was not provided for review. E-22 – start date 5/6/21 – TB testing not initiated until 5/17/21 E-23 – start date 12/1/20 – TB testing not initiated until 12/29/20 E-24 – start date 6/24/20 – TB testing not initiated until 7/8/20 E-26 – start date 7/26/21 – Positive reactor – no signs and symptoms check list completed and chest xray was not done until 9/21/21.		

Section 146.220 Resident Participation Requirements, 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. The requirement is not met: R-15 – Admitted on 2/23/20 – Illinois Department of Corrections Parolee check was not available for review. R-16 – Admitted on 4/6/21 – Illinois Department of Corrections Parolee check was not available for review. R-17 – Admitted on 7/24/18 – Illinois Department of Corrections Parolee check was not available for review. R-18 – Admitted on 2/15/21 – Illinois Department of Corrections Parolee check was not available for review. R-22 – Admitted on 8/28/20 – Illinois Department of Corrections Parolee check was not available for review. R-27 – Admitted on 2/16/21 – Illinois Department of Corrections Parolee check was not available for review. R-28 – Admitted on 6/30/20 – Illinois Department of Corrections Parolee check was not available for review. R-32 – Admitted on 9/27/20 – Illinois Department of Corrections Parolee check was not available for review.		

R-42 – Admitted on 11/15/19 – Illinois Department of Corrections Parolee check was not available for review. ***The facility SLP printed out inmates at the time of admission instead of the parolees. All residents were checked against the parolee site the week of 12/13/21.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation, c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. The requirement is not met: R-3 – RAI dated 12/2/21 was completed greater than 366 days from the RAI dated 11/22/20. R-5 – RAI dated 7/21/21 was completed greater than 366 days from the previous RAI dated 6/25/20. R-6 – RAI dated 7/13/21 was completed greater than 366 days from the previous RAI dated 6/17/20. R-7 – RAI dated 9/5/21 was completed greater than 366 days from the previous RAI dated 7/29/20. R-8 – RAI dated 7/22/21 was completed greater than 366 days from the previous RAI dated 6/17/20. R-9 – RAI dated 6/16/21 was completed greater than 366 days from the previous RAI dated 6/10/20. R-11 – RAI dated 5/13/21 was completed greater than 14 days from admission on 4/18/21. R-13 – RAI dated 6/29/21 was completed greater than 366 days from the previous RAI dated 6/10/20. R-14 – RAI dated 8/11/21 was completed greater than 366 days from the previous RAI dated 7/17/20. R-16 – RAI dated 4/29/21 was completed greater than 14 days from		

admission on 4/6/21. R-17 – RAI dated 8/25/21 was completed greater than 366 days from the previous RAI dated 7/28/20. R-18 – RAI dated 3/31/21 was completed greater than 14 days from admission on 2/15/21. R-19 – RAI dated 6/11/21 was completed greater than 366 days from the previous RAI dated 6/10/20. R-20 – RAI dated 9/30/21 was completed greater than 366 days from the previous RAI dated 9/24/20. R-22 – RAI dated 9/1/20 was completed in less than 7 days from admission on 8/28/20. RAI dated 9/16/21 was completed greater than 366 days from the previous RAI dated 9/1/20. R-23 – RAI dated 5/29/19 was completed greater than 14 days from admission on 1/25/19. R-24 – RAI dated 1/25/19 was completed in less than 7 days from admission on 1/25/19. R-28 – RAI dated 7/27/21 was completed greater than 366 days from the previous RAI dated 7/6/20. R-29 – RAI dated 11/25/21 was completed greater than 366 days from the previous RAI dated 11/10/20. R-30 – RAI dated 4/20/21 was completed greater than 14 days from admission on 3/31/21. RAI dated 4/20/21 was also not thoroughly completed. F.2.b. was blank. R-31 – RAI dated 2/16/21 was completed greater than 14 days from admission on 1/25/21. R-32 – RAI dated 10/13/20 was completed greater than 14 days from admission on 9/27/20. RAI dated 11/2/21 was completed greater than 366 days from the previous RAI dated 10/13/20. R-33 – RAI dated 11/2/21 was completed greater than 366 days from the previous RAI dated 10/17/20. R-34 – RAI dated 4/13/21 was completed greater than 14 days from admission on 3/18/21.		

R-35 – RAI dated 7/21/21 was completed greater than 366 days from the previous RAI dated 6/5/20. R-36 – RAI dated 8/11/21 was completed greater than 366 days from the previous RAI dated 7/17/20. R-37 – RAI dated 6/15/21 was completed greater than 366 days from the previous RAI dated 6/3/20. R-38 – RAI dated 9/5/21 was completed greater than 366 days from the previous RAI dated 9/2/20. R-40 – RAI dated 12/21/20 was completed greater than 14 days from admission on 11/24/20. RAI dated 1/3/22 was completed greater than 366 days from the previous RAI dated 12/21/20.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation, d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. The requirement is not met: R-4 – The facility's ISS dated 12/4/19 was completed greater than 7 days from the RAI assessment dated 11/22/19. R-7 – The facility's ISS dated 9/14/21 was completed greater than 7 days from the RAI assessment dated 9/5/21. R-10 – The facility completed an ISS instead of an ISP. R-10 did not have initialed that R-10 chose to receive services from SLP provider.		

R-10 did not initial that R-10 received a copy of the SLPs resident rights. R-10 did not include areas important to the resident such as goals, interests, preferences or choices. The facility's ISS dated 4/21/21 was completed greater than 7 days from the RAI assessment dated 4/2/21. R-11 – The facility completed an ISS instead of an ISP. R-11 did not have initialed that R-11 chose to receive services from SLP provider. R-11 did not initial that R-11 received a copy of the SLPs resident rights. R-11 did not include areas important to the resident such as goals, interests, preferences or choices. R-12 – The facility completed an ISS instead of an ISP. R-12 did not have initialed that R-12 chose to receive services from SLP provider. R-12 did not initial that R-12 received a copy of the SLPs resident rights. R-12 did not include areas important to the resident such as goals, interests, preferences or choices. R-19 – ISP dated 7/27/21 was completed greater than 7 days from the RAI assessment dated 6/11/21. R-22 – ISP dated 10/21/21 was completed greater than 7 days from the RAI assessment dated 9/16/21. R-25 – ISP dated 12/10/21 was completed greater than 7 days from the RAI assessment dated 11/3/21. R-26 – ISP dated 12/7/21 was completed greater than 7 days from the RAI assessment dated 11/2/21. R-28 – ISP dated 8/10/21 was completed greater than 7 days from the RAI assessment dated 7/27/21. R-32 – ISP dated 12/27/21 was completed greater than 7 days from the RAI assessment dated 11/2/21.		

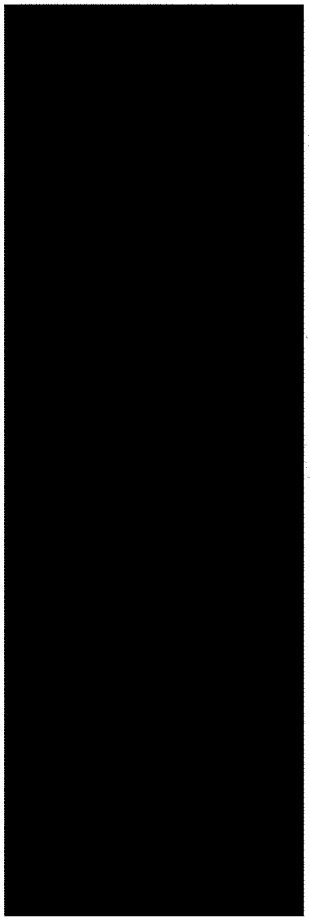
R-41 – ISP dated 5/14/21 was completed greater than 7 days from the RAI assessment dated 5/5/21. R-42 – ISP dated 12/4/19 was completed greater than 7 days from the RAI assessment dated 11/22/19.		

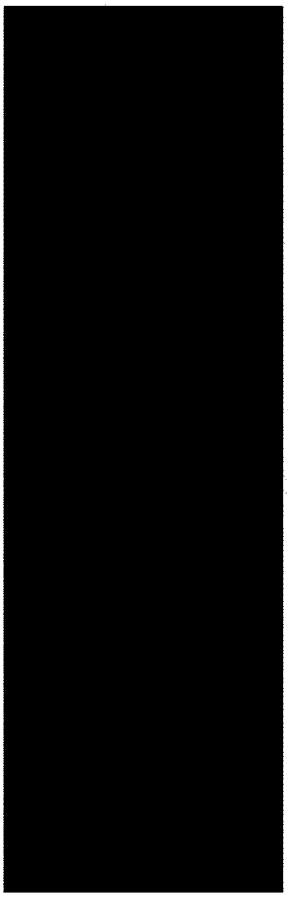
Section 146.245 Assessment and Service Plan and Quarterly Evaluation, e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R-10 – No quarterly assessments available for review since RAI assessment completed on 4/21/21. R-17 – Quarterly assessment dated 12/2/21 was completed greater than 92 days from previous RAI assessment dated 8/25/21. R-18 – Quarterly assessment dated 10/11/21 was completed greater than 92 days from previous quarterly assessment dated 6/30/21. R-21 – Quarterly assessment dated 10/11/21 was completed greater than 92 days from the RAI assessment dated 6/30/21.		

Signature of SLP Provider Representative [redacted] Date 2/28/22

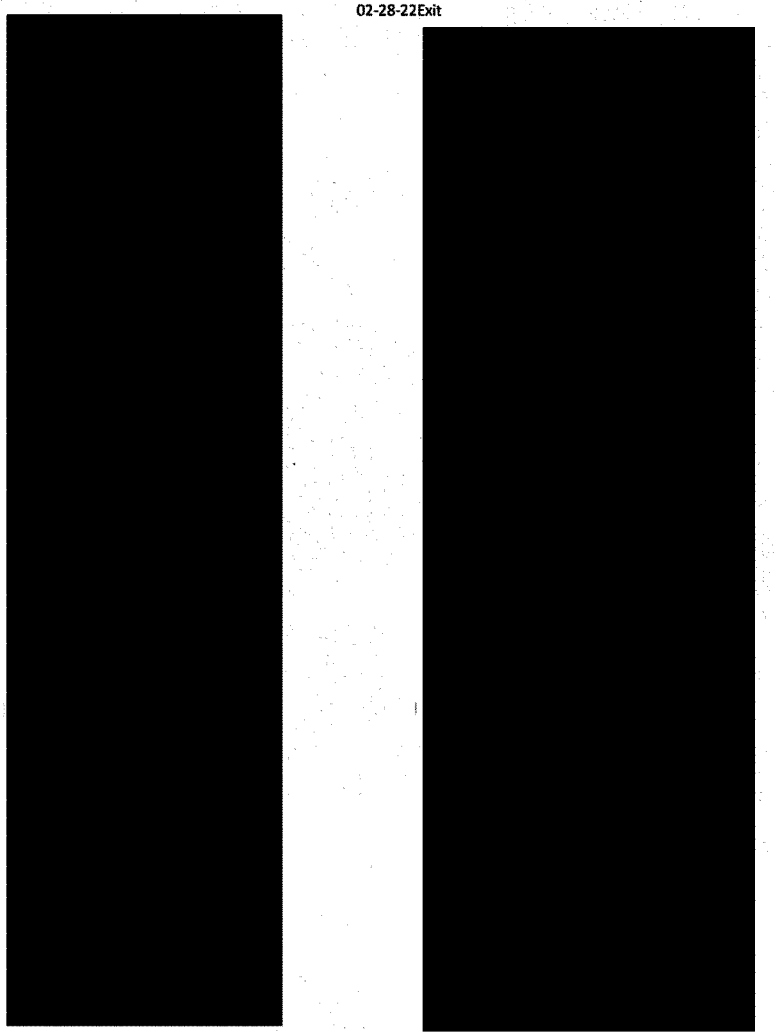
HW Minooka 2021 Annual review
02-28-22Exit

Resident/Staff Identification Key

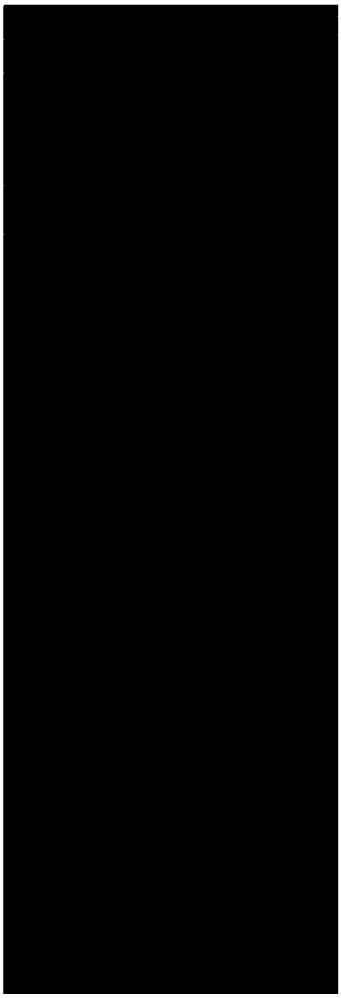


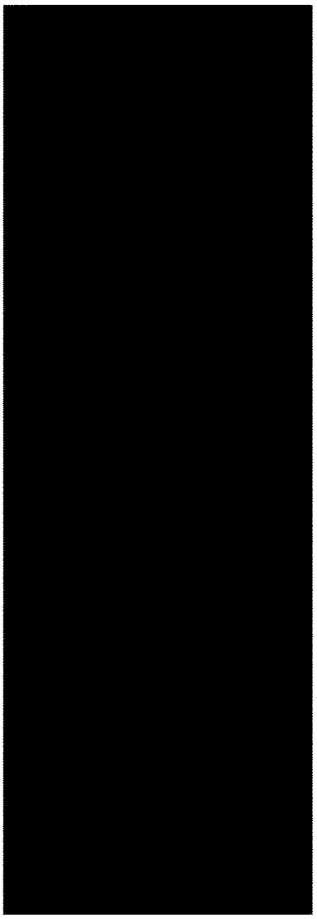


HW Minooka 2021 Annual review
02-28-22Exit



HW Minooka 2021 Annual review
02-28-22Exit





ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS Page 1 of 4

SLP NAME: Heritage Woods - Moline
CHECK ONE: [redacted]W/23

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐

ENTRANCE DATE: 8.1.23 EXIT DATE: 12.28.23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

12/28/23
Date

12.28.23
Date

Signature of Bureau of Long Term Care Regional Supervisor

Date

Signature of Bureau of Long Term Care Area Manager

Date

POC: 1.11.24
20-day. correction: 1.27.24
10-day f/u: 1.21.24 - 2.9.24

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods- Moline AR WY23 REFERRAL DATE: 8.1.23

Initial (X) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services b) Nursing Services 5) All nursing services shall be provided in accordance with the Nurse Practice Act [225 ILCS 65]. CNAs are practicing outside their scope of practice- R20 PRN effectiveness is being documented by CNAs. Only Licensed nurses can document effectiveness. CNAs can document their observation such as "resident sleeping, watching TV, Eating in the dining room"		

Signature of SLP Provider Representa [redacted] Date 12/28/23

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Heritage Woods- Moline AR WY23 REFERRAL DATE: 8.1.23

Initial (X) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. HCWR not checked prior to start date/late/30-day re-check late- E1, E5, E6, E7, E8, E9		

Signature of SLP Provider Representati [redacted] Date 12/23/28

Comments:

Sex Offender checks not completed appropriately- R1 (remediated onsite)

RAI late/inaccurate- R2, R19

ISP/ISS wrong form used/not individualized- R8, R9

Missing Annual training on non-discrimination- E1, E2

Resident and Employee Key

[redacted]

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of __**

SLP NAME: Heritage Woods of Mt. Vernon

CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES D NO D

ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES X NO D

ENTRANCE DATE: 07-05-2023 EXIT DATE: **08-02-2023**

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES O NO ☐

ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

() **COMPLAINT REVIEW** **DATE OF COMPLAINT:_____**

REFERRAL DATE:_____ **REVIEW FINDINGS:** YES ☐ NO 0

BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(**JS** BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO☐

93531595.2

RESPONSE TO ON-SITE REVIEW FINDINGS **Page2of ____**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within IO working days of the notification or take other appropriate steps to detennine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the

= oo ompH ee

Signature of SLP Provider Representative	08-02-23 Date
Signature of Bureau of Long Tenn Care HFSN	08-02-23 Date
Signature of Bureau of Long Term Care Regional Supervisor	Date
Signature of Bureau of Long Term Care Area Manager	Date

93531595.2

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE_1_oF 1

SLF NAME: Heritage Woods of Mt Vernon REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements, b) Private pay residents seeking to convert to Medicaid while residing in an SLF shall be screened by the Department using the DON prior to the point of conversion and must be found to be in need of nursing facility level of care before Medicaid payment may be authorized. R-11 Medicaid application O1/10/2023. Medicaid approval date 01/01/2023. The SLP did not request a conversion screening. The last DON was done on admission on 02/23/21 with a DON score of 69. The administrator and BOM notified on 07/05/23 and will contact DOA today to request a conversion screening ASASP. Kara Helton notified by C. Lietz HFSN on 07/05/23. DOA conducted a conversion screening 07/06/23, DON score 58.		

Signature of SLF Representative_____ Date_____

93531595.2

SLF NAME: Heritage Woods of Mt Vernon REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key **(R-1,** R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Piao and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. R-2 - RAI dated 6/14/23 F.3.g Phone usage is coded 2- "Done		

with Help" however ISP dated 6/14/23 does not address phone usage. R-8 - ISS dated 12/6/22 was completed prior to the RAI dated 12/9/22. R-10 ISP dated 01/30/23 the resident did not initial the ISP indicating that choose SLP waiver services. The circle for the I choose is filled in and the date line has a date of O1/30/23 but there is no resident initial/signature. Remediated onsite 07/05/23. The resident did not sign or initial that received a copy of the Resident Rights SLP brochure. The line for this date is dated 1/30/23 but the resident signature line is blank. Remediated onsite 7/05/23. R-11 ISP dated 10/11/22 "What is important to me" is blank. The ISP is not signed by the resident, the resident did not sign/initial that choose or did not choose SLP waiver services. Both remediated on 07/05/23. The resident did not sign/initial that received a copy of the SLP's resident rights. Remediated on 07/05/23. The ISP dated I0/I1/22 inaccurately stated that resident requires assist with dressing lower body, set up and oversight with dressing upper body, and assist with zippers, buttons, and fasteners. DON confirmed on 07/05/23 that resident is Independent with dressing as coded on the RAI dated I0/11/22 coded (0). Shopping is coded as a (3), transportation is coded (3) and transfers is coded (0). The ISP inaccurately stated that the resident is able to shop with assist, sets up own transportation with assist from staff/family and requires assist with transfers. Per DON on 07/05/23 resident is totally dependent on staff and family for shopping and transportation arrangements and does not require transfer assist. R-14 ISP dated 11/14/22 "What is important to me" was left		

blank. ISP dated 11/14/22 does not address resident's dialysis/shunt, resident receives Dialysis every M-W-F per the nurses notes and quarterly evaluation. R-15 ISP dated 08/24/23 "What is important to me" was left blank. R-17 The ISP dated 11/16/22 is not co-signed by the RN.		

Signature of SLF Representative..... Date.....

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 9

SLF NAME: Heritage Woods of Mt Vernon REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in the resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities. R-3 - 12/22/22- R-3 tested positive for Covid. No documentation of the physician or family notification 1/18/22. R-3 complained of cough/congestion and increased blood pressure with physician notification with family not notified. 3/1/23 admitted to the hospital with the diagnosis of hypocalcemia. No documentation of family notification.		

R-9 - No documentation of designated representative notification of an ER visit on 9/19/22 from UTI symptoms, for an ER visit on 10/14/22 for complaints of leg discomfort, and for an ER visit on 2/24/23 following a fall with confusion.		

Signature of SLF Representative_____Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 12

SLF NAME: Heritage Woods of Mt Vernon REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.** R-4- RAI dated 9/15/22 was completed greater than 14 days from admission date of 9/1/22. R-5 - RAI dated 5/25/23 was completed greater than 14 days from admission date of 8/10/22. R-6- RAI dated 11/29/22 was completed greater than 14 days from the admission date of 11/15/22. R-7 - RAI dated 11/29/22 was completed greater than 14 days from the admission date of 11/15/22. R-10 RAI dated 01/30/23 Section AA.6.b. Medicare number is blank.		

R-12 RAJ dated 10/11/22 Section AA.6. b. Medicare number is blank. R-15 RAI dated 08/24/22 was completed greater than 14 days from admission date of08/10/22, section B3 Cognitive skills was left blank. Remediated on 07/05/23 for accurate coding for LOCO.		

Signature of SLF Representative..... Date_____

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE_loF.3**

SLF NAME: Heritage Woods of Mt Vernon REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key **(R-1, R-2,** etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.** R-1 - Quarterly evaluation dated 6/6/23 was completed more than 92 days from the quarterly evaluation dated 2/15/23. R-13 The Quarterly evaluation dated 07/05/23 was completed more than 92 days from the previous Quarterly evaluation dated 03/28/23. The Quarterly evaluation was due on or before 06/27/23. R-16 RAI dated 12/23/22 Quarterly evaluation dated 03/22/23 completed timely however the RN did not co-sign. R-17 Quarterly evaluation of04/28/23 is not co-signed by the RN.		

Signature of SLF Representative_____ Date _____

93531595.2

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE OF

SLF NAME: Jieritage Woods of Mt Vernon REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Informational Notice dated 12/12/07 Re: Readmission of Resident **From** Nursing Facility: Residents of supportive living facilities (SLFs) who are admitted to a nursing facility must be discharged from the SLF on the Department's Recipient Data Base to allow admission data for the nursing facility to be added. An SLF may hold the resident's apartment during the nursing facility stay if it is anticipated to be a short-term stay. An SLF may hold the apartment free of charge or make arrangements with the resident's family to pay. The Resident Contract should provide the SLF's policy for holding an apartment for a short-term nursing facility stay, including the length of time the apartment will be held, the charge to hold the apartment and the need for the SLF to conduct an assessment prior to readmission to ensure the resident's needs can continue to be met by the SLF. If a resident returns to the same SLF from a nursing facility within 30 days without a break in service, a new Resident Assessment Instrument (RAI) and Resident		

Informational Notice dated 12/12/07 Re: Readmission of Resident From Nursing Facility Continued: Service Plan (RSP) does not have to be completed unless there is a significant change in the resident's status. If there is no significant change, the RAJ and RSP in place prior to the resident's discharge to the nursing facility must be reviewed and updated accordingly, within 24-hours of readmission to the SLF. Since the resident is not technically discharged from the SLF, completion of future assessments remains on the same timeline. The SLF does not have to do the following at the time of readmission to the SLF if readmission from the nursing facility is within 30 days, without a break in service, from the date of the SLF discharge: Determination of Need (DON), sign a new Resident Contract, advance directives, sex offender registration website, and tuberculosis test. R-4 - Admission date 9/1/22. Orientation checklist with emergency plan is dated 6/13/23 (greater than 10 days). (Readmission greater than 30 days). R-5 - Standardized Interview and Initial Assessment were not provided for review from readmission greater than 30 days.		

Signature of SLF Representative_____ Date_____

PRINTED: 12/27/2022
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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Residential State Licensure Survey and the Investigation of Complaints IN00395024, IN00394445, IN00392599, IN00392510, IN00392529, IN00392595, IN00392402, IN00391839, IN00390635, IN00390450, IN00387827, IN00386790, IN00384259, IN00384273, IN00384278, IN00383869, and IN00383799. Complaint IN00395024 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00394445 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00392599 - Substantiated. State deficiencies related to the allegations are cited at R0297 and R0240. Complaint IN00392510 - Substantiated. State deficiencies related to the allegations are cited at R0297, R0240, and R0349. Complaint IN00392529 - Unsubstantiated due to lack of evidence. Complaint IN00392595 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00392402 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00391839 - Substantiated. No deficiencies related to the allegations are cited.	R 0000	This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Heritage Woods of Newburgh respectfully requests consideration for a desk review of this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	Administrator	12/18/2022

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determin 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 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.

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Complaint IN00390635 - Substantiated. State deficiencies related to the allegations are cited at R0349. Complaint IN00390450 - Substantiated. State deficiencies related to the allegations are cited at R0240 and R0297. Complaint IN00387827 - Substantiated. State deficiencies related to the allegations are cited at R0036, R0297, and R0407. Complaint IN00386790 - Substantiated. State deficiencies related to the allegations are cited at R0273. Complaint IN00384259 - Substantiated. State deficiencies related to the allegations are cited at R0297. Complaint IN00384273 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00384278 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00383869 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00383799 - Unsubstantiated due to lack of evidence. Survey dates: November 14, 15, 16, 17, 18, & 21, 2022 Facility number: 014377 Residential Census: 121 These State Residential Findings are cited in			

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	accordance with 410 IAC 16.2-5. Quality review completed on December 2, 2022.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, interview, and record review, the facility failed to ensure residents, resident representatives, and families were notified of suspected or confirmed COVID-19 cases in the facility during 3 of 6 days during the survey. (Resident L, Resident C, Resident H) Finding includes: During an interview on 11/17/22 at 1:20 P.M., CNA 8 indicated that Resident L had tested positive for COVID -19. During an observation on 11/17/22 at 1:30 P.M., Resident L's room door had a sign posted that the resident was on contact/droplet isolation precautions for 10 - 14 days. During an observation on 11/17/22 at 2:00 P.M., the main entrance to the facility did not have signage indicating there was a positive case of COVID-19 in the facility.	R 0036	1. **The administrator placed signage at the Main Entrance, the morning of 11/18/22 before beginning her workday. The administrator placed a message informing of COVID in the facility via Care Merge communication system to all residents and family. Signage had been placed at the main table in the foyer as you walk into the facility on 11/17/22.** **2. All residents and visitors had the potential to be affected by the lack of signage on the main entrance.** **Administrator reviewed the new guidelines with the Director of Nursing and will follow them with each outbreak in the future.**	12/23/2022

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	During an observation on 11/18/22 at 8:30 A.M., the main entrance to the facility did not have signage indicating there was a positive case of COVID-19 in the facility. During record review on 11/18/22 at 10:30 A.M., Resident L's nurses note dated 11/18/22 at 9:55 A.M., included, "resident returned from ER [Emergency Room] 11/17/22 COVID positive resident put in quarantine in residents room with isolation precautions..." During an interview on 11/18/22 at 9:16 A.M., Resident C indicated the facility usually informed residents of COVID-19 during meals or via a letter in their mailbox. Resident C indicated she has not heard of any recent COVID-19 cases in the facility. During an interview on 11/18/22 at 9:30 A.M., the Facility Administrator indicated Resident L had went out to the hospital on 11/16/22 and tested positive for COVID-19, then returned to the facility that night. During an interview on 11/8/22 at 1:25 P.M., Resident H indicated they had heard from other residents that someone had tested positive for COVID-19, but that no one from the facility had informed them. During an interview on 11/18/22 at 2:43 P.M., the Facility Administrator indicated they have been letting visitors and residents know of the COVID -19 positive case in the facility by word of mouth. The Administrator indicated they were not trying to hide the positive case and were alerting people when asked. On 11/18/22 at 2:40 P.M. the Facility Administrator supplied an updated facility packet titled, New		**3.** All department heads will be in serviced by the Administrator, DON, or designee on the new COVID Guidelines including communication to staff, residents, family, and visitors. Communication will include signage at the entrance, at the table in the facility foyer, at each door with a COVID infected individual, also an isolation cart at each door of a COVID infected individual, signage at the timeclock in the breakroom. A message via care merge system to all residents and families. 4. The DON/Administrator will monitor the signage to communicate COVID is in the building daily while COVID outbreak is in the building. The DON/Administrator will monitor the signage to communicate transmission levels and community levels weekly when facility is free of COVID. All findings will be reported to the QA Committee monthly.	

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	COVID Guidance, dated 11/16/22. The guidance included, "...Outbreak Considerations. Post signage that you have COVID-19 illness in the facility." This Residential tag relates to complaint IN00387827.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on an interview and record review, the facility failed to ensure a First Aid certified staff member was present on all shifts for 2 of 7 days reviewed.	R 0117	1. **The administrator reviewed the schedule and pay sheets for the noted dates of 11/8/22 and 11/11/22 and found the proper coverage for each of**	12/23/2022

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Finding includes: On 11/17/22 at 1:00 P.M., the staffing schedules were reviewed for 11/8/22 through 11/14/22. The staffing schedule lacked a First Aid certified staff member for the following dates: 11/8/22 night (6:00 P.M. - 6:00 A.M.) 11/11/22 night (6:00 P.M. - 6:00 A.M.) During an interview on 11/18/22 at 2:18 P.M., the Administrator indicated that she was unsure if a First Aid certified staff member had to be in the building at all times. During an interview on 3/22/22 at 3:05 P.M., the Regional Nurse Consultant indicated there should be someone in the building at all times that was First Aid certified. On 11/21/22 at 9:45 A.M., a CPR and First Aid Certifications policy, dated 9/2021, was provided and indicated, "...It is the responsibility of the Director of Nursing or designee to ensure at least one on-duty employee has current CPR & First Aid Certifications at all times..."		**these days and the shifts of 6pm to 6am. NO DEFICIENCY WAS FOUND.** **2. All residents had the potential to be affected but were not affected as there was coverage during the dates/times noted.** **3.** Facility will provide CPR/First Aide training to all Nurses and QMA's. 4. The DON will continue to complete the schedule with the coverage in mind that all shifts must have a CPR/First Aide qualified individual at all time per shift. An audit will be completed of current nurse and QMA's not certified, and training will be scheduled. All new hires will that are not certified with CPR/First Aide will be scheduled for the next class for CPR/First Aide training.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure residents that required assistance with bathing received at least 2 baths or showers weekly for 3 of 4 residents reviewed for assistance with ADL's (activities of daily living). Residents did not receive showers on their scheduled	R 0240	1. **Director of Nursing reviewed shower days and times with residents affected. All residents affected received showers upon their next scheduled shower day.**	12/23/2022

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	bathing days. (Resident C, Resident J, Resident B) Findings include: 1. During an interview on 11/15/22 at 8:53 A.M., Resident C indicated she has had an ongoing problem with receiving showers on her shower days. Resident C indicated she only receives showers once a week and has voiced her concern with the Director of Nursing (DON), and her issue has still not been resolved. During record review on 11/14/22 at 1:48 P.M., Resident C's Level of Service Assessment/ Evaluation dated 10/22/22, indicated, "...Bathing ...is highly involved in the activity but requires assistance with minimal parts of bathing, i.e., wash back, feet, rinse hair, etc. Includes person who cannot get into the bathtub/shower and may require some other standby assistance and/or bathing equipment..." Resident C's scheduled shower days were Wednesday and Saturday evenings. Resident C's documented bathing schedule during October and November, 2022 lacked showers or baths on the following dates; 10/8/22 (Saturday), 11/5/22 (Saturday) , 11/12/22 (Saturday) , and 11/16/22 (Wednesday). 2. On 11/16/22 at 11:30 A.M., Resident J indicated they had not received their scheduled shower the day prior. During record review on 11/16/22 at 11:00 A.M., Resident J's Level of Service Assessment/ Evaluation dated 6/3/22, indicated, "...Bathing ...physical help in transfer or in performing part of the bathing activity.		**2. All residents had the potential to be affected but were not affected as there was coverage during the dates/times noted.** **3.** Shower tasks reviewed in electronic record and any missing shower tasks were added by nursing director and/or designee. Inservice will be completed by December 23, 2022 by Director of Nursing for all nursing staff on use of electronic medical record for identifying daily tasks and documentation of completed/refused tasks. Director of Nursing will audit task documentation daily x 2 weeks, then weekly x 6 months. 4. Audits will be reviewed by monthly QA committee for 6 months; QA committee will make recommendations as needed.	

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Resident J's scheduled shower days were Tuesday and Friday evenings. Resident J's documented bathing schedule during October and November, 2022 lacked showers or baths on the following dates; 10/4/22 (Tuesday), 10/14/22 (Friday), 11/1/22 (Tuesday), 11/4/22 (Friday), and 11/15/22 (Tuesday). 3. During record review on 11/14/22 at 1:00 P.M., Resident B's Level of Service Assessment/ Evaluation dated 6/8/22, indicated, "...Bathing ...physical help in transfer or in performing part of the bathing activity. Resident B's scheduled shower days were Sunday and Thursday days. Resident B's documented bathing schedule during October and November, 2022 lacked showers or baths on the following dates; 10/9/22 (Sunday), 10/13/22 (Thursday), 10/23/22 (Sunday), 10/27/22 (Thursday), 10/30/22 (Sunday), and 11/10/22 (Thursday). During an interview on 11/17/22 at 12:45 P.M. CNA 5 indicated residents who require assistance with bathing should be assisted twice a week on their scheduled shower days. If residents refuse their shower or a shower is not given, staff should document why the shower was not given. On 11/21/22 at 9:45 A.M., the Facility Administrator supplied an undated facility policy titled, Bath/Shower. The policy included, "...It is the policy of this community to provide physical assistance to residents in accordance with the resident's service plan. This service will be entered on the CNA worksheet, individualized			

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	service plan and weekly shower schedule..." This Residential tag relates to Complaints IN00390450, IN00392510, and IN00392599. 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 record review, the facility failed to ensure food was stored and distributed in accordance with professional standards for food service safety during 2 of 2 kitchen observations of the and 1 of 1 meal services observed. Food was not labeled and dated, food was left open to air, an ice scoop was stored in the ice machine, and staff did not perform proper hand hygiene during meal service. Finding includes: During the initial tour of the kitchen on 11/14/22 at 9:19 A.M., the following was observed: Dry storage: An open bag of wide noodles, undated An open bag of premium rice, undated An open bag of nachos, dated 10/22 Refrigerator: A full can of shredded sauerkraut with the lid removed and sauerkraut was open to air. Freezer: A clear bag of sausage links sitting in a cardboard box open to air, undated. A clear bag of pork patty fritters sitting in a			
R 0273 Bldg. 00		R 0273	b=""> 1. No residents were affected by the alleged deficient practice. **2. All residents had the potential to be affected by the alleged deficient practice.3. In-Service completed by Dietary Manager with all kitchen staff. In service topics will include proper food storage including labeling and dating, hand hygiene, and proper storage of the ice scoop. All new hires in the culinary department will be trained on these topics upon onboarding.4. The Culinary Manager, or designee, will audit staff hand hygiene daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The Culinary Manager, or designee, will audit dry storage and walk ins daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure no food**	12/23/2022

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	cardboard box open to air, undated. A clear bag of dough puff sitting in a cardboard box open to air, dated 7/15. A clear bag of pasta shell sitting in a cardboard box, undated. Ice Machine: The ice scoop was resting on top of the ice in the ice machine. During an observation on 11/14/22 at 11:15 A.M., cook 1 was observed to lather his hands for 3 seconds. Cook 1 obtained gloves, placed a hamburger on a bun, picked up a slice of cheese, tomatoes, onions, and pickles and placed them on the hamburger with his hands and failed to change gloves. Cook 1 was observed to touch the above items throughout the entire meal preparation and never changed gloves. During an interview on 11/18/22 at 10:28 A.M., the Dietary Manager indicated food should not be open to air and should be placed in a bag that can be sealed and dated with the date the item arrived at the facility, date the item was opened, and the expiration date of the item. The ice scoop should be stored in a container on the side of the ice machine or on the hook on the ice machine. At that time, she also indicated you should sing the happy birthday song three times when hands are lathered during hand washing. On 11/21/22 at 8:47 A.M. the Facility Administrator supplied an undated facility policy, titled Dry Food Storage. The policy included, "...Food, whether raw or prepared, if removed from the container or package in which it was obtained it shall be in a clean, covered container ...Container covers shall be resistant and nonabsorbent ...The delivery date shall be written		**is left open to air in these areas. The Culinary Manager, or designee, will audit the ice machine daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure proper storage of the ice scoop. The results of the audits/reviews will be discussed at the monthly Quality Improvement Meeting monthly for 3 months and then quarterly thereafter once compliance is 100%.** ="" b="">
b="">="" b="">
b="">="" b="">
="" b="">br="">
="" b="">="" b="">="" b="">	

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	or identified on each product..." On 11/21/22 at 10:05 A.M., the Facility Administrator supplied an undated facility policy, titled Hand Hygiene. The policy included, "...All personnel must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water ...before and after eating or handling food..." This Residential tag relates to Complaint IN00386790.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were available for administration as prescribed by the physician for 5 of 7 residents reviewed for medications. Residents did not receive medications as ordered. (Resident L, Resident J, Resident D, Resident H, and Resident K) Findings include: 1. During an interview on 11/18/22 at 10:00 A.M., Resident L indicated they were not receiving some of their medications. During record review on 11/18/22 at 10:30 A.M, Resident L's diagnoses included, but were not limited to, polyneuropathy, chest pain, and general anxiety.	R 0297	b="">1. No residents were affected by the alleged deficient practice. **2. All residents had the potential to be affected by the alleged deficient practice.3. In-service training for the nursing staff to be completed by the Director of Nursing by December 23, 2022. All new nursing staff hires will be trained during onboarding by the Director of Nursing on the policy for med administration and documentation.4. Administrator /Director of Nursing or designee will audit eMAR**	12/23/2022

PRINTED: 12/27/2022
DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2022

NAME OF PROVIDER OR SUPPLIER HERITAGE WOODS OF NEWBURGH	STREET ADDRESS, CITY, STATE, ZIP COD 4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Resident L's physician orders included, but were not limited to; hydrocodone-acetaminophen 7.5-325 mg (milligrams) 1 tablet every 6 hours (started 5/11/22) and Aspercreme lidocaine 4% patch apply 1 patch every morning and remove after 12 hours every evening (started 2/4/22). Resident L's MAR (medication administration record) for the months of November and October, 2022, the facility failed to provide the following medications on the following dates and times: Hydrocodone-acetaminophen 7.5-325 mg 10/27/22 at 12:00 A.M. - no documentation 11/2/22 at 6:00 P.M. - "Missed - Too close to when she took noon meds [sic]" 11/4/22 at 6:00 P.M. - no documentation 11/7/22 (no time documented) - "Missed" 11/11/22 at 12:00 P.M. - "Other - Resident states that [family] is picking up medication..." 11/14/22 at 6:00 P.M. - no documentation Aspercreme lidocaine 4% patch 10/1/22 through 10/19/22 - "Not available" 10/22/22 - "Resident out of medication" 10/23/22 - "Not available" 10/27/22 through 10/29/22 - "Not available" 11/1/22 through 11/6/22 - "Not available" 11/10/22 - "Not available" 11/14/22 - 11/16/22 - "Not available" 2. During record review on 11/16/22 at 11:00 A.M., Resident J's diagnoses included Parkinson's disease. Resident J's physician orders included, but were not limited to; Oxycodone-acetaminophen 7.5 - 325 mg 1 tablet 4 times daily (started 11/4/22), Trazodone 100 mg 1 tablet at bedtime (started 5/3/22), and Oxycodone 5 mg 1 tablet every 6		**documentation to ensure appropriate documentation and administration of meds. Audit of eMAR will be daily for 1 week, then 5 times a week for 4 weeks, then weekly for 3 months. The results will be discussed at the monthly QA meeting monthly for 3 months and then quarterly thereafter once compliance is 100%.=""** span="">\ span="">="" span="">\ span="">="" span="">\ span="">="" span="">	

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	hours (started 10/5/22 - discontinued 11/4/22). Resident J's MAR for the months of November and October, 2022, the facility failed to provide the following medications on the following dates and times: Oxycodone-acetaminophen 7.5 - 325 mg 11/4/22 at 4:00 P.M. - "Not available" 11/4/22 at 8:00 P.M. - "Not available" 11/5/22 at 8:00 A.M. - "Not available" 11/5/22 at 12:00 P.M. - "Not available" Trazodone 100 mg 10/19/22 at 8:00 P.M. - "Did not have" 10/20/22 at 8:00 P.M. - "Not available" 11/13/22 at 8:00 P.M. - no documentation Oxycodone 5 mg 10/16/22 at 11:00 P.M. - no documentation 10/17/22 at 11:00 P.M. - no documentation 10/20/22 at 11:00 P.M. - no documentation 10/22/22 at 11:00 P.M. - no documentation 10/26/22 at 5:00 A.M. - no documentation 10/27/22 at 5:00 A.M. - no documentation 3. During an interview on 11/15/22 at 1:45 P.M., Resident D indicated, after returning to the facility from the hospital, she did not receive her Xanax medication for several days. During record review on 11/15/22 at 12:30 P.M., Resident D's diagnoses included, but were not limited to, atrial fibrillation, hypertension, and anxiety. Resident D's physician orders included, but were not limited; to Xanax 0.25 mg take 1/2 tablet three times a day (started 9/19/22), Ferrous sulfate 325 mg 1 tablet daily (started 9/19/22), and Sodium Chloride 1 gm (gram) 1 tablet by mouth twice daily (started 9/20/22).			

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Resident D's MAR from September through November 2022, indicated Resident D did not receive Xanax on September 20, 21, 22 and October 4, 5, 6, 7, 8, 9, 10, and 11. Resident D did not receive Ferrous sulfate on September 20, 21, and 22. Resident D did not receive Sodium Chloride on September 20, 21, 22 and October 2, 3, 9, 10, and 11. 4. During record review on 11/16/22 at 9:45 A.M., Resident H's diagnoses included, but were not limited to; manic depressive disorder. Resident H's orders included, but were not limited to, Buspar 10 mg by mouth twice daily (started 1/29/21), Dexilant 60 mg 1 capsule by mouth daily (started 1/20/21), Topamax 1 tablet by mouth twice daily (started 1/29/21), Artane 2 mg 1 tablet by mouth twice daily (started 1/29/21), and Effexor 75 mg 1 tablet by mouth once daily (started 1/31/22). Resident H's MAR (medication administration record) from October 2022 indicated Resident H did not receive Buspar on October 5. Resident H did not receive Dexilant on October 5 or October 22. Resident H did not receive Topamax on October 5 or October 22. Resident H did not receive Artane on October 5 or October 22. Resident H did not receive Effexor on October 5 or October 22. 5. During an interview on 11/21/22 at 8:54 A.M., Resident K indicated she does not always receive her Repatha when she is supposed to and the physician wanted her to start on a low dose of insulin, but she has not received it due to the insulin not coming in. During record review on 11/21/22 at 9:45 A.M.,			

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Resident K's diagnosis included, but were not limited to, congestive heart failure, chronic kidney disease, depression disorder, hyperlipidemia, and hypertension. Resident K's orders included, but were not limited to, Repatha 140 mg/ml inject 1 ml subcutaneous every 2 weeks (started 12/24/20), Levemir Flextouch inject 25 units subcutaneous daily (started 11/14/22). Resident K's MAR from October 2022 indicated Resident K did not receive Repatha on October 13. Resident K's MAR from November 2022 indicated Resident K did not receive Levemir on November 15, 16, 17, 18, 19, and 20. During an interview on 11/21/22 at 8:56 A.M., LPN 4 indicated if the residents are not administered a medication, a nurse's note should document why the medication was not given. LPN 4 indicated that, at times, medications are unavailable especially when it's a new order for a resident. On 11/21/22 at 9:45 A.M., the Facility Administrator supplied a facility policy titled, Medication Management, Administration, & Storage, dated 03/2022. The policy included, "...B. Medication Administration: Medication administration shall be administered as ordered by the resident's physician and shall be administered by a licensed nurse or a QMA [Qualified Medication Assistant]." This Residential tag relates to Complaints IN00387827, IN00390450, IN00392595, IN00392510, IN00384259, IN00394445, IN00392599, and IN00392402.			

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 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 interview, and record review the facility failed to maintain clinical records that were complete and accurate for residents receiving controlled substance for 3 of 5 residents reviewed for medications. Resident's narcotic drug count sheets lacked documentation and resident medication administration records were inaccurately documented. (Resident B, Resident J, Resident M) Finding includes: 1. During record review on 11/14/22 at 1:00 P.M. Resident B's diagnoses included, but was not limited to; schizoaffective disorder, depressive type, anxiety, and pain. Resident B's physician orders included, but were not limited to; alprazolam 0.5 mg (milligrams) 1 tablet every 8 hours as needed (started 8/22/22). Resident B's narcotic count inventory sheet dated 8/24/22, for medication alprazolam 0.5 mg 1 tablet every 8 hours as need lacked documentation between 8/31/22 at 8:54 A.M. and 9/1/22 at 8:30 A.M. The medication count for tablet #25 and #24 did not contain the time, amount given, amount remaining, or the staff initials that administered	R 0349	b=""><1. No residents were affected by the alleged deficient practice. **2. All residents receiving controlled substances had the potential to be affected by the alleged deficient practice.3. In-service training for all nurses and QMAs to be completed by the Director of Nursing by December 23, 2022. All new nursing staff hires will be trained during onboarding by the Director of Nursing on the policy for delivery, handling, and storage of controlled substances. 4. Director of Nursing or designee will audit eMAR documentation and pharmacy count sheets to ensure appropriate documentation and administration of controlled substances. Audit of eMAR will be daily for 1 week, then 5 times a week for 4 weeks, then weekly for 3 months. The**	12/23/2022

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	the medication. 2. During record review on 11/16/22 at 11:00 A.M., Resident J's diagnoses included Parkinson's disease. Resident J's physician orders included, but were not limited to; hydrocodone-acetaminophen 5 - 325 mg 1 tablet every 6 hours as needed. Resident J's narcotic count inventory sheet dated 07/2022, for medication hydrocodone-acetaminophen 5 - 325 mg 1 tablet every 6 hours as needed lacked documentation between 7/23/22 at 12:00 A.M. and 7/26/22 at 9:45 P.M. The medication count for tablets #23 thru #11 did not contain the date, time, amount given, amount remaining, or the staff signature that administered the medication. During an interview on 11/17/22 at 11:40 A.M. QMA 78 indicated the narcotic count sheets must be signed, dated, and new count given each time a medication is administered. QMA 7 indicated the facility had an issue with medications going unaccounted for. During an interview on 11/18/22 at 2:49 P.M. the DON (Director of Nursing) indicated the staff were not using the narcotic medication count sheets, and were just signing the medications off on the medication administration record (MAR). 3. During record review on 11/18/22 at 1:30 P.M., Resident M's diagnoses included, but was not limited to; diabetes, anxiety, and restless leg syndrome. Resident M's physician orders included, but was not limited to; Ropinirole 5 mg 1 tablet 4 times		**results will be discussed at the monthly QA meeting monthly for 3 months and then quarterly thereafter once compliance is 100%.**=" span="">span=""> span=""> span=""> =" span="">=" span="">	

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	daily. During an interview on 11/16/22 at 8:30 A.M., the Facility Administrator indicated Resident M's Ropinirole medication had gone missing. The Facility Administrator indicated during an investigation into the missing medication, QMA 13 admitted to documenting the Ropinirole had been administered on 11/14/22 at 12:00 P.M., and 4:00 P.M., when it had not been so the MAR would not show a medication had been missed. On 11/21/22 at 9:45 A.M., the Facility Administrator supplied a facility policy titled, Medication Management, Administration, & Storage, dated 03/2022. The policy included, "...E. Delivery, Storage, & Handling of Controlled Substances:....8. Each time a controlled substance is delivered, it will be reconciled with the Pharmacy Count Sheet and stored in a controlled medication binder. Completed count sheets will be filed in the resident record...11. Upon the request of the resident for a PRN [as needed] medication, the licensed nurse or QMA must document the controlled substances medication administration by signature date and time on the controlled substances Inventory Sheet. This must occur at the time the medication is removed from the controlled substances medication lockbox." This Residential tag relates to allegations IN00392510 and IN00390635.			
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 analyze patterns of known infectious symptoms.			

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	(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 interview, and record review, the facility failed to ensure residents, resident representatives, and families were notified of suspected or confirmed COVID-19 cases in the facility for 3 of 6 days of the survey. (Resident L) Finding includes: During an interview on 11/17/22 at 1:20 P.M., CNA 8 indicated that Resident L had tested positive for COVID -19. During record review on 11/18/22 at 10:30 A.M., Resident L's nurses note dated 11/18/22 at 9:55 A.M., included, "resident returned from ER [Emergency Room] 11/17/22 COVID positive resident put in quarantine in residents room with isolation precautions..." During an interview on 11/18/22 at 9:30 A.M., the Facility Administrator indicated Resident L had went out to the hospital on 11/16/22 and tested positive for COVID-19, then returned to the facility that night. During an interview on 11/18/22 at 3:20 P.M., the Facility Administrator indicated they had not informed the state agency of a new COVID-19 outbreak in the facility. On 11/18/22 at 2:40 P.M. the Facility Administrator supplied a facility policy titled, COVID-19	R 0407	1. **The administrator placed signage at the Main Entrance, the morning of 11/18/22 before beginning her workday. The administrator placed a message informing of COVID in the facility via Care Merge communication system to all residents and family. Signage had been placed at the main table in the foyer as you walk into the facility on 11/17/22.** **2. All residents had the potential to be affected by the lack of signage on the main entrance.** **Administrator reviewed the new guidelines with the Director of Nursing and will follow them with each outbreak in the future.** **3.** All department heads will be in serviced by the Administrator, DON, or designee on the new COVID Guidelines including communication to staff, residents, family, and visitors. Communication will include signage at the entrance, at the table in the facility foyer, at each	12/23/2022

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	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD NEWBURGH, IN 47630

(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
	Infection Control Policy, dated 7/2022. The policy included, "...Required Communication During an Outbreak A. Under the direction and in collaboration with the RDO (Regional Director of Operations), the administrator, or designee is responsible for communications with public health authorities during a COVID-19 outbreak..." This Residential tag relates to complaint IN00387827.		door with a COVID infected individual, also an isolation cart at each door of a COVID infected individual, signage at the timeclock in the breakroom. A message via care merge system to all residents and families. 4. The DON/Administrator will monitor the signage to communicate COVID is in the building daily while COVID outbreak is in the building. The DON/Administrator will monitor the signage to communicate transmission levels and community levels weekly when facility is free of COVID. All findings will be reported to the QA Committee monthly.	

PRINTED: 09/05/2023
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	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 3 and 4, 2023 Facility number: 014213 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 10, 2023.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu of a Post Survey Review.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, record review, and interview, the facility failed to ensure exit doors on a locked dementia unit were kept locked and	R 0148	**1. What Corrective action(s) will be accomplished for those residents found to have been**	09/15/2023

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

[redacted] | Regional Director of Operations | 08/25/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 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.

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	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(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
	alarmed for 4 of 4 doors that exited to the courtyard. Findings include: During an observation, on 8/3/23 at 10:40 a.m., the exit door in the Sun Room that led to the courtyard had a sign that indicated "For residents safety, all doors to the courtyard will remain secured and alarmed, for access, please see one of our staff for assistance." The door was able to be opened, no alarm sounded, and no staff responded to the area. During an observation, on 8/3/23 at 10:44 a.m., the exit door in Living Room 2 that led to the courtyard had a sign that indicated "For residents safety, all doors to the courtyard will remain secured and alarmed, for access, please see one of our staff for assistance." The door was able to be opened, no alarm sounded, and no staff responded to the area. During an observation, on 8/3/23 at 10:46 a.m., the exit door in Living Room 1 that led to the courtyard had a sign that indicated "For residents safety, all doors to the courtyard will remain secured and alarmed, for access, please see one of our staff for assistance." The door was able to be opened, no alarm sounded, and no staff responded to the area. During a meal observation, on 8/3/23 at 11:53 a.m., two residents exited out of Living Room 2 door into the courtyard. They walked with seated, four-wheeled walkers. No alarm sounded. During an interview, on 8/4/23 at 8:54 a.m., QMA 7 indicated they used a phone system for notifications. If a resident pushed their call		**affected by the deficient practice** a. No residents were adversely affected. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All White Oaks Memory Care residents had the potential to be affected. No memory care residents were adversely affected. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. Memory Care Courtyard door policy developed i. All Current Staff will be educated on memory care courtyard door policy ii. Memory care courtyard door policy will be incorporated into general orientation. iii. Education to be presented to family members and responsible parties via Care Merge **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(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
	pendent, a notification was sent to the phone. If someone entered onto the secure unit or exited from the secure unit, a notification was sent to the phone. The courtyard doors were not set up to send notifications to the phone. During the interview, the Living Room 1 exit door that led to the courtyard was opened and no alarm sounded. During an interview, on 8/4/23 at 10:07 a.m., CNA 5 indicated residents were allowed to go into the courtyard but a staff member needed to be with them. The doors were locked at night and unlocked in the morning. During an interview, on 8/4/23 at 10:13 a.m., CNA 12 indicated the doors to the courtyard were locked between 8:00 p.m. to 8:00 a.m. An alarm sounded if a resident tried to open a door to the courtyard. During an interview, on 8/4/23 at 10:16 a.m., CNA 9 indicated doors to the courtyard had an alarm to alert staff if a resident exited. During an observation of the Activity Room, accompanied by CNA 9, the door that exited to courtyard was not locked and no alarm sounded when door was opened. During an observation, accompanied by LPN 3 on 8/4/23 at 10:27 a.m., the Sun Room exit door to the courtyard was not locked and no alarm sounded when door was opened. During an interview, on 8/4/23 at 10:32 a.m., The Maintenance Director indicated the exit doors to the courtyard were to be armed and locked when not in use. Review of a current facility policy titled, "Admission Criteria," with a last revised date of		**will not recur, i.e what quality assurance program will be put into place:** a. All four White Oaks Memory Care courtyard exit doors will be checked twice daily for lock and alarm unless staff are outside with resident (s) two times daily for 4 weeks; then 2 times a day 4 times a week for 4 weeks; then 2 times a day 2 times a week for 2 weeks; then checks ongoing as needed **5. By what date will the systematic changes be completed**: 9/15/23	

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	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(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
	8/2017 and provided by the DON on 8/4/23 at 3:45 p.m., indicated the following: "...Prospective residents for the memory care community will be evaluated for appropriateness prior to move in. In addition, residents admitted will meet the the following criteria: 1. Diagnosis of Alzheimer's disease or related irreversible dementia. 2. Primary need for care and supervision are due to dementia and/or behavioral issues...6. Determined to be manageable within the physical environment and operational structure...." During an interview, on 8/4/23 at 3:48 p.m., the Administrator indicated they did not have policy related to the secure unit and exit doors and orientation education did not include secure unit and exit doors.			
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 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 and interview, the facility failed to implement an infection control program to analyze patterns of known infectious symptoms. This deficient practice had the potential to impact 119 of 119 residents. Findings include:	R 0407	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. May infection control log analysis completed, upon review 5	09/15/2023

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	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(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
	During record review on 8/4/23 at 3:02 p.m., the infection control resident log for May 2023 indicated 11 residents had symptoms documented as upper respiratory infection (URI): a. Residents on the fourth floor were with URI symptoms starting on 5/2/23, 5/5/23, and 5/6/23. b. Residents on the third floor were with URI symptoms starting on 5/4/23 and 5/5/23. c. Residents on the second floor were with URI symptoms 5/9/23, 5/10/23, and 5/12/23. The log contained no infection analysis, tracking or trending information, or COVID-19 testing. During record review on 8/4/23 at 3:02 p.m., the infection control resident log for June 2023 indicated 50 residents were prescribed an antibiotic medication. The log contained symptoms for 16 of the 50 residents listed. The log contained no symptoms, infection analysis, tracking or trending information, or COVID-19 testing. During an interview, on 8/4/23 at 3:05 p.m., the DON indicated she had not updated the Infection Prevention binder to include the areas she intended to follow such as mapping locations for communicable infections. The months in question were prior to her being hired. The policy the facility used for infection control was the "COVID-19 Infection Control Policy." During an interview, on 8/4/23 at 3:45 p.m., QMA 2 indicated when a resident showed new respiratory symptoms she would obtain vitals, report to the scheduled floor nurse, and send a message to the DON immediately.		residents noted to have URI (duplicate entries noted). Residents' information was added to floor plans, tracking and trending reviewed no common issues found except husband/wife both had UTI and share apt. June and July infection control logs analysis completed and found no residents affected by alleged deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All 119 residents have potential to be affected by alleged deficient practice. No residents were found to be affected by alleged deficient practice. 3. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. Director of Nurse will be completing monthly log, analysis, tracking and trending. COVID policy and procedure review with Director of Nursing by the Regional Director of Clinical services on August 22,2023. Director of Nursing inserviced nursing staff on Infection Control Program on August 22, 2023. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality**	

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	08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(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
	Review of a current facility policy, titled, "COVID-19 Infection Control Policy", last revised 11/18/22 and provided by the DON on 8/4/23 at 3:45 p.m., indicated the following: "... Residents are encouraged to report any signs or symptoms of COVID-19 or other illness to a staff member right away. ...Residents with close contact exposure should have daily wellness screening and vital signs for 10 days. ...Isolation Precautions: ...For residents with suspected and/or confirmed COVID-19. This isolation precaution type will be implemented immediately for the care of residents with suspected and/or confirmed COVID-19, as recommended by the CDC...."		**assurance program will be put into place:** a. The QAPI committee will review Infection Control Program monthly information and make recommendations if needed. Infection Control Program will remain a monthly Key Performance area x 6 months to ensure analysis of Infection Control Program is being adequately evaluated. **5. By what date will the systematic changes be completed**: 9/15/23	

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: Heritage Woods of Ottawa
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☒
ENTRANCE DATE: 11/13/23 EXIT DATE: 12/13/23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.
BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____
REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐
BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**
(1st) BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐
(2nd)BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

12/14/23
Date

12/13/23
Date

12/13/23
Date

Signature of Bureau of Long Term Care Area Manager

Date

Heritage Woods of Ottawa Annual

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider Heritage Woods of Ottawa ID #_____

Address 801 Etna Rd Freestanding (X) ~~Rehab NF ( )~~

City Ottawa IL 61350 Zip Code 61350

Phone # 815-431-1400 Fax # 815-431-9147

Occupancy Information

# of Single Occupancy Apts.	81	Current Medicaid Census	50
# of Double Occupancy Apts.	1	Current Private Pay Census	33
Total # of Apts.	84	**Total** Current Census	83
Maximum Potential Occupancy	115	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes (X) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (X) No ( )

Type of Certification Review (complete only one)	Entrance Date	Exit Date
Final		
Annual	11/13/23	11/13/23

REVIEW FINDINGS: YES ( ) NO (✓)

Ombudsman was notified on 11-6-23 about the date of the review.
Ombudsman participated in review: Yes ( ) No (✓)

Provider Manager/Designee Signature/Date [redacted]

Review Team's Signature/Date [redacted]

Regional Supervisor Signature/Dat[redacted]

Area Manager Signature/Date

Bureau Chief Signature/Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: HW of RKFD Annual review 8-25-22 REFERRAL DATE: 7/14/23
First Follow-up (X) rewrite after 1st follow up Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.235 Staffing		
e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials.	RDO to in service all department managers on the importance of all staff attending general orientation and completing department training within 30 days of hire date.	
1) The SLP setting shall provide staff and subcontractors who provide direct care with:	Semi-annual in service scheduled and to be completed with all staff. Staff training to include, residents right, non discrimination, abuse, neglect and financial exploitation, crisis/behavioral intervention, resident inquiry and admission, TB identification and infection control	

Section 146.235 Staffing (continued) e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) B) training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy (these subjects shall be trained as part of staff orientation and at least annually thereafter); E1-E3, E4-E16. Non-discriminatory and Resident Inquiry Application Training not completed as part of orientation training. E17-E19. No orientation training done at all.	Monthly review for compliance to be checked during quality assurance meeting.	

Section 146.235 Staffing **m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** • E25. DOH 6/28/22. 1st step 4/25/23, neg read 4/27/23. 2nd step 4/30/23, neg read 5/2/23. • E29. DOH 5/3/23. 1st step 5/3/23, neg read 5/5/23. 2nd step 5/16/23, no 2nd step read done. • E2. DOH 10/5/22. No TB documentation at all. • E28. DOH 3/22/22. No TB documentation at all. • E3. DOH 1/2/23. No TB documentation at all. • E5. DOH 3/21/23. No TB documentation at all. • E6. DOH 5/24/22. No TB documentation at all.	RDCS to inservice all staff on tuberculin skin test , signs, symptoms and screenings. Executive Director or designee to audit all staff TB test documentation on monthly basis for compliance. Newly hired staff will have first step of TB test completed on day of orientation. Both steps will be completed and documented within 21 day of hire or removed from schedule until completed. TB compliance to be monitored in quality assurance meetings	

Section 146.235 Staffing l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. E24. DOH 4/29/22. Initial registry check 4/26/22. Next verification 12/2/22. No 30-day verification. E25. DOH 6/28/22. Initial registry check 6/27/22. Next verification 12/2/22. No 30-day verification. E26. DOH 4/19/23. Initial registry check 4/17/23. Next verification 6/14/23. No 30-day verification. E1. DOH 3/14/22. Initial registry check 3/13/22. Next verification 6/14/23. No 30-day verification.	Executive Director or designee to audit all employee files for verification of 30 day HCW registry. . RDO to in-service all department managers on importance of completion of initial registry check, six websites checks and 30 day verification registry check on all employees. Executive Director completed background check on all employees on 7/18/2023. Audit tool put into place to easily track completion of initial registry check, six websites and 30 day verification check. Compliance to be reviewed during monthly quality assurance meeting.	

Section 146.235 Staffing **l) continued** • E2. DOH 10/5/22. Initial registry check 10/3/22. Next verification 6/15/23. No 30-day verification. • E27. DOH 7/22/22. Initial registry check 7/11/22. Next verification 12/2/22. No 30-day verification. • E28. DOH 3/22/22. Initial registry check 3/21/22. Next verification 6/14/23. No 30-day verification. • E3. DOH 1/2/23. Initial registry check 1/11/23, late. • E29. DOH 5/3/23. Initial registry check 5/1/23. Next verification 6/13/23. No 30-day verification. • E30. DOH 5/10/23. Initial registry check 5/10/23. Next verification 6/13/23. No 30-day verification. • E31. DOH 5/10/23. Initial verification 5/10/23. Next verification 6/13/23. No 30-day verification. • E6. DOH 5/24/22. Initial registry check 7/3/22, late. Next verification 6/14/23. No 30-day verification. • E7. DOH 4/5/22. Initial registry check 4/4/22. Next verification 6/12/23. No 30-day verification. • E8. DOH 8/4/22. Initial registry check 12/2/22, late. Next verification 6/14/23. No 30-day verification. • E9. DOH 8/24/22. Initial registry check 8/19/22. Next verification 6/14/23. No 30-day verification.		

Section 146.235 Staffing **l) continued** E11. DOH 11/16/22. Initial registry check 11/16/22. Next verification 6//13/23. No 30-day verification. E12. DOH 12/1/22. Initial registry check 12/1/22. Next verification 6/14/23. No 30-day verification. E14. DOH 12/19/22. Initial registry check 12/19/22. Next verification 2/16/23, late. E36. DOH 4/26/23. Initial registry check 4/26/23. Next verification 6/13/23. No 30-day verification. E33. ODH 8/22/22. Initial registry check 8/12/22. Next verification 6/14/23. No 30-day verification. E34. DOH 11/30/22. Initial registry check 11/29/22. Next verification done 2/16/23, late. E19. DOH 6/1/22. Initial registry check 7/2/22. Next verification done 12/2/22, late E34. DOH 11/30/22. Initial registry check 11/29/22. Next verification 2/16/23, late. E16. DOH 1/3/23. Initial registry check 1/5/23. Next verification done 2/16/23, late. **Six Registry Websites:** E3. DOH 1/2/23. Websites checked late 1/11/23. E6. DOH 5/24/22. Websites checked late 7/3/22. E19. DOH 6/1/22. Website checked late 7/2/22		

Section 146.235 Staffing **l) continued** **Fingerprint Check:** E26. DOH 4/19/23. 1st day worked 4/21/23. Fee App 5/18/23, late. Was not taken off the schedule until fingerprints were obtained per E23. E3. DOH 1/2/23. 1st day worked 1/2/23. Fee App 5/18/23-late. E23 noticed fingerprints were late and was taken off the schedule on 5/16/23 until 5/18/23.	Administrator or designee to request fingerprints of new staff that are not in Health Care Worker Background Registry. New employees will not be scheduled for orientation until proof of fingerprints being completed are turned into department manager. Audit tool put into place to easily track requesting of fingerprints and completion of fingerprints.	

Section 146.215 SLP Participation Requirements **o) The SLP provider shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests. The SLP provider shall provide all residents with information about advance directives, including the Durable Power of Attorney for Health Care, Statement of Illinois Law on Advance Directives, Living Will, Declaration for Mental Health Treatment and Do Not Resuscitate Advance Directive. The SLP provider shall maintain in a resident's file any of these documents authorized by the resident.** • R19. No documentation that advanced directive information was given. • R34, No documentation that advanced directive information was given.	Regional Director of Operations to in service department managers on Advanced Directive potocol given to new residents. Move in Coordinator to complete a monthly audit for verification of compliance. Results to be discussed in monthly quality assurance meeting. R19 and R34 provided with information regarding advanced directives on 7/18/23.	

Section 146.220 Resident Participation Requirements **d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** R1. Admit 4/6/22. 1st step 5/5/22-late, read neg 5/7/22. 2nd step 5/16/22, neg read 5/19/22. S&S late on 5/5/22, late. R17. Admit 3/31/23. TB testing was initiated 4/14/23-late. S&S 4/14/23-late R19. Admit 8/22/22. S&S 9/1/22-late. R20. Admit 1/24/22. 1st step 1/25/22, read neg 1/27/22. S&S 1/25/22. No 2nd step was done at this time. Additional TB testing done 5/5/23, neg read 5/7/23. 2nd step 5/16/23, neg read 5/19/23. R22. Admit 7/22/22. No TB documentation. R25. Admit 5/17/22. 1 step 6/6/22, read neg 6/8/22. No 2nd step or S&S done. R27. Admit 7/12/22. 1st step 7/12/22, no read date. No 2nd step done. R33. Admit 3/12/22. 1st step 5/16/22-late, no read date. R33 was in hospital on 5/17/23. No 2nd step documentation. S&S 5/12/22-late. R38. Admit 11/11/22. No TB documentation.	Regional Clinical Director to in-service nurses and Administrator on tuberculin skin test and symptoms check list. Audit of resident charts to be completed by Director of Nursing or designee for compliance of tuberculin skin test. Monitoring and ensuring timely compliance will be overseen by Director of Nursing and reported on monthly at community quality assurance meeting.	

Section 146.230 Services **b) Nursing Services** **5) All nursing services shall be provided in accordance with the Nurse Practice Act [225 ILCS 65].** **R8.** New order received 3/16/23 for Famotidine 20mg twice daily. Order not transcribed on March Pos. **R8.** New order received 5/15/23 for Humalog 75/25. On 5/16/23 pharmacy report was received that states insurance does not cover 75/25 with suggestion to change to 70/30. Physician agreed on 5/16/23. **New order for 70/30 not transcribed on May POS.** Per May 2023 emar, 75/25 was approved by nurse on 5/16/23 and documented as given on 5/16/23 at 12 pm, 4 pm. **However, the facility did not have the 75/25 Humalog, pharmacy never sent it.** 70/30 was documented as first given on 5/16/23 at 4 pm. **R12:** Physicians order sheet for April, May, June 2023 did not have any orders for wound treatment noted. **R12:** 4-23-23 Daughter took R12 to urgent care notes from urgent care visit in the chart stating R12 needed consult with bum and wound care clinic. **R12.** Wound care treatment orders on POS For April, May and June 2023 are not being followed.	Regional Clinical Director and Transitional Care Management to provide education and in-service the Director of Nurses, Staff Nurse and Administrator on Nursing Services listed under section 146.230 (b): documentation, order clarification and nurse follow through of physician orders. Regional Clinical Director to provide education to Director of Nursing, Staff nurse and Administrator of oversight and guidelines related to wound care. The Director of Nursing or designee to complete weekly audits of resident's medical records. Results of weekly audits and process improvement initiatives to be reported at monthly quality assurance meeting.	

Section 146.230 Services b) Nursing Services 5) **continued** R12: 4-25-23 Note from Swedish American order states wash burn BID with mild soap and water thin layer of antibiotic ointment may cover with nonstick bandage. R12: 4-27-23 R1 seen at Swedish American wound clinic. New order (N/O) Lidocaine 2% jelly, saline wound wash and gauze for wound cleansing daily. Apply plurogel daily to tan slough areas of right thigh wound cover the entire wound with saline moistened gauze then cover with Abd pad daily. R12: 5-5-23 wound care clinic paperwork states full thickness burn right thigh treatment cleanse with hibiclens and soft cloth rinse with normal saline apply plurogel and lidocaine to wound bed cover with xeroform then ABD pad secure with kerlix change daily. R12: 5-11-23 seen at Swedish American for wound visit. R12: 5-12-23 Not faxed over from visit states right thigh cleanse with hibiclense soap rinse off cover with xeroform and ABD secure with tub grip and change 3 times weekly. R12: 6-7-23 R1 seen at Swedish American for wound visit. Clinic note states Patient present to wound clinic for follow up and ongoing management of wound to right proximal anterior thigh. Patient arrives with dressing intact from this morning. Wound improving but treatment plan changed to accelerate wound healing. Wash wound with normal saline pat dry with gauze pad. Paint surrounding skin with protective wipe and allow to air dry.		

Section 146.230 Services **b) Nursing Services** **5) continued** R12: Apply cutimed sorbact hydroactive B to the wound bed change daily. R12: On second page of the note it states 3 times wkly if these dressings can not be obtained it is ok to use xeroform. R12: Clarification not gotten until 6-14-23 following HFS pointing out discrepancy. R12: When wound treatment got done according to nurses notes: 4-22-23 Resident refused treatment 4-25-23 order for BID treatment only charted that treatment was done 1 time. 4-26-23 order for BID only charted done 1 time. 4-27-23 order changed to daily. charted that treatment was done. 4-28-23 and 4-29-23 treatment charted. Nothing charted for 4-30-23 or 5-1-23 May 2nd,3rd, 4th, 5th, 6th treatment charted Nothing charted for May 7th, 2023 May 8th, 9th, 10th, 11th, 12 treatment charted May 12th order changed to three times per week. Treatment done May 13th.	Type text here	

Section 146.230 Services **b) Nursing Services** **5) continued** R12: Treatment done May 15th, 19th for the week of May14th treatment was only done 2 times per nurses notes. No dressing changes charted for the week of May 21st. Treatment done May 28th, 31st, June 2nd Treatment done June 8th (order also changed clarified on 6-16-23 after HFS found discrepancy for three times per week) and June 10th. The week of June 4th is missing one treatment. Treatment done June 12th, 14th.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse.** • R1. Admit 4/6/22. Initial assessment and service plan completed but it was not signed or dated. • R34. Admit 2/6/23. Initial assessment and service completed but it was not signed or dated. • R32. Admit 9/21/22. No initial assessment and service plan completed. • R36. Admit 3/26/23. No initial assessment and service plan completed. • R37. Admit 10/12/22. Initial assessment and service plan completed 10/14/22-late. • R38. Admit 11/11/22. Initial assessment and service plan not completed.	RDCS to in-service Director of Nursing and Staff Nurse to review initial assessment and service plan protocol and regulatory standards. Director of Nursing or designee to audit charts for accuracy and completion of inititial assesments and service plans Director of Nursing or staff nurse to perform monthly audits and report at monthly quality assurance meeting	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R1. Admit 4/6/22. RAI 4/22/22, late. R7. RAI 12/1/22. Meds scored 1. During HFSN interview the med assist was observed and R7 should be coded 2. R10. RAI dated 8/10/22 and previous RAI dated 7/13/21. Greater then 366 days apart. R12. RAI dated 3/2/23 was updated/corrected 6/13/23 when HFSN asked for RAI. Shopping corrected from 2 to 3. Finances corrected from 1 to 3. Meals, laundry, and housekeeping corrected from 2 to 3. RAI dated 3/2/23 had some updates noted from 6/13/23 however section K skin conditions was coded h. none of the above. R16. Admit 3/31/23. RAI 6/12/23-late. R19. RAI 8/28/22. Section E, Mood and behaviors left blank. R20. Admit 1/24/22. RAI 4/20/22-late.	RDCS to in-service Director of Nurses and Staff Nurse to review change of condition protocol, RAI initial and annual protocol Director of Nursing or designee to audit charts for accuracy and completion of change in conditions and annual compliance Change of conditions to be discussed in department managers morning meeting and Director of Nurse to bring action plans to quality assurance meeting monthly.	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: R21. Admit 11/4/21. RAI 1/3/22-late. R23. Admit 7/22/22. RAI 8/6/22-late. RAI is also not accurate. RAI was updated/corrected 6/13/23 when HFSN asked for RAI. Section A/Guardianship marked yes, corrected to responsible for self. Cognition coded 0, corrected to 1. Communication and mood/behavior left blank, corrected. Physical function coded 2 corrected to 0. Meds coded 0 corrected to 1. Shopping coded 0, corrected to 1. Meals and laundry coded 2 corrected to 3. Pain coded 1, corrected to 2. R23 has ostomy, not on RAI, corrected 6/13/23. RAI missing the following dx; htn, arthritis, asthma and glaucoma. This was also corrected 6/13/23. R25. Admit 5/17/22. No RAI completed for admission. 1st and only RAI 5/2/23. R27. Admit 7/12/22. RAI 7/27/22-late and many sections left blank R30. Admit 6/13/22. RAI 7/26/22-late. R34. Admit 2/6/23. RAI 2/22/23-late. R36. Admit 3/23/23. RAI 6/7/23-late.	Type text here	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment:** R39. RAI 2/1/22-signed by LPN. R39. RAI 1/22/23 was updated by E21 on 6/13/23 to reflect current needs. R39 has a decline in health in June 2023 with hospice starting 6/9/23. However, medications after update still coded a 1, should be coded a 3. R39 is a medication reminder/assist to all meds except Morphine which is a nurse give.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** R1. RAI 4/22/22. ISS 4/19/22, prior to RAI. ISP should have been completed. ISP signature page remediated on site 6/14/23 (resident signature, choose services, resident rights). R2. ISP 12/26/22 not signed by resident. Remediated on site 6/13/23 (resident signature, choose services, resident rights). R4. ISP 8/22/22 not signed by resident. Remediated on site 6/13/23 (resident signature, choose services, resident rights). R5. ISP 8/28/22 not signed by resident. Remediated on site 6/13/23 (resident signature, choose services, resident rights).	RDCS to inservice nursing staff on facility policy and regulatory standards on Assessment and Service plans quarterly evaluations Director of Nursing or designee to audit charts for accuracy and completion of service plans and quarterly evaluations monthly Director of Nursing to include audit in quality assurance monthly meeting.	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan:** R12. RAI dated 3/2/23. ISS dated 6/13/23. No ISS with 3/2/23 RAI. ISS dated 6/13/23 did not have any mention of burn or wound care. R19. RAI 8/28/22. ISS 8/24/22-not after RAI. R24. ISP not signed by resident. Remediated on site 6/13/23 (resident signature, choose services, resident rights). R25. Admit 5/17/22. ISP completed 5/2/23 and no prior one. R26. ISP 10/18/22-late and not signed by resident. Remediated on site 6/15/23 (resident signature, choose services, resident rights). R27. Admit 7/12/22. RAI 7/27/22, ISP 10/16/22-late and not signed by the resident. Remediated on site 6/15/23 (resident signature, choose services, resident rights). R28. ISS completed 9/18/22, should have been ISP. Not MCO. ISP remediated for resident signature while onsite 6/15/23 (resident signature, choose services, resident rights). R31. ISP 4/13/23-not signed by resident. Remediated on site 6/15/23 (resident signature, choose services, resident rights). R32. ISP 10/2/22-not signed by resident. Remediated on site 6/15/23 (resident signature, choose services, resident rights). R34. Admit 2/6/23. RAI 2/22/23. ISP 6/14/22-late. R36. Admit 3/23/23. RAI 6/7/23. ISP not completed as of 6/13/23.		

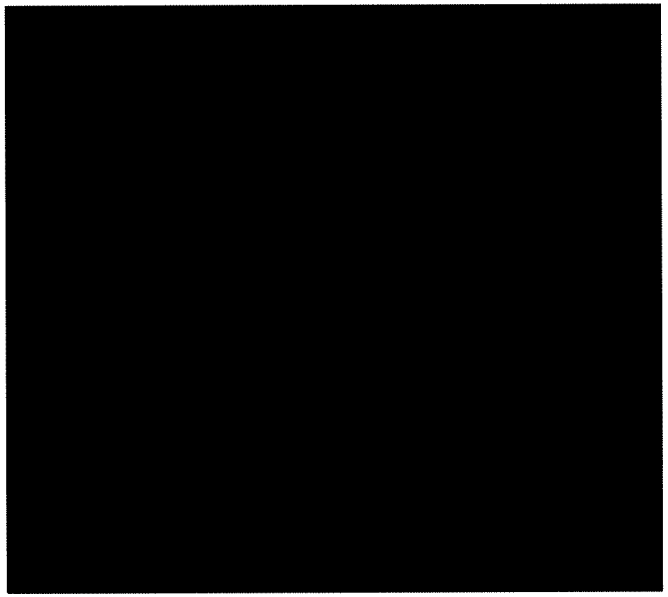
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan:** R37. Admit 10/12/22. ISP not signed by resident. Remediated on site 6/14/23 (resident signature, choose services, resident rights). R38. Admit 11/11/22. ISS completed 11/19/22. MCO 6/1/23. ISP should have been completed. Remediated on site 6/14/23 (resident signature, choose services, resident rights). R39. RAI 1/22/23, updated 6/13/23. ISS 10/23/22 date does not correlate to RAI 1/22/23 (previous RAI 2/1/22). ISS was also updated 6/13/23.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** • R3. RAI 1/17/23. Last three quarterlies would have been due in October 2022, July 2022 an April 2022. No quarterlies in chart per E17. • R24. RAI 12/27/21. Quarterly due 3/2022, no quarterly done. MCO ended 9/30/21 and did not resume until 9/1/22 per sample list. • R32. Admit 9/19/22. RAI 10/2/22. MCO 6/1/23. Only quarterlies in chart are 12/11/23 and 5/31/23. Missing quarterlies from 1/2023 and 3/2023. • R33. Admit 3/12/22. RAI 3/12/22. MCO 11/1/22. Missing quarterlies from 6/2022 and 9/2022. • R34. RAI 2/22/23. Quarterly was due 5/2023-not completed. • R35. Admit 10/9/21. RAI 12/27/21. Quarterly due 3/2022, not completed. MCO 5/1/22.		

Section 146.295 Emergency Contingency Plan **e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.** • R23. Admit 7/22/22. No documentation emergency plan education was given. • R34. Admit 2/6/23. No documentation emergency plan education was given. Type text here	Regional Director of Operations to in service all department managers on the facility emergency contingency plan for new residents during resident orientation. Move in Coordinator to complete a monthly audit for verification of compliance. Results to be discussed in monthly quality assurance meeting. R 34 was given information on emergency contingency plan on 7/18/23. R23 moved out of building June 23, 2023.	

Signature of SLP Provider Representa [redacted] Date 7-14-23

Resident and Employee Key:



HW of Rockford Annual review Findings

[redacted]

6/12/19

86

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 5**

SLP NAME: Heritage Woods of South Elgin AR WY23

CHECK ONE:

( ) INTERIM CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS:** YES ☒ NO ☐

ENTRANCE DATE: 7.11.23 EXIT DATE: 8/30/23

( ) CHANGE OF OWNERSHIP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) INCIDENT FOLLOW UP **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW **( ) SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 5**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office.
BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

8-30-23
Date

8/30/23
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 3 OF 5**

PROVIDER NAME: Heritage Woods of South Elgin AR WY23 REFERRAL DATE: 8/30/23
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements **a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting:** **2) Be screened by the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON), or successor tool, screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. If the**		

individual is transferring directly from a nursing facility and has a history of a developmental disability or serious mental illness, as evidenced in the medical history accompanying the individual, the SLP provider must submit a referral for a specialized evaluation to be completed by the DHS Division of Developmental Disabilities (DHS-DDD) Independent Service Coordination (ISC) agency or the Division of Mental Health (DHS-DMH) Preadmission Screening Resident Review (PASRR) agency to evaluate for need for active treatment or the existence of serious functional risks and needs associated with the diagnosis to determine if they exceed the capacity of the SLP setting. Private pay individuals may choose to be admitted into the SLP setting when the screening assessment does not justify nursing facility level of care. **R40 admission date 7/19/22.** SLP initial assessment done late on 7/20/23. **R9 admission date 11/17/22.** SLP initial assessment done late on 7/20/23. **R27 admission date 7/22/22.** SLP initial assessment done late on 7/20/23. **R39 admission date 3/31/23.** SLP initial assessment done late on 7/20/23. **R28 admission date 8/11/22.** SLP initial assessment done late on 7/20/23.		

R38 admission date 5/4/23. SLP initial assessment done late on 7/20/23. **R13 admission date 3/1/2023.** SLP initial assessment done late on 8/21/23. **d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** **R1 admission date 9/4/22.** TB Screening test not performed in accordance with Control of TB Code. TB 1st step done 07/12/23, read negative on 07/14/23; Step 2 was not done. Step 2 was started during annual survey. Remediated **R2 readmission date 4/19/23.** TB Signs/symptoms checklist was not done for readmission on 4/19/23. **R4 admission date 3/14/23.** TB Signs/symptoms checklist was not done for readmission on 3/14/23. Remediated on site during survey. **R28 admission date 8/11/22.** TB step 1 done on 8/11/23 but not read and Step 2 is missing. Remediation started on site during survey- Step 1 given on 7/12/23. **R11 admission date 9/17/22.** TB step 1 done on 9/19/22 but not read and Step 2 is missing. Remediation started on site during survey.		

Signature of SLP Provider Representat[redacted] Date 8-30-2023

DEPT OF HEALTHCARE AND
FAMILY SERVICES
BUREAU OF LONG TERM CARE
200 S WYMAN ST #307C
ROCKFORD, IL 61101
815-987-7731 Direct OFFICE
Fax: (217) 557-5061

facsimile transmittal

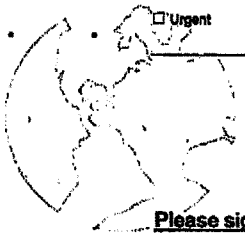
To: [redacted] Administrator Fax: 815 625 ~~2045~~ 7054

From: HFS BLTC ROCKFORD REG Date: 11-20-23

Re: 12-12-22 Annual findings Pages: to Follow 20 pages

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle



CONFIDENTIAL

Please sign page 2 of 2 and return, also sign page 15 of 18.

A plan of correction is due within 14 days and must be completed within 30 days. Thank you.

Cal if questions.

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: HW Sterling
CHECK ONE:

( ) INTERIM CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) FINAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

(X) ANNUAL CERTIFICATION REVIEW FINDINGS: YES ☒ NO ☐
ENTRANCE DATE: 12-12-22 EXIT DATE: 11-20-23

( ) CHANGE OF OWNERSHIP REVIEW FINDINGS: YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) INCIDENT FOLLOW UP REVIEW FINDINGS: YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.
BEGIN DATE: EXIT DATE:

( ) COMPLAINT REVIEW DATE OF COMPLAINT:
REFERRAL DATE: REVIEW FINDINGS: YES ☐ NO ☐
BEGIN DATE: END DATE:

( ) FIRST FOLLOW-UP REVIEW ( ) SECOND FOLLOW-UP REVIEW
(1st) BEGIN DATE: END DATE:
FINDINGS CORRECTED: YES ☐ NO ☐
(2nd)BEGIN DATE: END DATE:
FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS Page 2 of 2

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative	Date
[redacted]	11/20/23 Date
[redacted]r	11-20-23 Date
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: HW Sterling AR 12-23-22 findings REFERRAL DATE: 10-23-23
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). **Resident TB:** R1 – TB 2 step never initiated. Admission 9-22-21. R21- admit 7/29/21. TB started on 9/7/21., late. R23 – admit date 12-3-21, TB 1st step initiated on 12-31-21. Late but had both steps completed.		

Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). **Signs and Symptoms Check List:** **R1 - admit 9/22/21 check list completed on 11/17/21.** **R21 - admit 7/29/21, check list done on 9/7/21.** **R20 - admit 10/19/21. Check list completed on 11/17/21. Late**		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. **RAI:** **R1 – Admitted 9-22-21, RAI date is 1-28-22, late, not completed within 7-14 days of admission.** **R2 – Admit date 6-23-22, RAI date 8-22-22, late.** **R5 – Admit 3-31-22, RAI 5-10-22, late.** **R7 – admit 12-31-21, RAI 1-18-22, late.** **R10 – admit 1-25-22, RAI 3-7-22. Late.** **R11 – admit 7-14-21, RAI dates 7-28-21 and 9-26-22, late.** **R12 – admit 11-15-22, RAI 12-1-22, late.** **R19 - admit 3/10/22. RAI dated 5/9/22. Late** **R23 – admit 8/26/22. RAI 9/25/22. Late.**		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation		
c) Comprehensive Resident Assessment		
R25 – admit 12-3-21, RAI 4-7-22, late.		
R26 – admit 9-1-21, RAI 10-22-21, late.		
R27 – admit 8-11-22, RAI date is 9/25/22, late.		
R45 admit 9/1/18. Is MCO. RAI on tool is dated 7/22/21 and 9/25/22. More than 366 days.		
R28 admit 8/25/21. RAI on admit dated 10/6/21, Late.		
R29 Admit 5/25/22, RAI date is 6-13-22, late.		
R17 - admit 3/1/22. RAI date 5/2/22. Late		
R21 - admit 7/29/21 RAI done on 9/8/21. Late		
R 31- admit 3/31/22. RAI dated 5/9/22. Late		
R4 - admit 11/1/21. RAI date 3/2/22. Late		
R16 - admit 8/29/12. RAI dated 6/9/21 not signed by RN. RAI dated 6/20/22 is more than 366 days.		
R35 - admit 9-2-22, RAI 9/26/22, late.		
R36 – admit date 7/9/22., RAI date 9/25/22. Late.		
R46 - admit 11/3/14. RAI dated 11/1/21 and 11/29/22. Longer than 366 days.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment R14 - admit 11/2/21 RAI date 12/9/21 late. R44 - admit 9/28/18. RAI date 11/10/21 and 11/30/22. Longer then 366 days. R43 admit 12/20/14 MCO 7/1/19. RAI date 10/16/20 and 1/6/22. longer than 366 days. R42 admit 4/1/09, MCO 7/1/19. RAI dated 11/1/21 and 11/30/22. Longer than 366 days between. R20 - admit 10/19/21. RAI date 1/28/22 late R41 - admit 8/31/12 MCO 7/1/19. RAI date 5/18/21 and 7/7/22. R40 - admit 2/28/17. RAI dates 1/19/21 and 4/8/22. Longer than 366 days. 1/19/21 RAI was not cosigned by an RN. R34 - admit 12/30/16. RAI dates 11/27/20 and 3/11/22. R13 - admit 1/12/22, RAI date 3/4/22. Late R15 - admit 7/27/21, move in 8-5-21. RAI date 9/13/21. Late. R37 - admit 2/28/22. RAI date 3/23/22. Late.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. **ISP / ISS:** R1 – admit date 9-22-21, RAI date is 1-28-22 and IP date is 1-24-22 before RAI date. R19 admit 3/10/22. ISP dated 5/9/22. RAI date 5/9/22. Late. ISP Resident's Rights section was not initialed by the resident. Remediated on 12/28/22. R18 - admit 5/11/22. RAI dated 5/23/22, ISP dated 5/18/22. ISP done before RAI. Resident Rights section on ISP was not initialed. Remediated on 12/27/22. No RN signature.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: **R21 - admit date 7/29/21. MCO date 12/1/21. No ISP only ISS dated 9/7/22.** **R23 –ISS 9/8/22 is not initialed and is dated before RAI date of 9/25/22.** **R31 admit 3/31/22. ISP dated 3/31/22. RAI 5/9/22. ISP done before RAI, out of sequence. ISP Resident's Rights initials remediated on 12/28/22.** **R33 –RAI date 9/27/22. ISS date 9/8/22 out of sequence.** **R3 - admit 5/31/21. ISP date of 5/29/21 was not signed or initialed by the resident. Remediated on 12/28/22.** **R13 - admit 1/12/22. Is Private Pay. ISP date 3/8/22. Was not signed or dated. the Resident Rights was not initialed. Was remediated on 12/28/22.** **R15 - admit 7/27/21, move in 8/5/21. ISP date 9/28/21 is late and was not signed or initialed. Was remediated on 12/28/22.** **R12 - admit 11/15/22. ISP date 12/1/22 was not signed by resident. Remediated.** **R20 - admit 10/19/21, ISS date 1/28/22. Not signed by RN, only LPN.** **R14 - admit 11/2/21. ISP date 12/9/21. Signed by LPN only.**		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. **R15 – quarterlies are dated 6/16/22, 9/28/22, late.** **R3 – Quarterly dated 9/29/22 late, annual 6/15/22.** **R7 –RAI dated 1-18-22, R7 should have had a quarterly in 4/2022 but none completed. MCO started 6-1-22.** **R8 – No quarterlies found from admit 11-6-19 to MCO date 9-1-20.** **R9 – admit 6/2/22, RAI 6/16/22,1st quarterly 10/3/22, late.** **R19 – quarterly dates 8/25/22 is greater than 92 days from RAI dated 5/9/22.** **R22 –quarterly 2/2/22 and 6/13/22 are late.** **R24 – RAI 5/17/22, 1st quarterly 6/13/22 and 2nd quarterly late 9/29/22.** **R25 – Admit date is 12-3-21, RAI date is 4-7-22, quarterly is dated 8-24-22 (late).** **R26 – RAI date is 10-22-21, Quarterly date is 3-22-22, late.**		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: R28 - RAI date 10-6-21, Quarterly date is 3-13-22, late. R29 – RAI Date is 6/13/22, Quarterly date is 9/29/22, not signed by RN and late. R30 - admit 9/11/19. Quarterly dates 7/9/21 and 9/23/22. Late R31 - RAI date is 5/9/22, 1st quarterly 8/30/22 late, 2nd quarterly is 12/2/22, late. R32 - admit 4/12/19. RAI 5/3/22, Quarterly 8/24/22, late. R33 – RAI annual 9/9/21, quarterly 12/10/21, late R18 - RAI dated 5/18/22. 1st Quarterly done 9/23/22. MCO date 10/1/22. Late R5 - Quarterlies dated 11/28/22, 8/30/22 are signed by an LPN and not co-signed by an RN. R5 – RAI date 5-10-22, quarterly 8-30-22, late. R29 - quarterly dated 9/29/22 is not signed by an RN, by LPN only. R13 - admit 1/12/22. Only one Quarterly completed 6/15/22, late. RAI date 3/4/22.		

Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). E1 hire 4/25/22. TB started 5/17/22. Late E2 hire 5/19/22. TB started 11/30/22. Late E3 hire 9/14/21. TB started 5/20/22. Late E4 hire 8/3/21. TB started 8/19/21. Late E5 hire 9/8/21. TB started 10/25/21. Late		

Section 146.235 Staffing		
l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. **30 Day Check:** E3 hire 9/14/21. No 30-Day Check completed. E6 hire 6/22/21. No 30-Day check completed. **HCWR Check:** E6 hire 6/22/21. Healthcare worker Registry (HCWR) ran on 7/2/21. Late **Six Website Checks:** E6 hire 6/22/21. Six Website Checks completed on 7/2/21. Late		

Section 146.235 Staffing e) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLP setting shall make changes in the training materials. 1) The SLP setting shall provide staff and subcontractors who provide direct care with: B) training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; encouraging independence; **potential resident inquiry and admission application policy; and non-discrimination policy (these subjects shall be trained as part of staff orientation and at least annually thereafter);** Employees that didn't have the Resident Inquiry and Non-Discrimination training. E3, E7, E1, E4, E8, E9, E10, E2, E12		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. **Sex Offender Checks:** R2 –admit 6/23/22, sex offender checks done on 12-13-22, late. R3 –admit 5/13/21, no sex offender checks on file, remediated 12/13/22. R10 - admit 1/25/22. Sex offender checks 12-13-22, late. R9 - admit 7/1/22. National sex offender checked 1/11/22. No date on the other agencies. Sex Offender checks were run again on 12/13/22. R35 - admit 9-2-22 and sex offenders ran 12-13-22, late. R36 – Admit date 7/9/22, sex offenders no dates for Illinois state police and Dept. of corrections, reran on 12/13/22.		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) continued R8 - admit 11-6-19 and background checks run 12-13-22. late R 39 - admit 5/12/21. Dru Sjodin checked on 4/29/21. Others checked but no dates noted. Re-ran on 12/13/22. R37 - admit 2/28/22. Dru Sjodin dated 2/8/22. No dates on the other checks. Re-ran on 12/13/22. R14 - admit 11/2/21. Dru Sjodin was checked on 11/2/21. No dates on the other checks. Re-ran on 12/13/22. R7 - admit 12-31-21, sex offenders checked 12-13-22. R6 - admit 3-31-21, sex offenders done 12-13-22, late. R5 - admit 3/31/22, sex offenders done 12-13-22, late. R4 - admit 11/1/21, sex offenders done 12-13-22, late. R2 - admit 6/23/22, sex offenders done 12-13-22, late.		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) continued R20 - admit 10/19/21. Sex offender checks not all had dates on them. Dru Sjodin was dated 11/4/21. Sex offender re-ran on 12/13/22. R38 - admit 9/29/20, Dru Sjodin was checked on 9/28/20. No dates on the other checks. Re-ran on 12/13/22. R36 - admit 7/9/22. Dru Sjodin ran on 6/15/22. Other checks ran but no dates on the papers. Sex offender checks re-ran on 12/13/22.		

Signature of SLP Provider Representative_____Date_____

HW Sterling Annual Review AR findings

RESIDENT KEY

[redacted]

6/4/18

HW Sterling Annual Review AR findings

[redacted]

HW Sterling Annual Review AR findings

[redacted]

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

4-24-23
Date

4/24/23
Date

Signature of Bureau of Long Term Care Regional Supervisor — Date

Signature of Bureau of Long Term Care Area Manager — Date

Exit c findings AR FY 23
Heritage Woods Wautoma

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _1_ OF 16___**

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.215 SLF Participation Requirements **o) The SLF shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests. The SLF shall provide all residents with information about advance directives, including the Durable Power of Attorney for Health Care, Statement of Illinois Law on Advance Directives, Living Will, Declaration for Mental Health Treatment and Do Not Resuscitate Advance Directive. The SLF shall maintain in a resident's file any of these documents authorized by the resident.** This requirement is not met as evidenced by: R2 No documentation to show being informed of advance directives upon admit R7 Advance Directives: No documentation to show resident was informed of Advance Directives. R13 Resident not informed of Advance Directives until 7/9/22. Admit date 11/23/21. R19 No documentation resident informed of advance directives.		

Signature of SLF Representativ[redacted] Date 4-24-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _2_ OF _16__**

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _ _ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements **c) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696** This requirement is not met as evidenced by: R2 1st step initiated but not read. 2nd step not given. R3 1st step initiated 12/9/19 read 12/12/19. No documentation of a 2nd step. R6 TB test not given or read within 7 days of admit date 8/13/21. TB test given 3/18/22 read 3/20/22, 2nd step given 3/27/22 read 3/29/22. R7 No documentation of a TB test or S/S checklist R8 TB test: No documentation of a TB test or s/s checklist R10 No TB test after admit date of 6/3/21 presented. TB test completed 3/17/22 read 3/20/22, 2nd step done 3/27/22 read 3/29/22. Nurses note state " no TB test due to 1st COVID shot. Note dated 6/4/21. R12 1st step initiated but not read. New TB test given 3/19/22 read 3/22/22, 2nd step given 4/2/22 read 4/5/22. R14 Resident admitted 10/7/21, no documentation of a TB test. TB test given 3/14/22 read 3/19/22, 2nd step given 3/23/22 read 3/25/22. S/S checklist not completed until 11/19/21.		

Signature of SLF Representative [redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements-CONTINUED This requirement is not met as evidenced by: R24TB test given late. Resident admitted per facility's admit date 12/30/21. TB test not given until 3/17/22 read 3/20/22, 2nd step given 3/27/22 read 3/30/22. R20 No documentation of 2 step TB test until March 2022 – admitted 1.29.21. R22 Tb screening test not completed until 3.17.22 – admitted 8.24.21 R23 TB screening test not performed or documented – No signs and symptoms of TB checklist done. R25 TB screening -initially 1st step completed timely, no second step completed. Restarted 2 step and completed series on 4/26/21. R29 TB screening and S/S completed late, admitted 10/6/21, 1st step initiated 3/16/22, S/S checklist completed 7/1/22.		

Signature of SLF Representative [redacted] Date 4-24-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _4_ OF _16__**

SLF NAME: _Heritage Woods Watseka AR FY 23_____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.230 Services **a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF:** **4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLF** This requirement is not met as evidenced by: R7 Background check: Resident was admitted 2/21/22 and did not have name checked against the three required sex offender websites until 3/22/22. R9 Had name checked against the three required sex offender websites after admission on 1/19/22. Admit date 1/17/22. R24 Name not checked against the three required sex offender websites until 1/3/22. R20 No dates on required Illinois State Police and Illinois Department of Corrections sex offender checks – remediated on site. R22 Illinois State Police and Illinois Department of Corrections Sex Offender checks not dated – remediated onsite. R26 Admitted 12/31/22, background checks not completed until 1/4/22		

Signature of SLF Representative [redacted] Date 4-24-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _5_ OF 16___**

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.230 Services **n) Daily Check The SLF shall implement a system to check on the welfare of each resident daily** This requirement is not met as evidenced by missing checks on the following residents R1,R2, R5, R6, R8, R9, R11, R13, R14, R15, R16, R17, R19, R21, R22, R23, R26, R27, R28, R29, R30 Well-being checks missing for multiple dates		

Signature of SLF Representative [redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.235 Staffing **l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check.** This requirement is not met as evidenced by: HCWR checks completed late for the following employees: E8, E9, E10, E11, E12, E13 The registry was not updated as required by regulation for: E2, E3, E4, E5, E8, E14, E15, E16, E17, E18, E20, E21, E22		

Signature of SLF Representat [redacted] Date 4-24-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _7_ OF _16__**

SLF NAME: _Heritage Woods Watseka AR FY 23_____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.235 Staffing **m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** This requirement is not met as evidenced by: TB screenings completed late for the following employees: E2, E3, E4, E5, E6, E7		

Signature of SLF Representati[redacted] Date 4-24-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 8__ OF _16__**

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.** This requirement is not met as evidenced by Untimely initial assessment and Service Plan or not signed/dated: R3 Initial Assessment & SP: completed prior to admit date of 12/8/19. R19 Initial Assessment and Service Plan not completed within 24 hours after admission R20 Initial Assessment and Service Plan – has no nurse signature or date. R23 Initial Assessment and Service Plan not completed within 24 hours after admission – admit date 2.23.22 – assessment date 6.25.22 R26 24 hour initial assessment completed late on 1/4/22		

Signature of SLF Representative [redacted] Date 4-24-23

942

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.** This requirement is not met as evidenced by: R2 RAI Not completed until 6/15/21 by the LPN and co-signed by the RN 6/22/21. Not thoroughly completed, Section AA.5 (marital status) is blank. Section E (No indicators) blank. RAI R6 Admit date 8/13/21. RAI not completed until 9/11/21 and not completed thoroughly. Section AA.4 is blank. R7 RAI not signed 7-14 days after admit of 2/21/22. RAI signed 7/14/22. R10 RAI not completed thoroughly, section AA.4 blank. Section AB. 3 blank. R11 RAI not completed and signed by RN until 5/26/21. R13 RAI: Completed by LPN 12/22/21, co-signed by RN 12/28/22. R14 RAI: not signed by RN until 12/27/21 R15 RAI: Not signed or co-signed by RN within 366 days of the previous assessment. Previous assessment completed 10/19/20, current assessment completed 11/26/21.		

Signature of SLF Representative [redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. __CONTINUED** This requirement is not met as evidenced by: R16 ISS not signed by the RN until 11/26/21. RAI completed 11/18/21. R17 RAI Not thoroughly completed, section J.1 (oral/Nutritional) status) blank, b) (wt) blank. R18 No 2020 RAI to determine if signed or co-signed within 366 days of previous assessment. R19 No RAI completed since admission R21 No 2022 RAI completed, was due by 6.19.22. Review completed using 2021 RAI and ISP R22 RAI not completed within 7-14 days after admission. R24 RAI not completed until 4/4/22. Resident admitted 12/30/21. R27 RAI not accurate, coded (F)(1)(B) "2" when should be "0" resident is independent with bathing.		

Signature of SLF Representativ [redacted] Date 4-24-23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 11__ OF _16__**

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _ _ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.** This requirement is not met as evidenced by: R2 ISP completed by the LPN and co-signed by the RN 10/8/21. R3 ISP signed 1/8/2020. RAI completed 12/31/19 R5 ISP: Not completed within 7 days of completing the RAI. RAI completed 9/17/21, ISP completed 10/7/21. R6 ISP does no include areas important to the resident. R8 ISS of 2/9/21 not signed within 7 days of completing the RAI dated 1/25/21 R11 ISS not signed by RN within 7 days of completing the RAI of 5/26/21. Co-signed by RN6/8/21. ISS completed by the LPN 6/6/21. Should have been completed 6/2/21		

Signature of SLF Representati[redacted] Date 4-25-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **d) Service Plan: CONTINUED** R17 ISS not signed by the RN within 7 days of completing the RAI. RAI completed 9/18/21, ISS completed 10/8/21. R18 ISP completed by RN 9/17/21 but not signed by the resident until 6/9/22. R19 No ISP completed since admission. R20 Resident signed ISP but there is no date of signature. R21 ISP not signed or dated by RN, ISP has no resident signatures. There is a 2022 ISP, completed, corporate nurse remediated signature on 2022 ISP but refused to remediate RN signature on 2021 ISP. R22 Resident did not sign for reviewing ISP or initial for receiving a copy of the SLP providers resident rights. – remediated onsite, ISP does not include areas important to resident. R22 ISP does not include areas important to resident. R23 ISP not signed by RN, ISP not signed by resident for reviewing, not initialed by resident for choosing or not choosing SLP provider services, or for receiving a copy of the SLP providers resident rights – remediated onsite. ISP does not include areas important to resident. R25 ISS completed instead of required ISP R30 ISP created 7 days after RAI (RAI-9/7/21, ISP-10/7/21)		

Signature of SLF Representa [redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _ _ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation **e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or cosigned by, a registered nurse** This requirement is not met as evidenced by: R2 Quarterly eval of 12/30/21 is > 92 days, should have been completed 12/18/21. Quarterly eval of 4/1/22 should have been completed by 3/31/22. R3 Quarterly eval: not completed every 92 days. Quarterly eval of 5/30/22 should have been completed 4/1/22. R5 Quarterly eval of 12/29/21 and 4/5/22 are > 92 days. R6 Quarterly eval not completed every 92 days. Quarterly of 1/6/22 should have been completed 12/11/21, Quarterly eval of 4/16/22 should have been completed 4/7/22. No quarterly for 7/16/22. R18 quarterly eval of 12/20/21 should have been completed 12/17/21 and 4/7/22 quarterly should have been completed by 3/18/22. RAI of 9/17/21 was completed between quarterlies of 7/21/21 and 12/20/21. R19 No Quarterly assessment completed since admission R20, R21, R22, R23, R27 Quarterly evaluations not completed every 92 days R24 Quarterly Eval 15 days late. Should have been completed 7/4/22, not completed until 7/19/22. R26 No quarterly assessments completed		

Signature of SLF Representat[redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _ _ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.240 Resident Contract **(a)The SLF shall have a signed contract with each resident, which specifies the terms of his or her agreement.** This requirement is not met as evidenced by: R1 Contract not signed by SLF provider. R3 Resident Contract: not signed by SLF provider. Remediated on-site. R6 Resident contract not signed by the SLF provider. Remediated on-site. R7 Resident Contract: Not signed by SLF provider. Remediated on-site. R12 Resident contract not signed by the SLF provider. Remediated on-site. R13 Resident contract: Not signed by the SLF provider. Remediated on-site 7/13/22. R14 Resident contract not signed by the SLF provider. Remediated on-site. R20 Resident contract not signed by SLP provider – remediated onsite. R22 Resident contract not signed by SLP provider – remediated onsite. R23 Resident contract not signed by SLP provider – remediated onsite		

Signature of SLF Representat[redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____ _____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.295 Emergency Contingency Plan **e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.** This requirement is not met as evidenced by: The following residents not orientated to emergency plans timely R2 admitted 5/12/21, not oriented to the emergency plans within ten days after admit. Orientation checklist dated 3/23/22. R6 Resident not oriented to the emergency plans within ten days after admit. R7 No documentation to show resident was oriented to the emergency plans within ten days after admit. R10 Emergency Plans: Resident was not oriented to emergency plans with ten days after admit. Orientation checklist noted for 3/23/22. R11 Not oriented to emergency plans until 3/21/22. R13 Resident not oriented to the emergency plans. Checklist dated 7/9/22. R23 Resident not oriented to emergency plan within 10 days after admission – admit date 02.23.22 – Orientation date 3.23.22 R24 Not oriented to the emergency plans within ten days after admit. Orientation checklist completed 3/23/22. R29 Admitted 10/16/21, orientated to emergency plans late on 7/1/22		

Signature of SLF Representative [redacted] Date 4-24-23

SLF NAME: _Heritage Woods Watseka AR FY 23_____REFERRAL DATE: _____7/11/22_____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities. This requirement is not met as evidenced by: R20 Resident sent to ER per 10.4.21 Nurses Notes – No documentation of resident representative/POA notification or resident refusal of notification. R23 Resident out to hospital overnight three (3) times in less than a month with no documentation of designated representative/POA notification, only one occurrence of resident going to the hospital documented in nursing notes. R27 Resident sent to hospital 4/12/21, no evidence of designated rep notification. R29 Two hospitalizations 1/28/22 and 12/22/21, no evidence of designated representative notification.		

Signature of SLF Representativ[redacted] Date 4-24-23

DEPT OF HEALTHCARE AND
FAMILY SERVICES
BUREAU OF LONG TERM CARE
200 S WYMAN ST #307C
ROCKFORD, IL 61101
815-987-7731 Direct OFFICE
Fax: (217) 557-5061

facsimile transmittal

To: [redacted] ED HW Yorkville **Fax:** 630 882 6504

From: HFS BLTC ROCKFORD REG **Date:** 9-19-23

Re: HW Yorkville 4-11-23 Annual **Pages:** 30 pages to follow

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

CONFIDENTIAL

Please sign pages 2 of 2 and return. Also sign page 22 of 28 and return. A plan of correction is due within 14 days and no plan of correction can be greater than 30 days. Call if questions.

Thank you.

[redacted]

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: HW of Yorkville
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐
ENTRANCE DATE: 04-11-23 EXIT DATE: 09-19-23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐
ENTRANCE DATE: EXIT DATE:

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.
BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____
REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐
BEGIN DATE: END DATE:

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**
(1st) BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐
(2nd)BEGIN DATE: _____ END DATE: _____
FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative	Date
[redacted]	9/19/23 Date
	09-19-23 Date
Signature of Bureau of Long Term Care Area Manager	Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: HW of Yorkville Annual Review 4-11-23 REFERRAL DATE: 9-19-23
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLP setting. R3: 146.220 a 4 No sex offender checks remediated on site on 4/12/23. Admitted 3/27/21.		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) continued R4: all three sex offender websites were checked late on 12/22/20, admitted 11/2/20. R5: did not have name checked against department of corrections remediated on site 4/12/22. the state police and Dru Sjodin checks were done on 10/10/22, 6 months after admission. Admission date 4/23/22. R6: National sex offender registry not checked on admission. Remediated on site 4/11/23 admitted 4/13/22. R7: sex offender check list completed late National and state police completed 10/5/22 parolee not completed, remediated on site 4/12/23. R8: State police parolee sex offender check not completed on move in remediated on site on 4/12/23. Admitted 3/29/22. R9: admitted 9/26/20 state parolee sex offender check not completed on move in, remediated on site 4/11/23. R10: Department of corrections parolee missing remediated on site 4/11/23. R17: Admitted 7/29/21 National Sex offender check not completed, remediated 4/12/23.		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) continued R18: Admitted 11/14/21 National sex offender checks not completed. Remediated on site 4/12/23. R19: National sex offender not checked and remediated onsite 4/14/23 State police sex offender check was done 1 day late on 4/19/22. Admission 4/18/22. R20: 146.220 a 4, Admitted 5/3/21 national sex offender check not completed, remediated on site 4/13/23. R21: admitted 7/15/21 missing national sex offender check, remediated on site 4/13/23. R22: admitted 11/8/2019 national sex offender check done late on 1/6/20, parolee not done, remediated on 4/13/23. R23: national sex offender not done, remediated on site 4/13/23. R24: Admitted 6/9/22. DOC parolee not checked and National sex offender checked late on 10/10/22 remediated on 4/13/23.		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 4) continued R25: Admitted 2/25/22. National sex offender not done, remediated 4/14/23. R26: Admitted 11/27/20, national sex offender not checked until 4/14/23, state police was done 12/25/20 late, parolee was done 12/22/20 late. R27: Admitted 1/9/21, National sex offender check not completed, remediated 4/13/23. R28: Admitted 4/19/19, National sex offender check not done completed on site 4/13/23. R31: department of corrections parolee sex offender website not done, remediated 4/13/23. R32: State police sex offender check done late 10/10/22. R32 admitted 1/17/20. National sex offender check not done, remediated onsite 4/14/23. R33: admitted 9/28/19 National sex offender check done late 1/6/20. Parolee check not done, remediated onsite 4/14/23.		

Section 146.220 Resident Participation Requirements 4) continued R34: Admitted 9/28/19, DOC parolee check not completed, remediated on site 4/13/23. R36: missing DOC and national sex offender checks, remediated onsite 4/13/23. R37: no sex offender checks done, remediated 4/14/23. R38: state police check and parolee check done late on 10/11/21 and national sex offender check wasn't done, remediated on site 4/14/23. R40: Admitted 5/21/22, National sex offender check not done, remediated onsite 4/19/23. R41: DOC parolee sex offender check was not done, remediated on 4/18/23. State police and National sex offender checks done late on 8/22/22, admission was 8/19/22. R42: Admitted 2/6/20. DOC parolee sex offender check not done, remediated on 4/18/23. R44: Admitted 12/18/19, IDOC parolee sex offender check not completed, remediated onsite 4/18/23. R45: admitted 4/10/21, National sex offender check not done remediated 4/17/23, Parolee sex offender check done late on 4/13/21.		

Section 146.220 Resident Participation Requirements 4) continued R46: Admitted 2/1/22, National sex offender not done, remediated onsite 4/17/23. R47: Admit 1/16/22, all three sex offender checks not done, remediated 4/18/23. R48: Admitted 12/16/22, All 3 sex offender checks not completed remediated onsite 4/18/23. R49: Illinois Dept. of Corrections (IDOC) parolee sex offender check not completed, remediated onsite 4/12/23. R50: National sex offender check not completed, remediated onsite 4/12/23.		

Section 146.295 Emergency Contingency Plan e) Each resident shall be oriented to the emergency plans **within ten days** after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. R4: oriented to emergency plans late on 1/13/21, admitted 11/2/20. R7: Orientated to emergency plan late on 10/5/22. Admitted 6/30/22. R23: orientation to emergency plans within 10 days of admission form not dated. R29: Orientation checklist does not have emergency plan documented. R37: oriented to emergency plan late on 10/5/22. Admitted 8/20/21. R44: Oriented to emergency plan late on 4/6/23 moved in 4/24/22.		

Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R9: 146.220 d, Res came from nursing facility, 2 step TB paperwork only shows give dates does not show read dates or results. R23: R23 had a 2 step TB done at Nursing facility (NF), SLP has a printout of NF documentation, 1st step was given on 10/7/21 and read negative but the result is not dated; step 2 was given on 10/30/21 and read negative but the result is not dated. R35: Admitted 9/13/22, 146.220 d 1st step TB done, no second step documented. R37: Second step TB not done, admitted 8/20/21. R38: Admitted 9/4/20. 146.220 d 1st step TB done late on 9/18/20. R41: 1st TB test read negative 1 day late on 4/23/22 step 1 given on 4/19/22. R49: Admitted 10/16/2020. 1st step done 10/2/20 no read date for 1st step. R50: Admitted 10/29/21. 1st and 2 step documented as negative and 1st step administer on 8/10/21 and 2nd step 8/17/21 dates read not documented.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. R6: Admitted 4/13/22. RAI completed 4/26/22 ISS completed 7/5/22 not done timely. R19: ISP was signed 1 day before RAI on 5/1/22 RAI was done on 5/2/22. R41: ISP done timely on 9/1/22 and was signed by an LPN but RN signature is missing, RAI was done 9/1/22. R54: Admitted 2/17/23. RAI dated 3/2/23 ISP wasn't done until 4/10/23, late.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. R10: admitted 1/13/22. RAI completed 2/3/22, late, R11: RAI dated 1/21/23 has medication coded 1 as in reminder. per E1 R11 needs assistance with insulin, should be coded 3. R12: RAI completed 1/1/21 and 12/06/22 longer than 365 days. R29: Admitted 1/15/21. RAI completed 2/1/21 late. R30: admitted 8/5/22. RAI completed 8/20/22 late. R40: RAI done 2 days late on 6/6/22, admission 5/21/22. R47: Admit 1/16/22. RAI done late on 2/16/23 and signed by LPN on 2/16/23 but was never signed by RN until 3/2/23. R48: RAI Admitted 12/16/22. RAI done 1/31/23, not done timely.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. R26: RAI completed 7/9/21 quarterly should have been done 10/8/21 not done. R26 went MCO 12/1/21. R31: Quarterly done 5 days late on 12/14/22, RAI done 9/9/22 Quarterly was due 3/14/22, missing. R35: Admit 9/13/22, RAI dated 10/14/22, no quarterlies completed. R31 does not have an MCO. R40: Quarterly assessment 1st one done late on 9/7/22, RAI done 6/6/22. R52: Quarterly dated 11/22/22 late, should have been completed 11/19/22. RAI dated 5/25/22.		

Section 146.240 Resident Contract a) The SLF shall have a signed contract with each resident, which specifies the terms of his or her agreement. R23: SLP did not sign contract, was remediated on site 4/13/23. R25: Admitted 2/25/22.- Contract not signed by administrator remediated on site. R36: Admitted 3/10/22. SLP did not sign the contract, remediated onsite 4/13/23. R40: Admitted 5/21/22.-SLP did not sign the contract. R42: Contract not signed by SLP remediated 4/18/23.		

Section 146.220 Resident Participation Requirements b) The SLP provider's assessment to determine if a potential resident's needs can be met by the SLP provider shall not occur until after the DON, or successor tool, assessment and other required PAS have been completed and determinations provided to the SLP provider. R7: Admitted 6/30/22 had an SLP Initial Screen completed on 4/18/23. There was no documentation in the file of the screening outcome. R31: Initial assessment 7/15/22 initial assessment and comprehensive was done on 7/17/22. There was no documentation in the file of the screening outcome. R19: admission 4/18/22. OBRA was done on 3/14/22 and MI or DD was suspected, and further evaluation was indicated but this was not done.		

Section 146.235 Staffing l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. E3: Date of Hire (DOH) 9/19/22. 30-day verification not done. E4: DOH 4/29/23. 30-day verification not done. E5: DOH 3/1/23. 30-day verification not done. E6: DOH 3/10/23. 30-day verification not done. E7: DOH 9/19/22. 30-day verification not done. E8: DOH 7/11/22, Health care worker registry (HCWR) check completed 7/19/22 late. 30-day verification not done.		

Section 146.235 Staffing l) continued E9: DOH 5/31/22, HCWR done 4/12/23 late. 30-day verification done 3/27/23 late. IDOC checks were not dated, remediated 4/12/23. All other checks done 5/31/22. E10: 30-day verification not done. E11: 30-day verification not done. E12: 30-day verification not done. E13: 30-day verification not done. E14: 30-day verification not done. E15: 30-day verification not done. E16: DOH 7/12/22 HCWR done 7/19/22 late. Missing IDOC sex offender background checks remediated onsite 4/13/23. Prior authorization not done. 30-day verification not done. E17: DOH 11/29/22. 30-day verification not done. E18: DOH 8/25/22. 30-day verification not done. E19: DOH 8/15/22 IDOC sex offender background checks not dated remediated 4/13/22. 30-day verification not done. E21: 30-day verification not done. E22: 30-day verification not done.		

Section 146.235 Staffing l) continued E23: Missing IDOC registries, remediated 4/13/23. 30-day verification not done. E24: 30-day verification not done. E25: 30-day verification not done. E26: 30-day verification not done. E27: 30-day verification not done. E28: 30-day verification not done. E29: 30-day verification not done. E30: 30-day verification not done. E2: Prior Authorization not done. 30-day verification not done. E31: 30-day verification not done. E32: DOH 1/13/23. 30-day verification not done.		

Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). E3: Date of Hire (DOH) 9/19/22, 1st step TB not done till 10/13/22 late. E4: DOH 4/29/23, No TB documented. E5: DOH 3/1/23, second step TB not done. E12: TB s/s not done QuantiFERON test done copy of test does not have date of test. E17 DOH 11/29/22. TB not done, E18: DOH 8/25/22 TB 1st step done 9/12/22 late. E20: DOH 1/24/22 1st step TB given 2/23/22 late. E21: TB not done.		

Section 146.235 Staffing f) The SLP provider shall employ certified nursing assistants (CNAs) as follows: 1) Qualifications Must be 18 years of age or older and have successfully completed no later than 120 days after employment a nursing assistant training course or a Department of Public Health approved equivalent training and competency evaluation. E7: DOH 9/19/22 E7 working as a CNA. Per the Healthcare Worker Registry (HCWR) for the state of Illinois E7 failed CNA competencies 4/23/18. E2 made aware E7 removed from floor. E7 brought in false documentation stating E7 had retaken the CNA courses, after E7 called school discovered E7 did not retake the course and E7 was terminated. E32: DOH 1/13/23. E32 had a CNA course in Wisconsin not Illinois. E2 notified E32 not allowed to work until Certified or approved in Illinois.		

Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to, the following: A) Name of resident; B) Name of medication, dosage, directions and route of administration; C) Type of oversight needed; i.e., reminders, assisting with opening container, etc.; D) Date and time medication is scheduled to be taken; E) Documentation showing that resident has taken, or refused to take, the medication; and F) Signature or initials of employee providing oversight.		

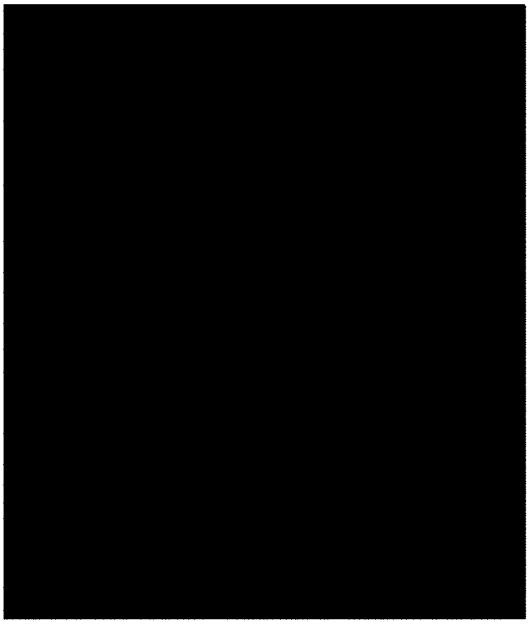
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 4) continued R11: Medication reminder sheets have reminders at 8:00am and 8:00pm per EMAR. R11 gets medications at 8am, 7am, 5pm, and 12pm, no reminders for 5pm or 12pm documented (Feb, March and April 2023).		

Section 146.230 Services g) Housekeeping 1) The SLF shall provide for general housekeeping services at least weekly (house cleaning, bed making, changing of linens, dusting and vacuuming). R51: HFS staff have seen R51's room before and it has progressively gotten worse. Clothes and toiletry items piled under the bathroom sink. Exercise bike in the shower R51 states he/she just washes up in the sink. Multiple clothes piles around bed unable to close closet door due to clothes piles.		

Signature of SLP Provider Representative_____Date_____

Identification Key

[redacted]



HW Yorkville Annual Review Findings

PROVIDER NAME: John Evans-Pekin REFERRAL DATE: 5.2.23
Initial Findings (X) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. *ISPs incorrect form not signed late no resident's rights R1, R4, R5, R6, R9, R13, R14, R15, R18, R21, R25, R26*		

Signature of SLP Provider Representative [redacted] Date 11-3-23

Section 146.245 Assessments and Service Plan and Quarterly Evaluation d)

SLP regulations provide for a completed Service Plan. Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes the coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency, and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated as dictated by changes in resident needs or preferences.

Of the records reviewed, the following was discovered:

12 records were not signed/late/no residents rights/ISP incorrect form

There were no ill effects suffered by the residents as a result of this finding.

Because the facility is dedicated to providing the best possible care and maintaining compliance with SLF rule and regulations regarding documentation standards, the licensed nursing personnel will be in-serviced on timeliness, correct form, necessary signatures and resident right signature page according to the SLF rule by the corporate Director of Health Services.

The Licensed Nurse and the Administrator are responsible for compliance with all SLF documentation requirements. Resident records will be audited monthly by Administrator and/or nursing staff as part of a Quality Assurance Process to ensure ongoing compliance. Ten percent of records will be audited.

Completion date: 12/01/2023

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: John Evans- Pekin REFERRAL DATE: 5.2.23

Initial Findings (X) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse. *RAI late not thorough inaccurate R1, R4, R5, R6, R7, R8, R10, R12, R13, R14, R18, R19, R20, R22, R23*		

Signature of SLP Provider Representative [redacted] Date 11-3-23

Section 146.245 Assessments and Service Plan and Quarterly Evaluation c)

SLP regulations provide for a completed Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be competed by or co-signed by a registered professional nurse.

Of the records reviewed, the following was discovered:

15 records were inaccurate (not individualized), not thorough or late.

There were no ill effects suffered by the residents as a result of this finding.

Because the facility is dedicated to providing the best possible care and maintaining compliance with SLF rule and regulations regarding documentation standards, the licensed nursing personnel will be in-serviced on timeliness and individualization of service plans, and signed, completed RAI's according to the SLF rule by the corporate Director of Health Services.

The Licensed Nurse and the Administrator are responsible for compliance with all SLF documentation requirements. Resident records will be audited monthly by Administrator and/or nursing staff as part of a Quality Assurance Process to ensure ongoing compliance. Ten percent of records will be audited.

Completion date: 12/01/2023

PROVIDER NAME John Evans-Pekin REFERRAL DATE 5.2.23
Initial Findings (X) First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. *Quarterly Evaluations not completed not completed timely R17, R18, R20, R22, R24, R27*		

Signature of SLP Provider Representative [redacted] Date 11-3-23

Section 146.245 Assessments and Service Plan and Quarterly Evaluation e)

SLP regulations provide for a completed Quarterly Evaluation of the health and behavior status of each resident using a Department designated form competed by or co-signed by a registered professional nurse.

Of the records reviewed, the following was discovered:

6 records were not timely.

There were no ill effects suffered by the residents as a result of this finding.

Because the facility is dedicated to providing the best possible care and maintaining compliance with SLF rule and regulations regarding documentation standards, the licensed nursing personnel will be in-serviced on timeliness of quarterlies according to the SLF rule by the corporate Director of Health Services.

The Licensed Nurse and the Administrator are responsible for compliance with all SLF documentation requirements. Resident records will be audited monthly by Administrator and/or nursing staff as part of a Quality Assurance Process to ensure ongoing compliance. Ten percent of records will be audited.

Completion date: 12/01/2023

Comments:

- Sex Offender checks not completed/no name- remediated R1, R2, R17, R28
- MD/POA not notified of emergency situation R1

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 6**

SLP NAME: **Lacey Creek Downers Grove**
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
(x) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐ ENTRANCE DATE: 05/22/2023 EXIT DATE:
( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)** Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff. BEGIN DATE: _____ EXIT DATE: _____
( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:**_____ **REFERRAL DATE:**_____ **REVIEW FINDINGS:** YES ☐ NO ☐ BEGIN DATE: END DATE:
( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW** (1st) BEGIN DATE: _____ END DATE: _____ FINDINGS CORRECTED: YES ☐ NO ☐ (2nd)BEGIN DATE: _____ END DATE: _____ FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

7/24/2023
Date

Signature of Bureau of Long Term Care Regional Supervisor

7/24/2023
Date

Date

Signature of Bureau of Long Term Care Area Manager

Date

PROVIDER NAME: **Lacey Creek Downer Grove** REFERRAL DATE: 07/24/2023
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services **d) Medication Administration, Oversight and Assistance in Self-Administration** **3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not be limited to, the following:** **A) Name of resident.** **B) Name of medication, dosage, directions, and route of administration.** **C) Date and time medication is scheduled to be administered.** **D) Date and time medication was administered; and** **E) Signature or initials of employee administering the medication** **R18** -MAR - no staff initials for following dates 3/27/23, 4/11/23, 4/14/23, 4/26/23, 5/16/23 **R3** -MAR – no staff initials for following dates 5/2/23, 4/16/23, 4/9/23, 4/5/23, 3/27/23, 3/3/23 **R24**- MAR – no initials for following dates 3/12/23, 3/15/23, 3/21/23, 4/2/23, 4/8/23, 5/11/23, 5/12/23 **R27** – MAR – no initials for following dates 3/16/23 and 3/23/23 **R32**- MAR – staff initials mission for following dates 4/5/23, 3/3/23, 3/4/23, 3/16/23, 3/7/23		

PROVIDER NAME: **Lacey Creek Downers Grove** REFERRAL DATE: 07/24/2023
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
n) Daily Check **The SLF shall implement a system to check on the welfare of each resident daily.** **R13** -admitted to SLP 1/23/2023. No evidence of wellness checks on 4/23/23. **R17** -admitted to SLP 10/01/2017. No evidence of wellness checks on 4/7/2023 and 4/23/23 **R21** – admitted to SL on 12/14/2017. No evidence of wellness checks on 4/8/23 and 4/13/23 **R23** – admitted to SLP on 11/20/2017. No evidence of wellness checks on 4/8/23 and 4/13/23		

PROVIDER NAME: **Lacey Creek Downers Grove** REFERRAL DATE: 07/24/2023
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) **Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** **R12** – admitted to SLP on 6/13/2022. Quarterly evaluation due 9/26/2022 and not completed. MCO started on 12/1/2022. **R14** -admitted to SLP on 3/19/2022. 1st quarterly evaluation completed on 10/12/22, 2nd quarterly evaluation completed on 1/9/2023. MCO started on 4/1/2023 – missing one quarterly evaluation, quarterly evaluation was not completed every 92 days. **R15** – admitted to SLP on 3/3/2022. Missing quarterly evaluation. Only one quarterly completed on 6/27/2022. MCO started on 5/1/2023. **R22** – admitted to SLP on 5/1/2020. Quarterly evaluation was not completed every 92 days – last 3 quarterly evaluations completed on 4/6/22, 9/22/22 and 3/16/23 **R28** – admitted to SLP on 2/22/2022. Quarterly evaluation was not completed every 92days. No quarterly evaluation completed after 2/22/2022 admission. **R30** – admitted to SLP on 4/9/2022. Quarterly evaluation was not completed every 92 days. 2 quarterly evaluations completed on 1/18/23 and 10/25/2022. **R31** – admitted to SLP on 12/28/2021. Quarterly evaluation was not completed every 92 days. Last quarterly evaluation completed on 4/23/22 and 3/24/23 **R32** – admitted to SLP on 4/28/2022. Quarterly evaluation dated 9/10/22 was not signed by RN (was signed by LPN)		

PROVIDER NAME: **Lacey Creek Downers Grove** REFERRAL DATE: 07/24/2023
First Follow-up ( ) Second Follow-up ( )

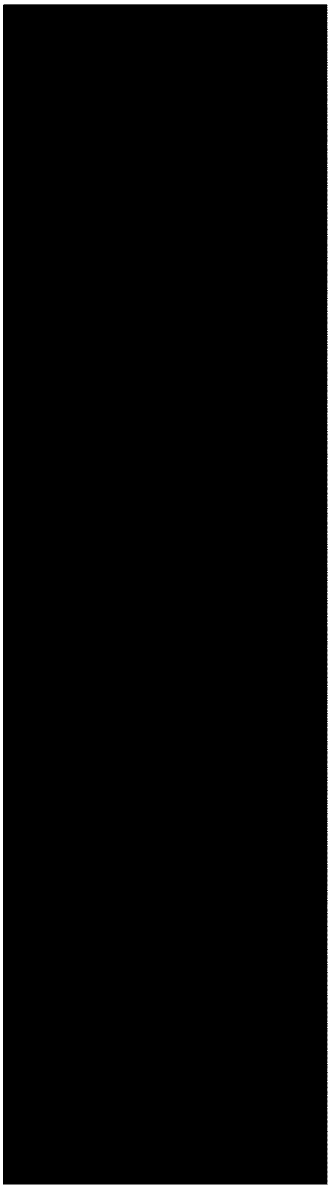
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

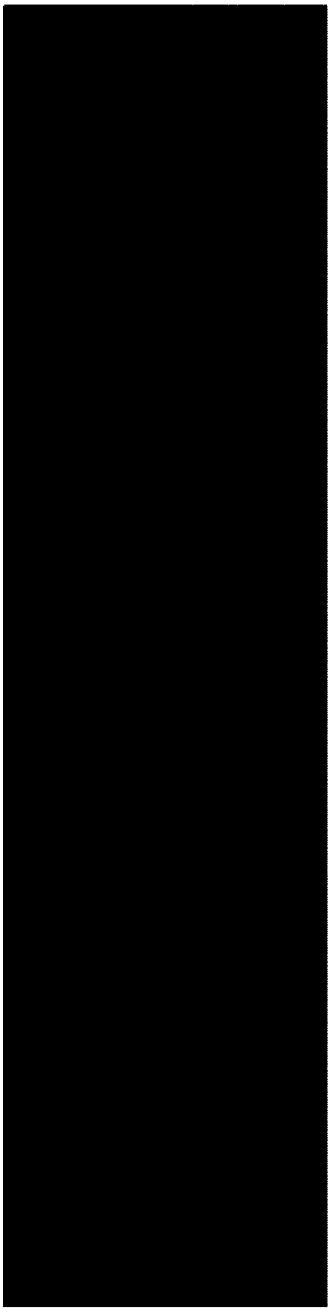
COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.295 Emergency Contingency Plan **e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.** **R7** – re-admitted to SLP on 2/13/2023 – no evidence of resident orientation to emergency plans within 10 days after admission **R11** – admitted to SLP on 10/23/2022 – no evidence of resident orientation to emergency plan within 10 days after admission. **R12** – admitted to SLP on 06/13/2022 – no evidence of resident orientation to emergency plan within 10 days after admission. **R13**- admitted to SLP on 1/09.2023, oriented to the emergency plan late on 3/31/23, not within 10 days after admission. **R16** – admitted to SLP on 06/03/2022 – no evidence of resident orientation to emergency plan within 10 days after admission. **R29** – admitted to SLP on 01/14/2022 – no evidence of resident orientation to emergency plan within 10 days after admission **R33** – admitted to SLP on 10/24/2022 – no evidence of resident orientation to emergency plan within 10 days after admission		

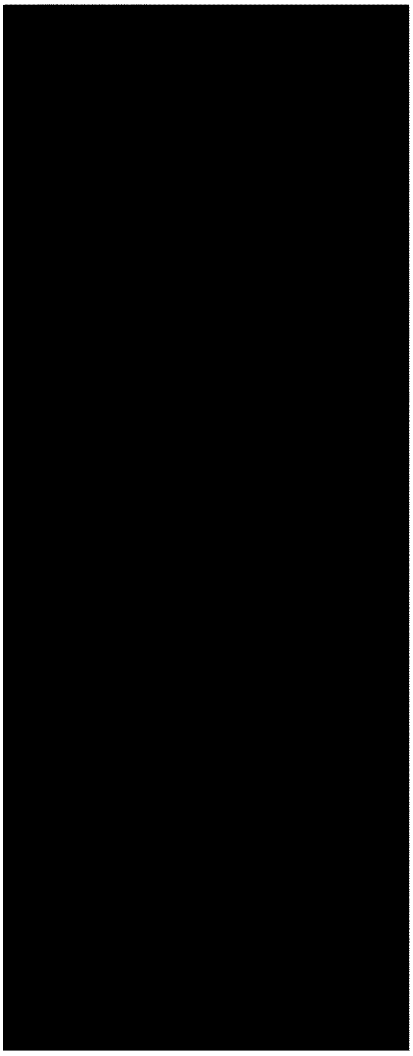
Signature of SLP Provider Representative_____ Date_____

Lacey Creek Downer Grove AR23

Resident/Employee Identifier Key







ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of** 2

SLP NAME: Montclare
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☒

ENTRANCE DATE: 2-27-23 EXIT DATE: 4-6-23

( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

4-6-23
Date

4-6-23
Date

Signature of Bureau of Long Term Care Regional Supervisor

Date

Signature of Bureau of Long Term Care Area Manager

Date

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM CERTIFICATION/REVIEW TOOL

Provider Montclare of Lawndale ID # 1922543917

Address 4339 W. 18th Pl Freestanding (X) ~~Rehab NF ( )~~

City Chicago Illinois Zip Code 60623

Phone # (773) 277-0288 Fax # 773-277-0312

Occupancy Information

# of Single Occupancy Apts.	120	Current Medicaid Census	120
# of Double Occupancy Apts.	0	Current Private Pay Census	2
Total # of Apts.	120	**Total** Current Census	118
Maximum Potential Occupancy	120	[redacted]	

Is the private pay rate higher than the Medicaid rate? Yes (X) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes (X) No ( )

Type of Certification Review (complete only one)	Entrance Date	Exit Date
Final		
Annual	2-27-23	4-6-23

REVIEW FINDINGS: YES ( ) NO (X)

Ombudsman was notified on _____ about the date of the review.
Ombudsman participated in review: Yes (X) No ( )

Provider Manager/Designee Signature/Date [redacted]

Review Team's Signature/Date [redacted]

Regional Supervisor Signature/Date _____

Area Manager Signature/Date _____

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0545
Toll Free: (844) 528-8444
TTY: (800) 526-5812

FAX

To: [redacted] Oak HILL	From: [redacted]
Fax: 847 201 1879	Date: 1-31-23 22 to follow
Re: 2023 Annual review findings	Pages: 20 pages to follow

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please

CONFIDENTIAL

A plan of correction is due within 14 days and must be completed within 30 days. Please sign page 2 of 2 and page 14 of 18 and return. Thank you.

Please call if questions

[redacted]

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 2**

SLP NAME: Oak Hill
CHECK ONE:

( ) **INTERIM CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **FINAL CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
(X) **ANNUAL CERTIFICATION** **REVIEW FINDINGS:** YES ☒ NO ☐ ENTRANCE DATE: 3-27-23 EXIT DATE: 1-31-24
( ) **CHANGE OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **INCIDENT FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐ ENTRANCE DATE: EXIT DATE:
( ) **GENERAL FINDINGS (Use for findings noted during informal visits to SLP)** Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff. BEGIN DATE: EXIT DATE:
( ) **COMPLAINT REVIEW** **DATE OF COMPLAINT:** **REFERRAL DATE:** **REVIEW FINDINGS:** YES ☐ NO ☐ BEGIN DATE: END DATE:
( ) **FIRST FOLLOW-UP REVIEW** ( ) **SECOND FOLLOW-UP REVIEW** (1st) BEGIN DATE: END DATE: FINDINGS CORRECTED: YES ☐ NO ☐ (2nd)BEGIN DATE: END DATE: FINDINGS CORRECTED: YES ☐ NO ☐

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 2**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative — Date

[redacted] — 1/31/24

Date

1/31/24

Date

Signature of Bureau of Long Term Care Area Manager — Date

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Oak Hill AR REFERRAL DATE: 1-31-24
First Follow-up ( ) rewrite Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.		

1004

146.245 (c) continued • R52. RAI 5/27/22, medication is scored a 1. Per ISP dated 5/27/22 resident gets eye drops twice daily. Medication should be scored a 3 on the RAI. • R48. RAI 8/12/22, medication is 0 and housekeeping a 1. Per ISP dated 8/12/22 resident is a nurse setup and facility does housekeeping. Medication should be scored a 1 and housekeeping a 3 on RAI. • R53. RAI 4/13/22, medication is 1. Per chart review resident is a medication reminder. • R54. RAI 7/11/20, score section I2 as daily pain, multiple sites. Pain not addressed on ISP 7/11/20.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. R29. RAI 9/11/21. ISS 9/11/21. MCO 3/1/22. ISP should have been completed. Signature, I choose and resident rights remediated while onsite 4/10/23. R48. ISP 8/12/22 does not address resident's goals.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan R49. ISP 2/14/23. ISP does not have resident signature, or initials for I choose and resident rights. Remediated signature and initials on 3/28/23. R50. ISS 3/1/22. MCO 8/1/22. ISP should have been completed. Signature, I choose and resident rights remediated while onsite 3/30/23. R51. RAI 8/13/21. ISS 8/13/21. ISP 7/31/21. Resident is not MCO. Untimely ISP. R31. ISS 2/23/22. MCO date 3/1/23. ISP should have been completed. Resident signature, initials for I choose and resident rights remediated while on site, 4/10/23. R43. ISS completed 1/11/22. MCO 5/1/22. ISP should have been completed. Resident signature, initials for I choose and resident rights remediated while on site, 3/28/23. R45. ISS 1/15/21. Resident is not MCO. ISP should have been completed. Resident signature, initials for I choose and residents rights remediated while on site, 4/4/23. R7. RAI 7/2/21. ISS completed 6/19/21. MCO 8/1/21. ISP should have been completed. Resident signature, initials for I choose and resident rights remediated while on site 3/30/23. ISS completed before RAI.		

R19. ISS 8/4/21. Resident is not MCO. ISP should have been completed. Resident signature, initials for I choose and resident rights remediated while on site 4/6/23. R9. ISS 10/8/22. MCO 12/1/22. ISP should have been completed. Resident signature, initials for I choose and resident rights remediated while on site 4/5/23. R16. ISS 11/12/22. MCO 1/1/23. ISP should have been completed. Resident signature, initials for I choose and resident rights remediated while on site 4/5/23. R5. RAI 12/03/21. ISS 11/20/21. MCO 5/1/22. ISP should have been completed and ISS was before RAI. Resident signature, initials for I choose and resident rights remediated while on site 3/3/23.		

Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse. • R25. RAI 10/27/21. MCO 4/1/22. No quarterly done for 1/26/22. • R20. Admit 11/1/19. MCO 12/1/20. RAI 8/2020, no quarterlies for 3/2020 or 5/2020. • R29. RAI 9/11/21. MCO date 3/1/22. No quarterlies were done for 12/2021. • R28. RAI 8/2/22. Quarterly completed 11/1/22, missed 1/31/23 quarterly. • R41. Facility admit 1/16/19. Annual RAI 2/14/23, quarterlies completed on 11/15/22, 8/15/22 and 5/16/22. 93 days between 11/15/22 and 8/15/22. • R42. RAI 11/1/19. MCO 3/1/21. No quarterlies completed in 2020 or 2021. • R36. RAI 7/27/18. No quarterlies for 2018, 2019, 2020, 2021 or 2022. MCO 6/1/22. • R43. RAI 1/11/22. Quarterly completed 4/12/22, one day late, should be 4/11/22. MCO 5/1/22.		

• R26. Quarterly completed 9/17/19, 12/17/19, annual RAI 3/17/20, no June 2020 quarterly. MCO 9/1/20. • R44. RAI 3/8/21. Quarterly completed 6/12/21, late. MCO 7/1/21. • R45. RAI 1/29/21. Quarterly completed 4/16/21. Missing all other quarterlies. Resident is Medicaid, not MCO per E1. • R6. RAI 10/21/21. MCO date 3/1/22. Quarterly due 1/2022, not done. • R18. RAI 1/23/22. MCO 7/1/22. Quarterly due 4/2022, not done. • R19. RAI 8/4/21. No quarterlies done at all. Resident is not MCO. • R11. RAI 5/20/22. MCO 11/1/22. Quarterly due 8/2022, not done. • R17. RAI 10/11/19. MCO 1/1/22. No quarterlies done. • R46. RAI 3/13/22. MCO 9/1/22. Quarterly due 6/2022, not done. • R12. RAI 12/4/22. PP. No quarterlies done in 2022 or 2023. • R5. RAI 12/03/21. MCO 5/1/22. Quarterly due 3/2022, not done. • R13. Admit date 8/30/20. MCO 4/1/21. No quarterlies		

done between admit and going MCO. • R47. Admit 9/10/21. MCO 9/1/22. No quarterlies done between admit and going MCO.		

Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R25. Admit date 10/27/21. S&S completed early 9/10/21. TB given early 9/8/21, read negative on 9/10/21 and 9/15/21, read negative on 9/17/21. R57. Admit 3/30/21. Two step from original admission in 2017. No documentation of 3/30/21 TB screening/testing.		

Section 146.220 Resident Participation Requirements h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities. • R43. 1/31/23 nurses note states that resident came to wellness office to report falling into chair on L side, c/o of pain when laughing. NP was notified, xray order received. No POA notification.		

Section 146.220 Resident Participation Requirements a) The SLP setting may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting: 2) Be screened by the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON), or successor tool, screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. If the individual is transferring directly from a nursing facility and has a history of a developmental disability or serious mental illness, as evidenced in the		

medical history accompanying the individual, the SLP provider must submit a referral for a specialized evaluation to be completed by the DHS Division of Developmental Disabilities (DHS-DDD) Independent Service Coordination (ISC) agency or the Division of Mental Health (DHS-DMH) Preadmission Screening Resident Review (PASRR) agency to evaluate for need for active treatment or the existence of serious functional risks and needs associated with the diagnosis to determine if they exceed the capacity of the SLP setting. Private pay individuals may choose to be admitted into the SLP setting when the screening assessment does not justify nursing facility level of care; • R4. Facility admit date 4/21/18. Conversion screen not requested timely. ME 4/1/20. MEDI 12/11/20 • R14. Facility admit 8/27/18. Per E1 resident converted on 4/1/20 but a conversion was never done until 4/13/23 = 31. **FINDING** for late conversion screen. ME 4/1/20 MEDI 4/1/20.		

• R20. Facility admit date 11/1/19. **FINDING.** No conversion screen for Medicaid eligibility that began 4/1/20. ME 4/1/20 MEDI 7/22/20 • R21. Facility admit date 5/29/19. **FINDING.** No conversion screen for Medicaid eligibility that began 4/1/20. ME 4/1/20 MEDI 4/1/20 • R26. Facility admit date 3/23/13. **FINDING.** Medicaid eligibility began 3/1/20. No conversion screen completed. ME 3/1/20 MEDI 7/22/20 • R30. Facility admit date 7/14/17. **FINDING.** No conversion screen. Medicaid eligibility began 2/1/20. ME 2/1/20 MEDI 5/26/20 • R31. Facility admit date 2/12/18. **FINDING.** No conversion screen. Medicaid eligibility began 4/1/20. ME 4/1/20 MEDI 4/9/19		

• R34. Facility admit date 2/9/19. **FINDING.** Medicaid eligibility did not begin until 11/1/21. ME 11/1/21. MEDI 2/9/22. • R37. Facility admit 8/3/19. Finding for conversion screen not being completed. ME 11/1/19 MEDI 1/9/20		

Signature of SLP Provider Representative_____ Date_____

1017

86

Oak Hill AR 3/27/23

Resident/Employee Key

[redacted]

Oak Hill AR 3/27/23

[redacted]

86

Oak Hill AR 3/27/23

[redacted]

6/4/18

PRINTED: 01/20/2023
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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00397134. Complaint IN00397134 - Substantiated. State deficiencies related to the allegations are cited at R0027. Survey dates: December 15, 16, 19 and 20, 2022 Facility number: 013347 Residential Census: 113 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 22, 2022	R 0000		
R 0027 Bldg. 00	410 IAC 16.2-5-1.2(b) Residents' Rights - Deficiency (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to maintain a dignified existence for 3 of 12 residents reviewed for dignity. (Residents B and L) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for	R 0027	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R027 **1. What Corrective action(s) will be accomplished for those residents found to have been**	02/10/2023

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

[redacted] RDO 01/10/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 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.

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message. 2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22. The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. On 12/19/22 at 9:19 a.m. the IED (Interim Executive Director) provided an 8/2/22 statement from the DM (Dietary Manager) regarding a staff altercation between CNA (Certified Nursing Assistant) 6 and Cook 8. The statement read, "When I arrived at work this morning, I pulled [name of Cook 8] into my office to talk about Sunday Breakfast. I also showed her a picture that someone sent me of her sleeping at my desk during lunch service. She asked me who sent the picture and I stated I didn't know. Someone told her [name of Kitchen Staff 7] took the picture, so she confronted her about it at the point an argument broke out. [Names of CNA 10 and CNA		**affected by the deficient practice** Staff members were terminated immediately following incident. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. b. c. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	5] and myself were trying to stop them when [Name of CNA 6] came charging at [name of Cook 8.] They went back and forth and [name of CNA 6] threw whatever she had in her cup on [name of Cook 8's] face and swung and hit [name of CNA 5] on the shoulder. [Name of Kitchen Staff 11] had to physically remove [name of CNA 6] from the kitchen." An interview was conducted with the DM on 12/20/22 at 11:15 a.m. She indicated Kitchen Staff 7 sent her a picture of Cook 8 sitting at her desk, thinking she was asleep. The DM spoke with Cook 8 about it the following Monday. One of the previous cooks informed Cook 8 that Kitchen Staff 7 took the picture. Cook 8 and Kitchen Staff 7 were discussing the picture and one thing led to another. CNA 6 was by the ice machine in the kitchen, when Kitchen Staff 7 told Cook 8 to talk to CNA 6. Then CNA 6 was like a "raging bull" and threw a cup of ice at Cook 8. The DM, CNA 5, and CNA 10, Kitchen Staff 11 were trying to hold CNA 6 back. CNA 6 hit CNA 5 in the shoulder, left a bruise, and was slightly bleeding. They got CNA 6 out of the kitchen. CNA 5 reported that CNA 6 hit her. There were no residents in the dining room at the time, but there were 3 or 4 in the hallway, just outside of the dining room, and the dining room doors were open. The DM was unsure which residents were in the hallway at the time. She indicated, "of course" residents could hear the altercation. An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated there was a fight in the kitchen between 2 staff members. She did not see them fighting, but she was sitting in the hallway, waiting to go to lunch, and heard them cussing, "what somebody was gonna do to somebody."			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	She heard commotion, stuff moving around, and saw other staff running to break it up. "I was like wow! Is this the type of place I'm living in? You think you're moving somewhere you don't have to deal with that, but evidently you do." It made her feel unsafe, because "in a situation like that you could get hurt whether involved or not." They could have picked something up, thrown it, then gotten hit herself. It made her uncomfortable, as she was a newer resident at the time. She stated, "I didn't like that." An anonymous interview was conducted with a resident. They indicated they were in the activity room. The dining room doors were open and she heard staff "cussing and carrying on." It scared her and still scared her. They stated, "I can't live scared." They don't socialize as much anymore or eat in the dining room anymore, because "it's always something in the dining room." The dining room staff were rude and won't let you sit where you choose, if they've already wiped the table. "It's the attitudes and way things are conducted. It's really, really bad." They just don't want to be in "this environment anymore. It's very hostile." They witnessed CNA 5 in the hallway outside of the dining room embarrass and talk down to Resident C for having an "accident" on himself. CNA 5 was saying, "You know better. Why are you doing that? You're being lazy." They used to go to activities regularly, now only go sporadically. It didn't have to be this way, but there were certain CNAs that made it hard, like CNA 13 and CNA 10. CNA 13 would get in "an uproar," was loud, obnoxious, rude, and discussed other residents' personal information. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated the kitchen staff and CNAs at the facility have "attitude			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	problems," and you can't ask them for anything. The previous Friday, one of the agency staff told her she didn't like her tone. An interview was conducted with Resident B on 12/16/22 at 8:57 a.m. She indicated some staff were respectful and others were not. CNA 5 spoke to her like a child and was rude. The Resident's Personal Rights Policy and Procedure was provided by the IED on 12/15/22 at 1:04 p.m. It read, "Each resident shall have the right to: ...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality." This Residential Tag relates to Complaint IN00397134.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure at least a minimum of one awake person with current CPR (cardiopulmonary resuscitation) and first aid certificates were on site at all times for 113 of 113 residents who reside at the facility. Findings include: The facilities staffing schedule, as worked, for the time period of December 9 - 20, 2022 was provided by Interim ED (Executive Director) on 12/15/22 at 1:04 p.m. The current CPR and first aid certificates for all staff were provided by BOM (Business Office Manager) on 12/20/22 at 12:05 p.m. Upon cross referencing the staffing schedule for the time period of December 9-20, 2022, the facility did not have a staff member with current CPR and/or first aid certification on the following dates and shifts: 12/9/22 - no one with first aid certification for the night shift (11 p.m. to 7 a.m.). 12/10/22- no one with first aid or CPR certification for the evening (3 p.m. to 11 p.m.) shift or the night shift. 12/11/22 - no one with first aid or CPR certification for the evening (3 p.m. to 11 p.m.) shift or the night shift. 12/12/22 - no one with a first aid certification for the night shift. 12/13/22 - no one with first aid or CPR certification	R 0117	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R117 **1. What Corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice** a. No residents experienced adverse effects from the alleged deficient practice. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put**	02/10/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	for the day shift. 12/14/22 - no one with first aid certification for the night shift. 12/15/22 - no one with first aid certification for the night shift. 12/16/22 - no one with first aid or CPR certification for the night shift. 12/17/22 -no one with first aid certification for the night shift. 12/18/22 - no one with first aid certification for the night shift. An interview with Interim ED conducted on 12/20/22 at 2:16 p.m. indicated, the facility had newly hired employees take a BLS (Basic Life Support) class and believed the class included first aid, but after speaking with the instructor from the class, he confirmed the BLS class that was completed did not include first aid certification.		**into place:** a. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to ensure the facility was clean, odor free, and in good repair for 10 of 14 residents' reviewed for environment. (Resident 37, 91, 92, 110, B, F, L, P, R and Z) Findings include: An observation was made of the facility on 12/15/22 at 2:17 p.m. The elevator by nurses station was observed with dirt, food crumbs along the corners and the flooring sides of the elevator.	R 0144	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R144 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **No residents were affected by the alleged deficient practice.**	02/10/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	The 3rd floor hallway had a sulfer like smell. Observations were made of the facility on 12/16/22 at 11:14 a.m., 12:10 p.m., 3:33 p.m. The front lobby flooring by the elevator was observed with black grime all long the corners and floor trimming. The elevator was observed with black dirt substance all along the trim and floor corners and a purple candy wrapper. The 1st floor wall bottom trim was observed to have grey dust and corners of the flooring had dust, dirt and cob webs. An observation of the facility on 12/19/22 at 12:10 p.m. The 1st floor hallway was observed with dust along the bottom floor trim and dirt and grime in the corners along the walls. The lobby flooring by the front elevator was observed with black grime in corners and along wall. The 3rd floor hallway had sulfer like smell. An interview was conducted with Resident F on 12/15/22 at 2:15 p.m. He indicated the 4th floor stinks, like urine, trash, body odor, people not taking care of themselves. You can smell "weed" at anytime, any floor, especially in the elevators, every now and then on the patio, it used to be a regular at the gazebo, but not much anymore. Sometimes, there's dirt, debris, sticky floors, but that's the residents who might drop a drink and won't tell anyone. An interview was conducted with Resident B on 12/16/22 at 8:57 a.m. She indicated the facility floors are dirty, and it smells bad. The 1st and 3rd floor was the worse with "reaking of marijuana" odor. An interview was conducted with Resident 91 on 12/16/22 at 9:10 a.m. She indicated there was a "heavy marijuana" odor on the 3rd floor.		**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. b. c. d. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. b. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	An interview was conducted with Resident R on 12/16/22 9:40 a.m. He indicated his apartment was in need of repairs. He had doors that needed to be replaced and walls with gouges that need to be repaired and painted. It has been in that condition since he moved in which was coming up to a year. An interview was conducted with Resident P on 12/16/22 at 9:47 a.m. He indicated on all the floors you can smell "marijuana" just by walking down the hallway. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated the hallway smells like urine. She has placed an air freshener outside her door. After interview, a plug in was observed in an outlet in hallway outside of the resident door. An environmental tour was conducted with the Maintenance Director (MD) on 12/19/22 at 2:15 p.m. During the tour, Resident Z was observed in her room. She indicated, there were times a "strange smell" in her hallway. Resident 37's room was observed with a warped floor at the entrance of the bathroom and dry wall exposed on the bathroom wall. The MD indicated the flooring had been like that for awhile. Resident R's room on the 3rd floor was observed with the following: several scrapes on walls with visible drywall paper observed in the living room, bedroom and kitchen area. 2 internal doors had large gouged holes, trim on a door frame was broken and missing, and 1 window had a diagonal crack the entire length of the window from corner to corner. Resident R indicated the apartment had been in that condition since move in date. The MD indicated at that time, the resident wanted to move in right away and had declined to wait for the apartment to be			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	repaired prior to his move in. He does have replacement doors for the resident. He has had the replacement doors for about a month. The 3rd floor hallway was observed with a sulfer like smell and corners of the hallway walls had debris in the corners. On the 4th floor, Resident 110's room was observed with a raised floor in the living area and a piece of flooring broke off in the kitchen. Resident 92's room was observed with a beach ball size mudded area on the ceiling. The MD indicated at that time, the ceiling had been repaired by the previous MD a year ago. After, The 1st floor hallway was observed. The wall floor trim was observed to have grey dust all along it. The lobby elevator had black grime and inside the elevator was observed with debris in the corners. The MD indicated at that time, the floors should be swept daily, and the common areas of the facility should be done on Fridays. The 1st floor has the most traffic. "The smell of marijuana can be smelled all the time on all the floors." The facility does not allow smoking in the facility, but "what do you do?" The resident(s) have to be caught, and it was difficult to catch them. The housekeeping policy was provided by the Interim Executive Director on 12/20/22 at 8:42 a.m. "...Responsibility:..B. It is the responsibility of the certified nursing staff to assist with maintaining public areas and ensuring they are clean and orderly....Procedure:...B. All public areas shall be maintained in a clean and orderly condition..."			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to ensure 24 hour access to the facility at all times. This had the potential to affect 113 of 113 residents in the facility. (Residents B, G, H, L, M, P and R) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message. 2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22.	R 0148	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R148 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **a. In-service completed will be completed for all staff on after hours protocol for front door bell.** **b. Residents will be educated on after hours protocol for entering community.** **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will**	02/10/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. 3. The clinical record for Resident M was reviewed on 12/16/22 at 10:30 a.m. The diagnosis included, but was not limited to, heart failure. A level of service assessment dated 9/30/22 indicated Resident M "...understands information conveyed without difficulty. Communicates information and is understood...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." The front double doors of the facility had a sign that read, "Doors locked 8:00 p.m. to 8:00 a.m. Ring door bell after hours," with an arrow pointing to a doorbell to the right of the double doors. An interview was conducted with the IED (Interim Executive Director) on 12/15/22 at 3:00 p.m. He indicated the front doors locked at 8:30 p.m. If a resident needed to get in after that time, there was a doorbell for them to use. An observation of the front double doors was made with the IED on 12/15/22 at 3:00 p.m. An interview was conducted with him at this time. He pressed the doorbell to the right of the double doors. No sound was heard. The IED indicated the doorbell signal went to the call light/pager system of the facility.		**be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** **a. In-service completed will be completed for all staff on after hours protocol for front door bell.** **b. Residents will be educated on after hours protocol for entering community.** c. d. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. b. c. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	On 12/15/22 at 3:02 p.m., after the above observation, the IED asked one of the staff members in the hallway near the nurse's station about the doorbell. She indicated to her knowledge, the front door bell didn't work and she didn't carry a pager to get the notification. An interview was conducted with the Admissions Coordinator in the presence of the IED on 12/15/22 at 3:05 p.m. She indicated the front doorbell was hooked up to the pager system and staff had to let you inside. She came to the facility the previous night around 10:00 p.m., and one of the staff members let her inside "after about 10 minutes." An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated the front doors locked at 8:00 p.m., and sometimes she was out until midnight or 1:00 a.m. after being with family. About a month ago, she came back to the facility around 1:00 a.m. Her grandson was ringing the front door bell, calling the facility on the phone, and knocking on the door for half an hour to get into the facility. No one ever responded, so "eventually I called another resident and they came and let us in." She and another resident now had an agreement with each other to let each other into the facility when they planned to be out after 8:00 p.m. and the doors were locked. She would call the other resident when she was on her way home and inform her when she would be arriving. She'd heard about some residents having to jump the patio fence to get into the facility. Over this past summer, around midnight, she was in the activity room playing cards, and she saw a male resident jump the patio fence to get into the facility. She was unsure who the resident was, because she was newer to the facility at the time.			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	An interview was conducted with Resident M on 12/16/22 at 11:32 a.m. He indicated after 8:00 p.m., the front doors are locked, and it is difficult to get into the facility. He has been out past 8:00 p.m., and was unable to get back in. After returning, he pushed the door bell and called into the facility for staff to let him in and no one would come to the door. He waited out front for 20-30 minutes calling and ringing the door bell, and staff would not answer. Resident P indicated he went around the back of the facility and jumped the privacy fence where the smoking area was due to that door was always left unlocked. He currently calls another resident that resides in the building to let him in the building, because staff do not answer the door bell or the phone. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated she was scared to leave the facility after 8:00 p.m., because she was scared to be left outside.4. The clinical record for Resident R was reviewed on 12/16/22 at 10:00 a.m. The diagnosis included, but was not limited to, coronary artery disease. A Saint Loius University Mental Status (SLUMS) assessment dated 8/27/22 indicated Resident R was cognitively intact. An interview was conducted with Resident R on 12/16/22 at 9:40 a.m. He indicated the residents have to be back in the building by 8:00 p.m., or the residents are unable to get back into the building. The door bell does not work and/or does not get answered by the staff. The residents will also call into the facility to alert staff they need to be let in, but the staff does not answer the phones. He has not witnessed, but has heard some residents have had to jump the privacy fence to use the unlocked back door in the smoking area to get into the			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	building due to no response from the staff. 5. The clinical record for Resident P was reviewed on 12/16/22 at 10:30 a.m. The diagnosis included, but was not limited to, heart failure. A level of service assessment dated 11/28/22 indicated Resident P "...understands information conveyed without difficulty. Communicates information and is understood...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." An interview was conducted with Resident P on 12/16/22 at 9:47 a.m. He indicated if a resident leaves the facility and returns after 8:00 p.m., they are unable to get back in. The staff do no answer the phone nor answer the door bell. 6. The clinical record for Resident H was reviewed on 12/15/22 at 3:00 p.m. The diagnosis included, but was not limited to, asthma. A level of service assessment dated 9/30/22 indicated Resident H "...understands information conveyed without difficulty. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." An interview was conducted with Resident H on 12/15/22 at 2:15 p.m. She indicated if she leaves the facility she makes sure she returns back before 8:00 p.m. She does not want to be locked out. She has heard that happens. 7. The clinical record for Resident G was reviewed on 12/15/22 at 3:00 p.m. The diagnosis included,			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	but was not limited to, hypertension. A level of service assessment dated 9/30/22 indicated Resident G "...understands information conveyed. May miss some part or intent of the message. Communicates information and is understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." An interview was conducted with Resident G on 12/15/22 at 2:18 p.m. She indicated the front door was locked at 8:00 p.m. "I wish there was a way to get into the building after 8:00 p.m." When she does leave, she "always" makes sure she returns before 8:00 p.m., because she does not want to get locked out. An interview was conducted with the Maintenance Director on 12/20/22 at 3:38 p.m. He indicated the staffs' pagers are notified if the door bell was pushed out front. The door bell had been broken recently for less than a week, but it was repaired on 12/2/22. The Resident Lease Agreement was provided by the IED on 12/15/22 at 2:24 p.m. It read, "RESIDENT ACCOMMODATIONS...3. Security. Security shall be provided 24 hours a day and shall include lockable entrances and on-site personnel. All residents shall have 24-hour access."			
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 manual, but at a minimum the needs assessment shall include an evaluation of the following:			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	(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 interview and record review, the facility failed to obtain semi-annual weights for 2 of 5 residents whose clinical records were reviewed. (Residents B and F) Findings include: 1. The clinical record for Resident F was reviewed on 12/19/22 at 2:30 p.m. The diagnoses for Resident F included, but were not limited to, chronic obstructive pulmonary disease. He was admitted to the facility on 3/20/20. The service plan, last updated 10/2/22, indicated Resident F agreed for the facility to coordinate all of his healthcare needs. The most recent weight in the vitals section of the electronic health record was from 10/4/21 at a weight of 195.6 pounds. There were no subsequent weights in the electronic health record or his hard chart. An interview was conducted with the RRN (Regional Registered Nurse) on 12/20/22 at 9:59 a.m. She indicated she was unable to locate any subsequent weights for Resident F. Some residents had weights documented sporadically in their electronic health record, because they had an order for weights, but there was no consistency in	R 0216	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R216 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents requiring semi-annual weights, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all CNAs, QMAs and Nurses on proper obtaining and documenting or weights. Employees found to be out of compliance with properly obtaining residents weights will receive additional education and possible corrective action.	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	how they'd been obtaining weights for everyone else. 2. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The vitals section of the electronic health record did not include any weights for Resident B. An interview was conducted with the RRN (Regional Registered Nurse) on 12/20/22 at 9:59 a.m. She indicated she was unable to locate any weights for Resident B after her initial admission weight. Some residents had weights documented sporadically in their electronic health record, because they had an order for weights, but there was no consistency in how they'd been obtaining weights for everyone else. An interview was conducted with the RRN on 12/19/22 at 12:53 p.m. She indicated they did not have a policy regarding weights and they just followed physician's orders and the regulations for obtaining a resident's weight on admission and semiannually.		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. A weights binder will be prepared and all nursing staff educated on the policy no later than January 31, 2022. Any clinical staff member out of compliance with facility's policies and protocols relating to weights will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to obtaining weights during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit weight binder two (2) times per month for two (2) months, then one (1) time a month for twelve (12) months, and then as needed to ensure that weights are being properly obtained and recorded. Results to be reviewed at monthly QI meetings and make further recommendations based off	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
			audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
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, interview, and record review, the facility failed to maintain the kitchen in a cleanly manner, store food properly, and ensure proper functionality of the dishwasher with the potential to affect 113 of 113 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 12/20/22 at 11:50 a.m. Interviews with the DM were conducted during the tour. During the tour an observation of the stove hood was made. There was dust and debris hanging from the sprinklers and around the light bases. There was grease splatter built up on the top of the hood. The DM indicated the stove hood was cleaned monthly. An outside company used to come in and clean it, but that hadn't been done in	R 0273	1. No residents were affected by the alleged deficient practice. 2. All residents had the potential to be affected by the alleged deficient practice. 3. In-Service completed by Dietary Manager with all kitchen staff. In service topics will include proper food storage including labeling and dating, hand hygiene, and cleanliness of dishes. All new hires in the culinary department will be trained on these topics upon onboarding. 4. The Culinary Manager, or designee, will audit staff hand hygiene daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months. The Culinary Manager, or designee, will audit dry storage	02/10/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	3 months. There was a rack of clean dishes against the wall in an area near the dishwasher. The plates and bowls on the rack were not stored inverted. A salad bowl had a one inch curly black hair on the rim. The silverware was stored in silverware holders on the top rack. The eating end of the silverware was facing outward for retrieval from the holder, as opposed to the handle side facing outward for retrieval. The DM indicated the handles of the silverware should be facing outward and the plates and dishes should be stored upside down. There was a plate dispenser with a stack of plates near the steam table. The plates were not inverted in the dispenser. Cook 9 was plating food for residents for the lunch service at this time. The top plate had a dried, yellow food substance towards the middle of the plate. Cook 9 retrieved the top plate with the dried, yellow food substance and proceeded to plate it with fries and a bratwurst. After Cook 9 was informed of the dried food substance on the plate, he moved the fries over with tongs, observed the dried food substance, and indicated he didn't notice it prior to plating. There was a sticker on the side of the dishwasher indicating the wash cycle was to reach 155 degrees Fahrenheit and the rinse was to reach 180 degrees Fahrenheit. The DM ran 3 cycles through the dishwasher. For the first 2 cycles, the rinse needle read 182 degrees Fahrenheit, but the needle never moved, even between cycles. The rinse cycle did not initiate during the third cycle. There was a brown, flaky substance built up on the top of the dishwasher. The DM indicated she was uncertain from where the brown flaky		and walk ins daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure no food s left open to air in these areas. The Culinary Manager, or designee, will audit the dishmachine daily for daily for 1 week, then 5 times a week for 2 weeks, then 2 times per week for 3 months to ensure proper temperatures are met. The results of the audits/reviews will be discussed at the quarterly Quality Improvement Meeting monthly until compliance is 100%. 5. Completion date 2/20/2023	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	substance was coming, but the dishwasher should be wiped down daily. She indicated the rinse needle was not moving at all and did not know what was wrong with it. The December, 2020 Dish Machine - High Temperature Sanitizing Log on the wall opposite the dishwasher indicated the wash temperatures were 180 degrees and the rinse temperatures were 150 degrees twice daily from 12/1/22 through the morning temperatures on 12/19/22. The DM indicated incompetence of the person who completed the December, 2022 dishwasher log. The walk in refrigerator had 4 pitchers of undated orange juice on one of the shelves. One of the pitchers' contents were significantly darker than the other three. The DM indicated the darker colored one was a different brand than the other three, and that all the pitchers should have dates on them. The walk in freezer had a pie with a white cream topping on one of the shelves. The pie had a piece missing and was not thoroughly sealed. There was no date on the pie. The dry storage area had a sugar bin with a Styrofoam cup inside. There was a bin containing plastic lids on the bottom shelf of one of the racks. There were crushed chips mixed in with the lids. The floors of the kitchen had debris, wrappers, and food packets on them. There was debris built up along the corners of the kitchen where the walls and floors met. The DM indicated the floors should be swept and mopped regularly. The DM provided the November, 2022 Monthly Dietary Cleaning Schedule on 12/20/22 at 2:05 p.m.			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The baseboards were signed off as completed, but did not indicate a date. There was no documentation of kitchen floors or stove hood cleaning provided. The Mechanical Cleaning and Sanitizing Policy and Procedure was provided by the DM on 12/20/22 at 2:05 p.m. It read, "Machines (single-tank, stationary-rack, door-type machines and spray-type glass washers) using chemicals for sanitization may be used provided that: ...8) High temperature sanitation will be at 180 degrees F or higher. d) All dishwashing machines shall be thoroughly cleaned at least once a day or more often when necessary to maintain them in a satisfactory operating condition. The Refrigerated Storage Policy and Procedure was provided by the DM on 12/20/22 at 2:05 p.m. It read, "Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation..." The Cleaning Frequency Policy and Procedure was provided by the DM on 12/20/22 at 2:05 p.m. It read, "Non-food contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to ensure the proper labeling of prescription medications by not ensuring prescription medication labels, with all needed information, were affixed to: individual insulin/diabetic medication pens, a box of Zofran tablets, an opened vial of methotrexate, used inhalers, an opened vial of testosterone, and 13 unidentified, loose tablets at the bottom of a wire basket for 1 of 1 medication rooms within the facility. Findings include: A medication storage observation was conducted on 12/20/22 at 10:22 a.m. with QMA (Qualified Medication Assistant) 4. 1. In the medication room on the main level by the nursing station, the following was observed: a. In a wire basket placed on top of a cardboard box sitting on the floor of the medication room was: - An opened vial of methotrexate 50 mg/2 ml (milligrams per milliliter) with no resident or prescription label affixed to it or its box. - An opened box of Zofran (anti-nausea) 4 mg tablets. The box indicated it contained 30 tablets, but there were only 5 tablets in the box. The box did not have a resident name or prescription label affixed to it. - At the bottoms of the wire basket, were 13 unidentified and loose pills.	R 0301	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R301 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do an audit of the medication room to ensure medications are properly labeled in accordance with the state regulation: (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	b. In the medication refrigerator, were two Basaglar (a diabetic medication) pens without a resident's name or prescription label affixed. c. In the sink: - A baggie that contained 5 used inhalers with inhalation medication canisters without a resident's name or prescription label affixed. - An opened vial of testosterone for Resident 124 without an opened date. 2. In a small grocery type cart parked in the nursing station, the following was observed: - A plastic bag with a prescription label affixed for Resident 47 contained a used Novolin pen. The Novolin pen itself did not have a prescription label affixed. - A plastic bag with a prescription label affixed for Resident 56 contained a used Lantus pen. The Lantus pen itself, did not have a prescription label affixed. - A plastic bag with "412" handwritten on the bag contained a used Basaglar (a diabetic medication) pen. The Lantus pen itself, did not have a prescription label affixed. An interview with RRN (Regional Registered Nurse) conducted on 12/20/22 at 11:17 a.m. indicated, if diabetic medication pens became separated from their respective boxes/baggies or caps which had the prescription labels affixed to them, she would not be able to identify to who the medication pen belonged.		issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of the medication room will be conducted by the DON or designee. Any prescription medications found to not be properly marked with all identifying factors, will be promptly destroyed. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to labeling of prescription drugs during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the medication room two (2) times per week for	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
			eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that any prescription medication that are not properly labeled are discarded. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure over the counter (OTC) medications were properly labeled with resident's name and physician's name for 1 of 1 medication rooms. Findings include: A medication storage observation was conducted on 12/20/22 at 10:22 a.m. with QMA (Qualified Medication Assistant) 4.	R 0302	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R302 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	In the medication room on the main level, within the nursing station the following was observed on a wire shelf: - An opened bottle of antacid tablets without a resident's name or physician's name affixed, no opened date, and an expiration date of 12/22. - Two opened bottles of Milk of Magnesia with a resident's name or physician's name affixed and no opened date. An interview with QMA (Qualified Medication Assistant) 4 was conducted on 12/20/22 during the medication room observation. QMA 4 indicated, she did not know to who the opened bottle of antacid tablets or the opened, two bottles Milk of Magnesia belonged.		a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do an audit of the medication room to ensure medications are properly labeled in accordance with the state regulation: (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of the medication room will be conducted by the DON or designee. Any OTC medications found to not be properly marked with all identifying factors, will be promptly destroyed. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to labeling of OTC medications during employee job-specific	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
			orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the medication room two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that any OTC medications that are not properly labeled, are discarded. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation and interview, the facility failed to ensure the timely disposal/disposition of medications for discharged residents for 1 of 1 medication rooms observed for medication storage. Findings include: A medication storage observation was conducted on 12/20/22 at 10:22 a.m. with QMA (Qualified Medication Assistant) 4. In the medication room on the main level, within the nursing station, the following was observed: 1. On the floor of the medication room was a cardboard box which contained: a. Medication pre-packs for Resident 125 which contained multiple pills. The continuous string of pre-packs were dated from 12/1/22's 8 a.m. dose through 12/6/22's 8 p.m. dose. All pre-packs were unopened. b. Medication pre-packs for Resident 126 which contained multiple pills. The continuous string of pre-packs were dated from 11/25/22's 8 a.m. dose through 12/8/22's 8 p.m. dose. All pre-packs were unopened. 3. Medication pre-packs for Resident 127 which contained multiple pills. The continuous string of	R 0306	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R306 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents receiving medication had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on proper and timely destruction of expired or discontinued medications. Employees found to be out of compliance with proper disposal of	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	pre-packs were dated from 11/25/22's 8 a.m. dose through 12/8/22's 8 p.m. dose. All pre-packs were unopened. 2. On the floor of the medication room was another cardboard box which contained a box of Zofran tablets. The box indicated it had contained 30 tablets, but only 20 tablets remained inside the box. An interview with RRN (Regional Registered Nurse) was conducted on 12/20/22 at 1:32 p.m. RRN indicated, Resident 125 had discharged from the facility on 10/31/22; Resident 126 had discharged from the facility on 11/10/22; Resident 127 had discharged from the facility on 11/10/22; and Resident 128 had discharged from the facility on 9/16/22. A Medication Disposal policy was received on 12/20/22 at 11:42 p.m. from RRN. The policy indicated, "D. All discontinued medications, refused/damaged medications, medications with passed expiration dates, and all medications of residents who have expired shall be disposed of by the facility nurse at the facility location. E. When discharging a resident, the facility nurse will dispose of any medications not sent with the resident...Medication Disposal Guidelines: A...1. Take the medication out of the original containers. 2. Mix medication, either with liquid or solid, with an undesirable substance...3. Dispose with the solid waste (i.e., regular trash) in the presence of two witnesses. 4. Document the disposal on the medication disposition record..."		medications will receive additional education and possible corrective action. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. Director of Nursing or designee with provide education to all QMAs and Nurses on the timely and proper disposal of expired and discontinued medications no later than January 31, 2022. Any clinical staff members out of compliance with facility's policies and protocols relating to appropriate disposal of medications will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to medication disposal during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the medication room and residents medication cabinets two (2) times per week	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
			for eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that weights are being properly obtained and recorded. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
R 0327 Bldg. 00	410 IAC 16.2-5-7.1(b) Activities Programs - Nonconformance (b) The facility shall provide and/or coordinate scheduled transportation to community-based activities. Based on interview and record review the facility failed to provide outside activities, as preferenced, to 5 of 9 residents reviewed for activity participation. (Residents B, G, H, L, and Z) Findings include: 1. The clinical record for Resident B was reviewed on 12/16/22 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hypertension. She was admitted to the facility on 3/14/22. The 9/30/22 Level of Service Assessment/Evaluation indicated Resident B was	R 0327	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R327 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **a. Bus will be evaluated for repairs.** **2. How the facility will**	02/10/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed, but may miss some part or intent of the message. 2. The clinical record for Resident L was reviewed on 12/20/22 at 2:00 p.m. The diagnoses for Resident L included, but were not limited to, anxiety. She was admitted to the facility on 7/1/22. The 10/5/22 Level of Service Assessment/Evaluation indicated Resident L was oriented to person, place and time or was sufficiently oriented to function independently if in familiar surroundings. She communicated information and was understood. She understood information conveyed without difficulty. 3. The clinical record for Resident H was reviewed on 12/15/22 at 3:00 p.m. The diagnoses included, but were not limited to, asthma. A level of service assessment dated 9/30/22 indicated Resident H "...understands information conveyed without difficulty. Communicates information and is understood .. oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." 4. The clinical record for Resident G was reviewed on 12/15/22 at 3:00 p.m. The diagnoses included, but were not limited to, hypertension. A level of service assessment dated 9/30/22 indicated Resident G "...understands information conveyed. May miss some part or intent of the message. Communicates information and is		**identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. b. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. b. **5. By what date will the systematic changes be completed** a. Compliance by 2/10/2023	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	understood ...oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings..." 5. The clinical record for Resident Z was reviewed on 12/20/22 at 1:45 p.m. The diagnoses included, but were not limited to, hypertension. She was admitted to the facility on 4/26/22. The 11/28/22 Level of Service Assessment/Evaluation indicated she communicated information and was understood. She understood information conveyed without difficulty. The 6/15/22 Resident Committee Meeting Agenda/Minutes was provided by the Marketing Director on 12/16/22 at 3:22 p.m. It read, "Resident Services: Bus, still not working. How or what is needed to asst [assist] members to & from the store, or go out to see movies. Issue: The bus is being repaired per [name of previous Administrator.]" The December, 2022 activity calendar was provided by the IED (Interim Executive Director) on 12/15/22 at 2:24 p.m. It did not include any outside activities like restaurants, shopping, bowling, etc. An interview was conducted with the AD (Activity Director) on 12/16/22 at 11:12 a.m. She indicated she'd worked there since August, 2021. When she first began working, the facility bus "worked twice and that was it," within her first month there. By September, 2021, the bus no longer worked. She wanted to take the residents to see a local Christmas lights display, but they didn't have transportation for getting them there. She hadn't been able to take them shopping, to			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	parks, restaurants, or picnics. If they had transportation, she would schedule an activity outside of the facility at least weekly. In August, 2022, they borrowed a bus from a sister facility to take residents to the state fair, but that was the last outside activity they'd had. She'd spoken to the IED a week or so ago about borrowing the bus again to take residents to the local Christmas lights display, but hadn't heard back yet. She stated, "I'm hoping to." Residents had been asking her about doing outside activities and when the bus would be ready. An interview was conducted with Resident B on 12/16/22 at 11:23 a.m. She indicated she went to the state fair in August, 2022, and that was the only outside activity the facility had. She would go on more if they had more. She would like to go to the museum, shopping, restaurants, and the park when it's warm. Sometimes she felt affected by not going out. She was told when she admitted that they had a bus for activities to take residents places. "Then to get here and find out the bus is broke down. I was like finally we get to go somewhere when we went to the fair," but they borrowed the bus. Sometimes she felt "cooped up" and wanted to get out, mostly when it was warm. An interview was conducted with Resident L on 12/19/22 at 11:58 a.m. She indicated she would like to go to outside activities, like going to the store, to the casino, bowling, and things like that "that we should be able to go to, like senior things that we can't do." An interview was conducted with Resident H on 12/19/22 at 2:15 p.m. She indicated the activity bus had not been working for 2 years, since she'd been living there. She got a local bus pass,			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	because there was no bus to take residents to outside activities. An interview was conducted with Resident G on 12/15/22 at 2:18 p.m. She indicated the facility did not have an activity bus. She went as a guest with Resident H and used her local buss pass sometimes, as Resident H was allowed to take 1 guest with her on the bus. If Resident H did not go anywhere, she couldn't go anywhere either. She would like to go to outside activities. An interview was conducted with Resident Z on 12/19/22 at 2:21 p.m. She indicated she would love to leave for outside activities, but they hadn't had a bus since she'd been there. The New Resident Orientation Policy-Activities was provided by the Regional Marketing and Sales Director on 12/19/22 at 3:00 p.m. It read, "PURPOSE: The purpose of this policy is to ensure that all new residents receive an orientation pertaining to the community activities in a timely manner. POLICY: It is the purpose of the community to create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life."			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a transfer form utilized for residents transferred to the hospital included the following information: the address of the facility being transferred to, resident property when transferred to an acute care facility, nurse's notes relating to the resident's functional abilities and physical limitations, condition of resident at the time of transfer, treatments, current diet, and date of chest x-ray and skin test for tuberculosis for 2 of 2 closed records reviewed. (Resident 73 and C) Findings include: 1. The clinical record for Resident 73 was reviewed on 12/20/22 at 10:00 a.m. The diagnosis included, but was not limited to, hypertension. A progress note dated 11/17/22 indicated Resident 73 had been transferred to the hospital due to a fall. The transfer paperwork that was provided to the Emergency Medical Services for Resident 73 on transfer date 11/17/22 was provided by the Regional Registered Nurse (RRN) on 12/20/22 at 11:44 a.m. It included the following: Notice of Transfer or discharge form and Emergency Printout form. The Emergency Printout form did not include the following resident information: current diet, the	R 0354	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R354 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do admission audit of all residents to ensure all proper documentation is listed on the residents facesheet (emergency printout) **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	resident's condition at the time of transfer, functional abilities and physical limitations, and date of chest x-ray and/or skin test for tuberculosis. An interview was conducted with the RRN on 12/20/22 at 12:53 p.m. She indicated she was unaware the residents' transfer forms needed to include specific information.2. The clinical record for Resident C was reviewed on 12/19/22 at 2:19 p.m. Resident C's diagnoses included, but not limited to, cirrhosis of the liver, hypertension, diabetes, and chronic obstructive pulmonary disease. A nursing note dated 12/12/22 at 11:37 a.m. indicated, Resident C's legs were swollen and was transferred to the local hospital for fluid overload. A Notice of Transfer or Discharge from and Emergency Printout were provided by RRN (Regional Registered Nurse) on 12/20/22 at 12:03 p.m. The transfer/discharge form nor the emergency printout contained the following information: the address of the facility being transferred to, resident's personal property when transferred to an acute care facility, nurse's notes relating to the resident's: functional abilities and physical limitations; nursing care; treatments, and current diet and condition on transfer, or date of chest x-ray and skin test for tuberculosis. An interview with RRN conducted on 12/20/22 at 11:54 a.m. indicated, the nurse in the facility the day of Resident C's transfer sent with the resident the emergency printout and the transfer/discharge form, but cannot indicate if the other necessary information had been relayed to receiving facility. Resident C's nursing notes did not indicate what		a. An audit of all new admissons will be conducted by the DON or designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit each admission as it occurs for for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all proper information is being properly reflected on the facesheet. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed**	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	information was given to the receiving facility.		a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	
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, interview and record review, the facility failed to maintain an infection control practice to help prevent the development and transmission of diseases and infection by not appropriately disinfecting a glucometer and lancet pen prior to and after use on residents for 22 of 22 residents who receive blood glucose checks and failed to properly prevent and/or contain COVID-19 for 1 of 5 residents observed during medication administration. (Resident 41). Findings include: 1. a. On 12/19/22 at 12:12 p.m., an observation was made of LPN (Licensed Practical Nurse) 2 performing a blood glucose check on Resident 119. LPN 2 placed a new lancet into the lancet pen and replaced the lancing device cover. LPN 2 did not clean or disinfect the lancet pen or cover prior to use. LPN 2 then performed the blood glucose check on the glucometer which was not cleansed or disinfected prior to use on Resident 119. After completion of the blood glucose check, she removed the lancet cover with bare hands, disposed of the lancet, and wiped down the lancet	R 0406	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R354 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will do admission audit of all residents to ensure all proper documentation is listed on the residents facesheet (emergency	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	pen and cover with an alcohol wipe. LPN 2 did not properly disinfect the lancet pen, its cover, or the glucometer after its use. b. An observation of LPN 2 was conducted on 12/19/22 at 12:25 p.m. LPN 2 entered into Resident 41's room to perform a blood glucose check. LPN 2 performed the blood glucose test on Resident 41, but had not cleaned/disinfected the lancet pen, its cover, or the glucometer prior to or after it being used with Resident 41. LPN 2 then placed the potentially contaminated glucometer into her pocket and headed to the next room. c. Another observation of LPN 2 was conducted on 12/19/22 at 12:37 p.m. LPN 2 entered Resident 47's room to perform a blood glucose check. Once in the room, she prepped the resident's finger with an alcohol wipe, and without any gloves on, she performed the blood glucose check on the glucometer. LPN 2 did not clean/disinfect the lancet pen, its cover, or the glucometer prior to or after its use with Resident 47. A list of residents with communicable diseases was provided by RRN (Regional Registered Nurse) on 12/19/22 at 2:30 p.m. The list indicated, the facility had one resident with viral hepatitis, one resident with HIV (Human Immunodeficiency Virus) and three residents with hepatitis C, who receive blood glucose checks within the facility. An interview with RS (Regional Support) was conducted on 12/19/22 at 1:03 p.m. RS indicated, the facility does not have a glucometer cleaning policy, but follows the recommendation of the CDC (Center for Diseases and Control) and state regulations. An interview with LPN 2 was conducted on		printout) **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. An audit of all new admissons will be conducted by the DON or designee. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit each admission as it occurs for for two (2) months, then every other month for twelve (12) months, and then as needed to ensure that all proper information is being properly reflected on the facesheet. Results to be reviewed	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	12/19/22 at 2:23 p.m. indicated, she had completed all of the blood glucose checks that morning. The glucometer manufacturer's instructions were received by RRN on 12/20/22 at 2:52 p.m. They indicated, "It is the recommendation of the manufacture [sic, manufacturer] to use mild soap and water, 70% iso-proply alcohol (IPA), or 1:10 diluted bleach solution; wipe front and back with soft damp cloth [sic] Clean outside of meter using a lint free cloth dampened with soapy water or IPA Disinfecting-1:10 dilution of water and bleach (or bleachwipe), dampen a paper towel and thoroughly wipe down the meter or use Super Sani-Cloth & Sani-Cloth HB Germicidal disposable wipes. Clean exterior with lint free tissue moistened with 1:10 bleach/water disinfectant, wipe dry. Apply an EPA-Registered disinfectant per product directions. Allow glucometer to dry thoroughly between uses." The Sani-Cloth wipes used by the facility were reviewed. The instructions on the container indicated, "To Disinfect: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three minutes. Use additional wipe(s) if needed to assure continuous 3 minute wet contact time. A thorough rinse with potable water is required for surfaces in direct contact with food." 2. An observation of the outside of Resident 41's room was conducted on 12/19/22 at 12:25 p.m. At that time, Resident 41's door did not have any signage indicating Resident 41 was under any isolation precautions, nor was there any personal protective equipment (PPE) located outside of her room. When LPN 2 entered Resident 41's room to perform a blood glucose check she was wearing a		at monthly QI meetings and make further recommendations based off audit results **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on January 27, 2023	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	cloth face mask, Resident 41 had indicated, she had COVID, but LPN 2 then corrected her, saying she had a cold. LPN 2 had not donned the proper PPE needed to enter Resident 41's room prior to entry. A nursing note in Resident 41's chart dated 12/16/2022 at 11:10 a.m. indicated, "Resident has not been feeling well since 12/13. Advised to quarantine to her room by staff. This morning resident developed additional symptoms and was tested for COVID which resulted in a positive result. Family, MD[sic, medical doctor], and staff notified. Appropriate notification made to all residents families. Will retest resident on 12/20. Resident will remain in isolation." An interview with LPN 2 conducted on 12/19/22 at 2:23 p.m. indicated, she was unaware that Resident 41 was in droplet isolation precautions because she had tested positive for COVID. A COVID-19 Infection Control Policy provided by Interim ED (Executive Director) was provided on 12/20/22 at 1:04 p.m. The policy indicated, in the event of a confirmed COVID-19 case in a resident, the resident should be placed in transmission based precautions (TBP) under droplet and contact precautions immediately for a 10 day time period. TBP personal protective equipment "will include: - Eye Protection-goggles or face shield that covers the front and sides of the face - One pair of clean, nonsterile gloves - Gown - Respirator mask N95 filtering mask"			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection			

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	control program that includes the following: (1) A system that enables the facility to 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 observation and interview, the facility failed to maintain an infection control program by not performing hand hygiene before and/or after glove use for 3 of 4 residents observed for blood glucose checks (Residents 119, 41 and 47) and placing a finger/fingernail inside a medication cup when administering medications for 1 of 5 residents during medication administration (Resident 94) Findings include: 1. a. On 12/19/22 at 12:12 p.m., an observation was made of LPN (Licensed Practical Nurse) 2 performing a blood glucose check on Resident 119. LPN 2 in preparation of performing the blood glucose check, donned a pair of gloves. LPN 2 did not perform hand hygiene prior to donning the gloves. As she placed the glove on her right hand, her ring finger penetrated the glove making a hole. She then readjusted her finger so that it then went into the glove correctly. LPN 2 placed a new lancet into the lancet pen and replaced the lancing device cover. LPN 2 did not clean or disinfect the lancet pen or cover prior to use. LPN 2 then performed the blood glucose check on the glucometer which was not cleansed or disinfected prior to use on Resident 119. After completion of	R 0407	Plan of Correction 01/02/2023 Facility ID: 013347 Survey Event ID: E35511 R406 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents requiring the use of glucometers, lancets and lancet covers by the facility, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriately disinfecting glucometers. Employees found to be out of compliance with	01/27/2023

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	the blood glucose check, LPN 2 doffed her gloves, picked up a pen to write down the blood glucose reading then performed hand hygiene. She then removed the lancet cover with bare hands, disposed of the lancet, and wiped down the lancet pen and cover with an alcohol wipe. LPN 2 did not perform hand hygiene after doffing her gloves then using the pen nor did she properly disinfect the lancet pen, its cover, or the glucometer after its use. b. An observation of LPN 2 was conducted on 12/19/22 at 12:25 p.m. LPN 2 entered into Resident 41's room to perform a blood glucose check. LPN 2 in preparation to perform the test, donned a pair of gloves but did not perform hand hygiene prior to donning the gloves. She then performed the test, doffed one glove, used her pen to record the results, exited the resident's room then doffed the other glove. She had not performed hand hygiene prior to picking up her pen, nor had she cleaned/disinfected the lancet pen, its cover, or the glucometer prior to or after it being used with Resident 41. LPN 2 placed the potentially contaminated glucometer into her pocket and headed to the next room. c. Another observation of LPN 2 was conducted on 12/19/22 at 12:37 p.m. LPN 2 entered Resident 47's room to perform a blood glucose check. Once in the room, she prepped the resident's finger with an alcohol wipe, and without any gloves on, she performed the blood glucose check on the glucometer. LPN 2 did not clean/disinfect the lancet pen, its cover, or the glucometer prior to or after its use. 2. An observation of QMA (Qualified Medication Assistant) 3 administering medications to Resident 94 was made on 12/19/22 at 11:57 a.m.		disinfecting glucometers, lancets and covers will receive additional education and possible corrective action. b. All residents in isolation precaution will have appropriate signage on the door and an appropriate PPE cart. It was indicated Resident 41 did not have appropriate PPE cart, however, resident had placed the cart inside her door. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. All clinical staff will be re-educated and in-serviced on disinfecting glucometers, lancets and covers no later than January 31, 2022. Any clinical staff member out of compliance with facility's policies and protocols relating to disinfecting glucometers, lancets and covers will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to disinfecting glucometers during employee job-specific orientation moving forward. b. Education will be given on the proper use of PPE, including gloves. Staff re-educated on checking proper signage at the	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
	QMA 3 had entered Resident 94's room, unlocked the medication cabinet in the unit, and retrieved the needed medication. She then grabbed a medication cup out of the supply box she carried with her and dropped the medication into the cup. QMA 3 then placed her index finger and long fingernail into the medication cup and pinched the cup between her index finger and thumb then handed it to the resident who then took the medication. QMA 3 had not performed hand hygiene since entering Resident 94's room and touching the resident's surroundings. In an interview with QMA 3 conducted immediately prior to entering into Resident 94's room for the medication administration, she indicated, she had used the washroom and had washed her hands otherwise she would have performed hand hygiene when entering the resident's room. A Hand Hygiene policy was received on 12/19/22 at 2 p.m. from Interim ED (Executive Director). The policy indicated, "It is the responsibility of all staff to follow proper handwashing and hygiene guidelines...B. Handwashing 1. All personnel must wash their hands for at lease twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...r. After removing gloves or aprons...C. Alcohol-Based Hand Rubs: 1. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, you may choose to use and alcohol-based hand rub...for all the following situations...b. Before preparing or handling medications...g. After removing gloves (hand hygiene is always the final step after removing and disposing of personal protective equipment)."		front door and in the breakroom regarding COVID positive residents in the community. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit the cleaning of glucometers, lancets and covers two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, then two (2) times a month for one (1) month and then as needed to ensure that proper disinfecting technique is being executed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results b. The Director of Nursing or designee will audit all COVID positive residents for proper signage and PPE carts on a case by case basis. Director of Nursing or designee will monitor proper donning and doffing of PPE by staff. **5. By what date will the systematic changes be completed** a. Education and in-service will	

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	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 30TH	5651 E 30TH STREET INDIANAPOLIS, IN 46218

(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
			be provided to all clinical staff between now and concluding on January 27, 2023	

PRINTED: 05/23/2023
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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00406211 and IN00406266. Complaint IN00406211-No deficiencies related to the allegations are cited. Complaint IN00406266- State deficiency related to the allegations is cited at R0240. Survey dates: April 17, 18. 19, and 20, 2023 Facility number: 014279 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 26, 2023	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to ensure the results of the most recent Complaint Surveys and corresponding plan of correction was made available to residents for examination for 114 of 114 residents in the facility. Findings include:	R 0042	R042 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will**	05/31/2023

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

[redacted] Executive Director 05/09/2023

Any deficiencystatement 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.

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	An observation of the IDOH (Indiana Department of Health) survey binder was made upon entrance to the facility on 4/17/23 at 10:15 a.m. and 4/19/23 at 10:25 a.m. It was on top of a side table next to a chair in the front lobby near the receptionist's desk. The survey binder was reviewed on 4/19/23 at 10:25 a.m. The most recent survey included in the binder was a Complaint Survey dated 7/18/22. All other surveys included in the binder were dated prior to 7/18/22. The Complaint Survey conducted at the facility on 2/10/23 that included a total of 10 individual complaints was not included in the binder, nor was its' plan of correction. The Complaint Survey conducted at the facility on 3/17/23 with no deficiencies was not included in the binder either. An interview was conducted with the ED (Executive Director) on 4/19/23 at 10:29 a.m. She indicated she updated the survey binder when she received the survey. She forgot and started to make another binder that was in her office. She pulled the most recent survey this morning and hadn't put it back out yet. After being informed there was only one survey binder present in the lobby since the beginning of the current survey, the ED indicated perhaps she pulled the most recent survey prior to 4/17/23. An interview was conducted with Receptionist 23 on 4/19/23 at 10:30 a.m. at the receptionist's desk. She indicated she'd worked at the facility since 2020 and there was always just one survey binder on the side table in the front lobby. An interview was conducted with the ED during exit conference on 4/20/23 at 1:25 p.m. She indicated even though the 2/10/23 Complaint		**identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. ED posted the survey results while the survey was in progress. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. The Executive Director or designee will post survey results and plan of correction timely. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Executive Director or designee will audit the survey binder for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all survey results and plan of correction are posted timely with the most recent ones available. Survey results and plan of correction to be reviewed at monthly QI meetings and make further recommendations based off	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	Survey and plan of correction was not included in the survey binder in the front lobby, it was present in the facility in her office, and she had conducted town halls at the facility informing residents of the plans they had in place to address the deficiencies cited at the 2/10/23 Complaint Survey.		audit results. **5. By what date will the systematic changes be completed?** The binder was updated April 19, 2023	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview, and record review, the facility failed to implement the Medication Management, Administration, & Storage policy by not assuring each controlled substance was reconciled with the Pharmacy Count Sheet and Stored in a controlled-medication binder, not assuring all controlled substances were physically counted by the outgoing and oncoming licensed nurse and/ or QMA (Qualified Medication Aide), and not ensuring that upon the completion of the controlled substance count, each party, both oncoming and outgoing, provided their signature, date and time on a Controlled Medication Shift to Shift Change Log for 3 of 3 medication carts and 1 medication storage room observed.	R 0091	091 1. What Corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice a. No residents experienced adverse effects from the alleged deficient practice 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	Findings include: On 4/18/23 at 9:30 a.m., Resident H was observed receiving his scheduled morning medications from QMA (Qualified Medication Aide) 8. Resident H approached the medication cart and asked for his medications. QMA 8 opened the drawer of the medication cart and removed Resident H's pill packet from the drawer, opened the pill pack and poured the medication into a plastic cup. QMA 8 did not remove Resident H's medication from a locked compartment in the medication cart. QMA 8 then handed the medications to Resident H. Resident H inquired if his pain pill was in the cup and QMA 8 indicated it was. Resident H took his medications and handed the cup back to QMA 8, who took it and threw it away. During an interview on 4/18/23 at 10:04 a.m., QMA 8 indicated that Resident H had received Oxycodone with his scheduled medications. When a resident receives a scheduled narcotic, it comes in the timed pill pack. The narcotic medications in the pill packs were not signed out on a narcotic count sheet and the counts of the narcotic medications were not reconciled with another nurse or QMA at shift change. There were no controlled- medication binders for any of the medication carts in the building, only in the medication room where the PRN (As Needed) controlled medications were stored. On 4/18/23 at 10:18 a.m., the narcotic storage box in the medication room was observed with LPN 11. LPN 11 located the controlled- medication binder inside of the double locked narcotic storage box. LPN 11 indicated she had not counted the controlled medications but understood that the night shift counted the controlled medications each night. She was unsure if they were counted		a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on shift-to-shift reconciliation of narcotics. b. DON or designee will provide an in-service to all QMAs and Nurses on properly recording medication administration in the narcotic log binder. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: a. DON or designee will do an audit of all narcotic logs ensuring accurate and timely completion. Any clinical staff member out of compliance with facility's policies and protocols relating to proper documentation will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to recording proper documentation during employee job-specific orientation moving forward. 4. How the corrective action(s) will be monitored to ensure the deficient practice will no recur, i.e what quality assurance program will be put into place:	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	at any other time of the day. The controlled-medication binder was opened by LPN 11, and she was unable to locate the current Change of Shift Controlled Medication Count Sheet. There were Change of Shift Controlled Medication Count Sheets present in the binder for October 2022, November 2022, and December 2022. The December 2022 Change of Shift Controlled Medication Count Sheet contained a signature of the 1st shift QMA on 12/1/22 and 12/2/22. The remaining days and shifts for December 2022 were blank. On 4/18/23 at 2:03 p.m., the RDHS (Regional Director of Health Services) indicated when narcotic medications came in a scheduled pill pack they were not signed out or tracked on a narcotic count sheet. She was unaware of where the current Change of Shift Controlled Medication Count Sheet and would try to locate them. During an interview on 4/18/23 at 3:06 p.m., RPH (Registered Pharmacist) 12 indicated the controlled medications, such as narcotics, were in the individual dose packs when they are scheduled. He believed that the facility had a "waiver" which allowed the controlled substances to be done this way. RPH had not seen the waiver, but the controlled medications had been dispensed to the facility that way for "years". Without a "waiver" the scheduled controlled medications would not come in the dose pack, but instead would come in a punch card and be signed out on a narcotic count sheet when each dose was given. On 4/19/23 at 10:10 a.m., the RDHC provided the Controlled Medication Shift to Shift Change Logs for January, February, March, and April 1st		a. The Director of Nursing or designee will audit incident narcotic logs for six (6 weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all narcotic logs are being properly completed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5. By what date will the systematic changes be completed a. Education and in-service will be provided to all clinical staff between now and concluding on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	through April 18th, which were completely filled in with no missing signatures for any shift. On 4/19/23 at 1:43 p.m., the RDHC provided the Daily Schedules as worked for March 21, 2023, through March 31, 2023. The daily schedules as worked were compared to the Controlled Medication Shift to Shift Change Log for March 2023. The follow days had discrepancies between the scheduled staff who worked and the staff who signed the Controlled Medication Shift Change Log: 3/19/23 the Daily Schedule as worked indicated QMA 13 was present for the 3rd shift, which started 3/19/23 at 10:00 p.m. and ended 4/20/23 at 6:00 a.m. The Controlled Medication Shift Change Log had QMA13's signature at the beginning of the shift and QMA 14's signature at the end of the shift. QMA 14 was not listed on the schedule as worked for the 3rd shift starting 3/19/23. The Daily Schedule as worked for 3/22/23 indicated QMA 13 was present for the 3rd shift. The Controlled Medication Shift Change Log was signed by QMA 14 at the beginning and end of the 3rd shift starting 3/22/23. QMA 14 was not listed on the Daily Schedule as worked for the 3rd shift on 3/22/23. The Daily schedule as worked for 3/26/23 indicated QMA 14 was present on the 3rd shift. The Controlled Medication Shift Change Log had the signature of QMA 14 at the beginning of the 3rd shift. The off going 3rd shift signature was QMA 13's. QMA 13 was not listed on the Daily Schedule as worked for the 3rd shift on 3/26/23. On 4/18/23 at 2:03 p.m., the RDHS provided the Medication Management, Administration, & Storage policy, last revised 3/23/22, which read " ...Delivery, Storage, & Handling of Controlled Substances...Each time a controlled substance is delivered, it will be reconciled with the Pharmacy			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	Count Sheet and Stored in a controlled-medication binder... The number of signature lines on the Controlled substance Inventory Sheet should be equal to the number of doses placed in the controlled substance medication box... Controlled Substances- Hand off Procedure 1. At shift change, the oncoming licensed nurse or QMA responsible for medication administration will verify the resident, medication, dosage and count of all controlled substances by physically counting each medication in the direct presence of an off going licensed nurse or QMA...2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log. a. In the event of a controlled substance discrepancy is discovered during the controlled substance count, the Director of Nursing, or designee, should be notified immediately..."			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review the facility failed to ensure a staff member, certified in first aide, was scheduled on each shift. This had a potential to affect 114 of 114 residents that reside in the facility. Findings include: The schedule, as worked, for 4/9/23 through 4/15/23 was provided by the Business Office Manager on 4/17/23 at 11:55 a.m. It indicated that on the following days and shifts there were no staff members who were certified in First Aid present in the building: 4/10/23 on the first shift, 4/11/23 on the second shift, 4/12/23 on the second shift, and 4/15/23 on the first shift. During an interview on 4/19/23 at 1:30 p.m., the Business Office Manager indicated the Certifications of CPR (Cardiopulmonary Resuscitation) and First aid which she had available to her for the staff were in the licensing binder. On 4/20//23 at 10:51 a.m., the Regional Director of Health Services provided the CPR & First Aid Certifications policy, dated 9/29/21, which read "...It is the responsibility of the Director of	R 0117	R117 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Executive director or designee will ensure that all staff will be certified in CPR and First aid. b. DON or designee will ensure that each shift will have an associate that is certified in CPR and First aid. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. DON or designee will do an audit of current associates to	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	Nursing or designee to ensure at least one on-duty employee has current CPR & First Aid Certifications at all times..."		identify associates certified in CPR and First aid. completion. Any staff member out of compliance with facility's policies and protocols relating to CPR and First aid certification will be offered certification classes. b. DON or designee will review weekly schedule to ensure that at least 1 associate certified in CPR and First aid is scheduled each shift. Newly hired staff will be offered CPR and first aid certification classes if needed. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit weekly schedule for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all narcotic shifts have an associate that is certified in CPR and First aid. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. CPR and first aid classes are being offered now and concluding on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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) COMPLETTON DATE
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to assure staff received resident rights and dementia training prior to working independently	R 0119	R119 **1. What Corrective action(s) will be accomplished for those residents found to have been**	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	in the facility for 2 of 5 employee's records reviewed (LPN 6 and QMA 7). Finding include: The employee file for LPN (Licensed Practical Nurse) 6 was reviewed on 4/18/23 at 2:10 p.m. The employee file indicated that LPN 6 has started employment with the facility on 9/23/22. The employee file did not contain information that she had received dementia training during the orientation process. The employee file for QMA (Qualified Medication Aide) 7 was reviewed on 4/18/23 at 2:20 p.m. The employee file indicated that QMA 7 had started employment with the facility on 9/20/22. The employee file did not contain information that she had received dementia training during the orientation process. During an interview on 4/18/23 at 9:45 a.m., the Business office manager indicated all available training information had been added to the employee files. On 4/20/23 at 10:51 a.m., the Regional Director of Health Services provided the Staff Training Policy and Procedure, last reviewed on 6/6/22, which read "...Within 30 days of employment, all staff members will complete orientation and training to the community and their assigned department and area of responsibility...training topics will include, but not be limited to...techniques for working with persons with disabilities and the elderly populations..."		**affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Executive director or designee will ensure that all current staff complete dementia training. b. The Executive Director or designee will ensure that each newly hired associate will complete dementia training in orientation. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. The ED or designee will do an audit of current associates to identify associates who have completed dementia training. Any staff member out of compliance with facility's policies and protocols relating to dementia training will be required to complete it before their next scheduled shift. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will not recur, i.e what quality assurance program will be put into place: a. The Executive Director or designee will audit employee education record for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all associates have completed dementia training. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** Dementia training is being offered now and concluding on May 31, 2	
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			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 the services to be provided. Based on interview and record review, the facility failed to discuss services plans with residents and ensure service plans are signed and dated by the resident for 2 of 6 residents reviewed for service plans (Resident K and L). Findings include: 1. The clinical record for Resident K was reviewed on 4/19/23 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, hypertension and chronic obstructive pulmonary disease. She was admitted to the facility on 11/8/19. A Level of Services Assessment, dated 2/23/23, indicated she was alert and oriented to person, place, and time. During an interview on 4/19/23 at 1:30 p.m., Resident K indicated that she had never attended a service plan meeting. She was unaware of what a service plan was. On 4/20/23 at 12:30 p.m., the RDHS (Regional Director of Health Services) provided Resident K's	R 0217	R217 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Director of nursing or designee will ensure that all current residents will have their service plans reviewed with them of their designee. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	current service plan, last updated 12/9/22. The service plan was not signed and dated by Resident K. 2. The clinical record for Resident L was reviewed on 4/19/23 at 9:32 p.m. The Resident's diagnosis included, but was not limited to, diabetes and hypertension. She was admitted to the facility on 1/1/21. A Level of Services Assessment, dated 4/11/23, indicated she was alert and oriented to person, place, and time. She was independent with decision making. During an interview on 4/20/23 at 11:15 a.m., Resident L indicated that she had never been invited to a service plan meeting. She was not familiar with a service plan and had never signed one. On 4/20/23 at 12:30 p.m., the RDHS provided Resident L's current service plan, last updated 12/22/22. The service plan was not signed and dated by Resident L. During an interview on 4/20/23 at 12:30 p.m., the RDHS indicated there was no documentation in the clinical records that the service plan had been reviewed with Resident K or Resident L. On 4/19/23 at 10:10 a.m., the RDHS provided the Service Plans policy, dated 1/12/22, which read "...The nursing staff along with the resident and/ or family members will identify resident problems, needs and strengths... All service plans are to be reviewed every quarter, upon significant change in condition and as dictated by changes in resident needs or preferences..."		**practice does not recur:** a. The Director of nursing or designee will do an audit of current residents' service plans to identify associates who signed their service plans. Any resident who did not sign their service plan will have an opportunity to have it reviewed and signed by them. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of nursing or designee will audit residents' service plans for signatures for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all associates have completed dementia training. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Resident service plans updated with signatures has been initiated and will be completed on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to timely obtain laboratory services for 1 of 5 residents reviewed for laboratory service provision. (Resident B) Findings include: The clinical record for Resident B was reviewed on 4/17/23 at 10:52 a.m. Her diagnoses included, but were not limited to, CHF (congestive heart failure,) coronary artery disease, hypertension, and anxiety. On 4/17/23 at 12:57 p.m., the BOM (Business Office Manager) provided a list of residents who administered their own medications in the facility. Resident B was on the list. Resident B's service plan, updated 12/12/22, indicated Nursing staff and the assigned department director and family were to assist Resident B with making appointments and transportation arrangements as needed. Resident B would request help with scheduling an appointment as needed. On 4/18/23 at 9:23 a.m., the RDHS (Regional Director of Health Services) provided the 3/23/23 BMP (basic metabolic panel) lab order for Resident B from Physician 4. It indicated for the lab to be drawn once, expected 4/6/23. On 4/18/23 at 9:23 a.m., the RDHS provided the 4/14/23 BMP lab results with verification of physician notification on 4/14/23. The results	R 0240	Survey Event ID: POBG11 R240 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Director of nursing or designee will work with residents and providers regarding lab orders. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. The Director of nursing or designee will do an audit of current residents' lab orders to assist with scheduling lab service. b. The Director of nursing or designee will work with resident care providers to assist with scheduling labs.	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	indicated her glucose and carbon dioxide was high, and her potassium and GFR (glomerular filtration rate-measure of how well your kidneys filter blood) was low. An interview was conducted with Family Member 3 on 4/17/23 at 12:13 p.m. She indicated Resident B was sent to the hospital earlier today to have fluid pulled off. She was supposed to have a BMP (basic metabolic panel) lab drawn 2 weeks ago at the facility on 4/7/23. Resident B gave the lab order to the DON (Director of Nursing) to schedule it after one of her doctor appointments. The facility was supposed to schedule it with their lab, who came to the facility on Fridays, but they didn't, so Resident B was a week late getting it, and didn't have it drawn until 4/14/23. The DON informed Resident B it would be scheduled with the facility's lab for 4/7/23. Resident B was currently on a diuretic medication, trying to figure out the most appropriate dose, and now today she was in the emergency room with a 3 pound weight gain overnight. They were currently unsure if she needed dialysis or just to have her diuretic medication adjusted. If the BMP lab was done timely, and the medication adjusted, perhaps she wouldn't' currently be in the hospital. Resident B was on a low salt diet, but the facility did not honor it. The other day, Resident B asked for a grilled cheese sandwich and a salad, but the grilled cheese was cold, and she was refused the salad. An interview was conducted with Resident B on 4/20/23 at 12:37 p.m. She indicated she just returned from the hospital the evening of 4/18/23 after a 4/17/23 admission where she had fluid pulled off and her diuretic medication adjusted. She felt like she couldn't breathe, so she called her cardiologist who instructed her to go to the		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of nursing or designee will audit residents' lab orders for completion of service for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that all services were completed, and results addressed. Audit results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Resident lab orders audit has been initiated and will be completed on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	hospital. Her torsemide (diuretic medication) was now scheduled for 80 mg in the morning and 20 mg in the evening. It used to be 20 mg in both the morning and evening. Resident B administered her own medications at the facility. She was supposed to have a BMP (basic metabolic panel) lab drawn in the facility on 4/7/23, but didn't get it done until 4/14/23. The DON (Director of Nursing) informed her it was scheduled for 4/7/23, but the following Monday, 4/10/23, she informed the DON the lab never came. The DON informed her she was 1 of 5 residents who didn't get their labs done on 4/7/23 and she didn't know why. This was not the first time she was late getting an ordered lab. After having the labs drawn on 4/14/23, here cardiologist increased her torsemide. As far as meals in the facility, she was always supposed to be able to select a salad as a substitute, which would coincide with her low salt diet, but it wasn't always available, especially at dinner and on the weekends when the DM (Dietary Manager) wasn't there. It was "ridiculous" that she had to go to the hospital, which she attributed to mostly "because I eat downstairs and my fluid goes up." An interview was conducted with the RDHS on 4/18/23 at 9:58 a.m. She indicated their lab provider was at will call, and was unsure why Resident B's labs were not drawn until 4/14/23. An interview was conducted with the DON (Director of Nursing) by phone on 4/18/23 at 10:31 a.m. She indicated their facility was considered a will call with their lab provider, and she had access to their lab services electronically. She took all the proper steps to schedule the lab to be drawn on 4/7/23, including calling the lab, but the lab didn't come to draw Resident B's BMP lab until 4/14/23. After Resident B missed the lab draw on 4/7/23, Resident B informed her it was okay to wait			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	until 4/14/23. The DON faxed the 4/14/23 lab results to Resident B's physician that same day. An interview was conducted with Call Center Service Representative 22 from the facility's laboratory services provider on 4/19/23 at 1:35 p.m. She indicated the facility was an at will facility. They can put in an electronic requisition for a lab to be drawn, but they also needed to call and get a confirmation number for them to send a phlebotomist to the facility for a draw. The DON was aware of their at will status with them and the process for obtaining labs. After a brief hold, Call Center Service Representative 22 returned to the line and indicated she reviewed the lab requisitions for Resident B and there was no request for a BMP lab draw for 4/7/23, only for 4/14/23. The facility did not call them for a 4/7/23 lab draw for Resident B for 4/7/23 either. If there was a requisition or phone call for Resident B's BMP lab to be drawn 4/7/23, she would be able to see it in their records, but there was nothing there. The 4/17/23, 9:15 a.m. QMA (Qualified Medication Aide) note read, "Resident called the nurses station to inform staff that she will be going out to the hospital. Resident stated that she was having difficulty breathing and that she had gained 4 lbs. over night. She called her doctor who directed her to go out to the hospital with concern about her CHF. Paper work including med [medication] list was given to resident to take to hospital with her." The Laboratory Services and Results policy was provided by the RDHS on 4/18/23 at 9:23 a.m. It read, "RESPONSIBILITY: A. It is the responsibility of the community Administrator or designee to establish a relationship with a local lab provider to provide routine lab draw services per physician's orders for the residents of the			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	community." This Residential Tag relates to Complaint IN00406266.			
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, interview, and record review, the facility failed to ensure proper food storage in the kitchen; wear beard covers in the kitchen; and ensure trash was covered when not in use. This affected 114 of 114 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 4/18/23 at 11:20 a.m. During the tour, an observation of a food preparation counter was made, and an interview was conducted with the DM. The counter had a large pot of potatoes on it. There was a cellular phone charging on the counter, plugged into an outlet above the counter. There was a large, white bin of sugar underneath the counter. The sugar bin was open, exposed to air, and not in use. The DM shut the lid to the sugar bin and removed the charging cellular phone. He indicated the counter was used to prepare meals, and the potatoes were for tonight's dinner meal. He indicated the cellular phone should not have been charging on the counter and belonged to one of the CNAs (Certified Nursing Assistants.)	R 0273	R273 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. The Executive Director or designee will ensure that food is store properly, trash is covered when not in use and that beard guard is worn per policy. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	During the tour, an observation of the trash bin was made. It was uncovered and not in use. The trash inside of the bin was extending beyond the rim of the bin. During the tour, the dry storage area was observed and an interview was conducted with the DM. There were gnats flying around the room. There were 2 open syrup condiments, partially empty, on one of the food racks. There was a gallon jug of syrup next to the 2 open syrup condiments with syrup remnants around the lid area. There was a 25 pound beef baste container on a bottom rack with an unsealed lid. There was beef baste remnants on top of the unsealed lid. The DM removed the beef baste from the bottom rack, placed it onto the floor, and snapped the lid into place. There was a maroon coat and a pink purse hanging from one of the dry storage racks. There was a black work bag hanging from a different dry storage rack. The DM removed the coat, purse, and bag from the racks and indicated the items should not have been stored on the racks. During the tour, the walk in refrigerator was observed. There was a jar of relish with a cracked lid, leaving the contents exposed to air. There was a container of yogurt with the lid not properly sealed. During the tour, the walk in freezer was observed. There was a large container of chocolate ice cream on a bottom shelf with the lid not properly sealed, leaving the ice cream inside visible and exposed to air. During the tour, the spice rack was observed, and an interview was conducted with the DM. There		a. The Executive Director or designee will audit food storage to ensure compliance. b. The Executive Director will monitor the use of beard guard in the kitchen to ensure compliance. c. The Executive director or designee will audit trash storage when the trash can is not in use. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Executive Director or designee will audit beard guard use, food and trash storage when trash can is not in use for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure that compliance with policies is met, and results addressed. Audit results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Education of staff on beard guard, food and trash storage is initiated and will be completed on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	were 6 spice containers with open lids, leaving the spices inside exposed to air. The DM closed each of the lids. A gnat flew up from one of the spices when he closed it. The DM indicated they were having issues with gnats. During the tour, the clean plate and dish rack was observed, and an interview was conducted with the DM. None of the dishes or plates were stored inverted. One of the small bowls on top of a stack of bowls was full of white sugar. The DM stated, "I couldn't even tell you what they doin' with that." He indicated he'd spoken with the DON (Director of Nursing) about how the CNAs who worked in the kitchen were to store clean dishes, but he hadn't heard back about it. The DM indicated he understood all of the concerns in the kitchen, but it wasn't his staff who was creating the concerns. The DM retrieved temperatures of hot foods from the steam table on 4/18/23 at 12:08 p.m. An interview was conducted with the DM at this time. The DM had beard hairs on his chin as long as one inch and was not wearing a beard cover. After retrieving the food temperatures, Dietary Aide/Cook 5 took over the steam table and began plating food from the steam table for the lunch meal. He also had beard hairs on his chin as long as 3/4 of an inch and was not wearing a beard cover. The DM indicated they normally wore beard covers. The Appearance and Dress policy was provided by the DM on 4/18/23 at 3:43 p.m. It read, "Hairnets or appropriate head coverings will be worn by all food service employees while in community kitchen and when handling food." The Garbage and Refuse Storage policy and			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	procedure was provided by the RDHS (Regional Director of Health Services) on 4/19/23 at 9:57 a.m. It read, "Garbage and refuse on the premises shall be stored in a manner inaccessible to insects and rodents...Lids shall be in place and remain closed at all times." The Dry Food Storage policy was provided by the RDHS on 4/19/23 at 9:57 a.m. It read, Containers of food shall be stored a minimum 18 inches from the ceiling and sprinkler heads. Also, six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area..." The Receiving policy was provided by the DM on 4/18/23 at 3:43 p.m. It read, "If any product has a seal that is open or tampered with it must be set aside for a credit and labeled do not use. Then the item must be discarded."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.	R 0298	R298	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	Based on interview and record review, the facility failed to timely address a pharmacy recommendation for 1 of 6 residents reviewed for pharmacy recommendations (Resident M). Findings include: The clinical record for Resident M was reviewed on 4/20/23 at 9:30 a.m. The Resident's diagnosis included, but were not limited to, hypertension. A physician's order, dated 1/27/2020, indicated she was to receive metoprolol (heart medication) extended-release tablet 100 mg (milligram) each day at bedtime. A physician's order, dated 1/26/22, indicated that she was to receive carvedilol (heart medication) 12.5 mg twice daily. A service plan indicated Resident M needed her medications administered by a QMA (Qualified Medication Aide) or licensed nurse and she needed a licensed nurse to follow up with prescriber as needed for medication management. The objective was for her to achieve the highest level of medication assistance while maintaining her independence. A Pharmacy Consultation Report, dated 1/13/23, indicated that Resident M was noted to have a potential duplicate beta- blocker (type of heart medication which decreased heart rate and blood pressure) order. She was receiving carvedilol 12.5 mg twice daily and metoprolol extended release one time daily at bedtime. The recommendation was to clarify which beta-blocker Resident M was to receive and discontinue the other order. A Pharmacy Consultation Report, dated 3/13/23,		**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents with physician orders have the potential to be affected by the alleged deficient practice. DON or designee will audit all pharmacy recommendations and resulting orders. DON or designee will work with pharmacy to ensure all recommendations have been addressed timely. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all pharmacy recommendations and resulting orders. DON or designee will work with pharmacy to ensure all orders resulting from the recommendations have been entered into the EMR. **4. How the corrective action(s) will be monitored to**	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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) COMPLETTON DATE
	indicated that Resident M was noted to have a potential duplicate beta- blocker (type of heart medication which decreased heart rate and blood pressure) order. She was receiving carvedilol 12.5 mg twice daily and metoprolol extended release one time daily at bedtime. The recommendation was to clarify which beta-blocker Resident M was to receive and discontinue the other order. The April 2023 Medication Administration Record indicated Resident M was continuing to receive both the carvedilol and metoprolol as ordered daily. During an interview on 4/20/23 at 12:20 p.m., the Regional Director of Health Services indicated that pharmacy reviews should be looked at and addressed by the nursing staff at the facility. The clinical record did not contain information that the pharmacy review from 1/13/23 or 3/13/23 had been addressed. The facility did not have a policy for pharmacy reviews.		**ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit all pharmacy recommendations and follow up for six (6) weeks, then every other week for eight (8) weeks, and then as needed to ensure that all pharmacy recommendations have been addressed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on March 31, 2023	
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose,			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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 APPROFRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to assure medications were labeled with the resident's full name, physician's name, prescription number, name and strength of the drug, directions for use, date issued, name and address of the pharmacy that filled the prescription for 2 of 8 resident records reviewed (Resident S and T). Findings include: 1. The clinical record for Resident S was reviewed on 4/19/23 at 1:30 p.m. The Resident's diagnosis included, but was not limited to, hypertension. A physician's order, dated 11/22/22 indicated she was to receive Norco (narcotic pain medication) 7.5-325 mg (milligram) three times daily. 2. The clinical record for Resident T was reviewed on 4/19/23 at 1:45 p.m. The Resident's diagnosis included, but were not limited to, stroke and diabetes. A physician's order, dated 12/16/22, indicated he was to receive Pregabalin (medication for nerve pain) 200 mg twice daily. On 4/19/23 at 10:32 a.m., the double locked narcotic box in the medication room was observed with QMA (Qualified Medication Aide) 9 and QMA 10. The narcotic medication box contained a clear, unlabeled bag of white oblong tablets. There was no label on the bag containing the resident's name, ordering physician, what	R 0301	R301 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents have the potential to be affected by the alleged deficient practice. DON or designee will audit all medication carts to ensure that medications are labeled per policy. DON or designee will request assistance from pharmacy for any medication out of compliance. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all medication carts to ensure that medications are labeled appropriately. Any medication not labeled appropriately will be removed from the cart and pharmacy notified. **4. How the corrective**	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	medication the bag contained or the strength of the medication inside of the bag, what pharmacy had filled the prescription or when the prescription had been filled QMA 9 indicated the tablets were Norco and belonged to Resident S. The tablets were counted by QMA 9 and QMA 10 and the unlabeled bag contained 12 oblong white tablets, which matched the count on the narcotic inventory sheet. QMA 9 removed another clear unlabed bag with the number "50" on it from the narcotic box. The clear bag was stapled shut and also had small holes beside the current staples. It appeared to have been restapled. The bag contained white, oblong tablets. There was no label on the bag containing the resident's name, ordering physician, what medication the bag contained or the strength of the medication inside of the bag, what pharmacy had filled the prescription or when the prescription had been filled. QMA 9 indicated it was another bag of Norco which belonged to Resident S. QMA 9 indicated that Resident S had brought a large amount of Norco with her when she admitted and the facility had been giving them to Resident S as prescribed. The Medication Count Sheet indicated on 10/25/22 there had been 9 bags of Norco 7.5-325mg. The last entry on the Medication Count Sheet was on 4/5/23 at 4:00 p.m. and indicated that 1 bag remained. QMA 10 indicated this was the last bag of Norco present in the narcotic box for Resident S. QMA 9 indicated there were 50 pills in the bag and that the staff did not normally count them since the bag was labeled with the number 50. QMA 9 and QMA 10 counted the white, oblong pills and the bag contained 50 of them. QMA 9 indicated the bag should have a label. Resident S's name had been written on the bags, but had worn off.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit all medication carts to ensure that medications are labeled correctly for six (6) weeks, then every other week for eight (8) weeks, and then as needed to ensure that medications are properly labeled. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Auditing of carts have been initiated and will conclude on March 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	QMA 9 removed a clear bag from the narcotic box which contained individual dose packets for Resident T. The individual dose packs were labeled with Resident T's name. Each pack was labeled as pregabalin 200 mg and the prescription number. There were 9 individual dose packs which were attached to each other in a roll, at the end of the roll there was a white soufle cup which was stapled together and taped to the roll of individual dose packs. A orange colored pill was in the stapled soufle cup. QMA 10 indicated that the Narcotic Inventory Sheet had a count of 10 pills remaining. On 3/25/23 someone had signed that a pregaballin 200 mg had been removed from the narcotic box and made a note on the narcotic inventory sheet that the pregabalin was now in the cycle pack and readjusted the count from 9 to 10. The pill must have been put into the soufle cup and taped to the pill pack roll at this time. It should not be stored that way and should have been destroyed. On 4/19/23 at 2:03 p.m., the RDHS (Regional Director of Health Services) provided the Medication Management, Administration, & Storage policy, last revised 3/23/22, which read "... The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines..."			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the facility failed to store a schedule II narcotic medication under double lock for 1 of 5 residents randomly observed for medication administration (Resident H). Findings include: The clinical record for Resident H was reviewed on 4/18/23 at 11:07 a.m. The Resident's diagnosis included, but were not limited to, knee pain and schizoaffective disorder. A physician's order, dated 12/14/22, indicated he was to receive oxycodone (schedule II narcotic pain medication) 5 milligrams three times a day at 8 a.m., noon, and 8 p.m. On 4/18/23 at 9:30 a.m., Resident H was observed receiving his scheduled morning medications from QMA (Qualified Medication Aide) 8. Resident H approached the medication cart and asked for his medications. QMA 8 opened the drawer of the medication cart and removed Resident H's pill packet from the drawer, opened the pill pack and poured the medication into a plastic cup. QMA 8 did not remove Resident H's medication from a locked compartment in the medication cart. QMA 8 then handed the medications to Resident H. Resident H inquired if his pain pill was in the cup and QMA 8 indicated it was. Resident H took his medications and handed the cup back to QMA 8, who took it and threw it away. During an interview on 4/18/23 at 10:04 a.m., QMA 8 indicated that when a resident receives a scheduled narcotic, it comes in the timed pill pack.	R 0304	R304 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents have the potential to be affected by the alleged deficient practice. DON or designee will audit all medication carts to ensure that narcotics are stored under double lock. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all medication carts to ensure that narcotics medications are stored under double lock. Education will be given to all current clinical staff and newly hired clinical staff. Any clinical found to be non-compliant will receive progressive discipline. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	Resident H's pill packets were stored in the regular medication drawer and not in a locked compartment in the medication cart. The narcotic medications in the pill packs were not signed out on a narcotic count sheet and the counts of the narcotic medications were not reconciled with another nurse or QMA at shift change. On 4/18/23 at 2:03 p.m., the RDHS (Regional Director of Health Services) indicated that Resident H's pill packs should have been located in the locked compartment inside of the medication cart. When narcotic medications came in a scheduled pill pack they were not signed out or tracked. On 4/18/23 at 2:03 p.m., the RDHS provided the Medication Management, Administration, & Storage policy, last revised 3/23/22, which read "...All controlled substances shall be kept in a designated, secure location under double lock..."		**will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit all medication carts to ensure that narcotic medications are stored under double lock for six (6) weeks, then every other week for eight (8) weeks, and then as needed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Auditing of carts and education of associates have been initiated and will conclude on March 31, 2023	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	restrictive and more independent living arrangements. Based on interview and record review, the facility failed to ensure comprehensive care plans were developed in cooperation with mental health service providers for 3 of 3 residents reviewed for a major mental illness. (Residents D, H, and N). Findings include: 1. The clinical record for Resident H was reviewed on 4/18/23 at 11:07 a.m. The Resident's diagnosis included, but were not limited to, knee pain and schizoaffective disorder. He was admitted to the facility on 9/12/22. A physician's order, dated 9/12/22, indicated he was to receive quetiapine (anti-psychotic medication) 100 mg (milligram) twice daily. The service plan, last updated 10/17/22, did not contain a comprehensive care plan addressing Resident H's diagnosis of schizoaffective disorder or anti-psychotic medication use. A physician's order, dated 3/31/23, indicated he was to receive an additional 50 mg of quetiapine with his bedtime dose (to equal 150 mg of quetiapine at bedtime). A list of residents in the facility with a major mental illness was provided by the RDHS (Regional Director of Health Services) on 4/18/23 at 2:00 p.m. Resident H was on the list as having schizophrenia. 2. The clinical record for Resident D was reviewed on 4/18/23 at 1:50 p.m. Her diagnoses included, but were not limited to, schizophrenia. She was admitted to the facility on 5/13/22.	R 0383	R383 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents diagnosed with mental illness/disorder have the potential to be affected by the alleged deficient practice. DON or designee will audit all residents diagnosed with mental disorder/illness and schedule appointments with mental health practitioner. **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** b. DON or designee will do an audit of all residents with mental health/disorder diagnosis to ensure that they have a practitioner. DON or designee will work with primary care physician(s) as needed for referrals to mental health practitioner. **4. How the corrective**	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	A list of residents in the facility with a major mental illness was provided by the RDHS (Regional Director of Health Services) on 4/18/23 at 2:00 p.m. Resident D was on the list as having schizophrenia. The March, 2023 and April, 2023 MARs (medication administration records) indicated she refused her daily scheduled quetiapine (antipsychotic medication) 27 times in March, 2023 and 13 times thus far in April, 2023. She also refused her other 7 scheduled medications/treatments thus far in April, 2023 as follows: daily amlodipine 17 times; daily Folic Acid 9 times; twice daily Lubrisoft Lotion 23 times; daily melatonin 13 times; twice daily metoprolol 32 times; twice daily Senna Plus 31 times; and daily Vitamin B-1 eight times. Resident D's service plan, updated 12/10/23, did not include a plan to address her schizophrenia diagnosis, nor did the service plan indicate it was developed in coordination with Resident D's mental health care provider. An interview was conducted with the RDHS (Regional Director of Health Services) on 4/19/23 at 1:37 p.m. She indicated she was unsure if Resident B received mental health services while residing in the facility. An interview was conducted with the RDHS on 4/19/23 at 2:04 p.m. She indicated she was informed Resident D did see a mental health provider and contacted them for their most recent note. Her service plan was not developed in coordination with a mental health provider and they did not have a policy specific to care plans for residents with a major mental illness.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit residents diagnosed with mental health/disorder charts to ensure that they have a mental health provider. PCP to assist with referrals for residents who do not have a mental health provider for six (6) weeks, then every other week for eight (8) weeks, and then as needed. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Auditing of charts have been initiated and will conclude on March 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	An interview was conducted with the RDHS on 4/20/23 at 11:30 a.m. She indicated she was unaware a resident with a major mental illness needed to have a care plan developed with their mental health care provider, and supposed moving forward, they could have the mental health care provider sign off on their service plan. 3. The clinical record for Resident N was reviewed on 4/19/23 at 3:00 p.m. His diagnoses included, but were not limited to, schizophrenia. He was admitted to the facility on 8/4/21. A list of residents in the facility with a major mental illness was provided by the RDHS (Regional Director of Health Services) on 4/18/23 at 2:00 p.m. Resident N was on the list as having schizophrenia. The April, 2023 MAR (medication administration record) indicated he received an every 28 day injection of Invega Sustenna (antipsychotic medication) 117 mg on 4/19/23. Resident N's service plan, updated 12/7/23, referenced needing monitoring related to a history of mood disturbance, behavioral disturbance, and needed support related to a diagnosis of schizophrenia. The service plan did not indicate it was developed in coordination with Resident N's mental health care provider. An interview was conducted with the RDHS (Regional Director of Health Services) on 4/20/23 at 10:57 a.m. She indicated she was unsure if his service plan was developed in coordination with his mental health care provider. She was trying to obtain the most recent notes from them, but currently did not have any.			

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	An interview was conducted with the RDHS on 4/20/23 at 11:30 a.m. She indicated she was unaware a resident with a major mental illness needed to have a care plan developed with their mental health care provider, and supposed moving forward, they could have the mental health care provider sign off on their service plan. On 4/19/23 at 10:10 a.m., the RDHS provided the Service Plans policy, dated 1/12/22, which read "...Service plans shall include coordination and inclusion of services being delivered to a resident by an outside entity..."			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to assure a QMA (Qualified Medication Aide) appropriately performed hand hygiene during medication administration for 4 of 5 residents randomly observed for medication administration (Resident H, P, Q, and R). Findings include: On 4/18/23 at 9:04 a.m., QMA 8 was observed during medication administration. QMA 8 was standing at the medication cart outside of Resident R's room. He opened the drawer of the medication cart and removed the pill packet from the drawer. He opened the pill pack and poured the medications into a plastic cup. He then knocked on Resident R's door and opened the	R 0414	R414 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** a. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken** a. All residents had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on hand hygiene.	05/31/2023

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	door. QMA 8 then gave the medications to Resident R and left the room, shutting the door. He did not perform hand hygiene after returning to the medication cart. QMA 8 then moved the medication cart down the hallway to Resident P's door. He opened the medication cart with the key and removed Resident P's medications from the drawer. QMA 8 opened the pill packet and poured the medications into a plastic cup. He picked up the water pitcher and poured water into another cup. He knocked on Resident P's door and waited for her to answer. He put his hands into his pockets while waiting for Resident P to answer the door. When Resident P answered the door, QMA 8 picked up the cup of medications and the cup of water and handed them to Resident P. When Resident P was done taking her medications, QMA 8 took the cups from her and threw them away. QMA 8 did not perform hand hygiene prior to preparing Resident P's Medications or after administering them. QMA 8 then pushed the medication cart to the outside of Resident Q's door. QMA 8 knocked on Resident Q's door and opened the door, telling Resident Q that his medications were coming. QMA 8 then shut Resident Q's door and opened the medication cart draw, removing Resident Q's pill pack from the drawer. QMA 8 opened the pill pack and poured the medications into a plastic cup. QMA opened Resident Q's door and entered the room, handing the medications to Resident Q. When Resident Q was finished taking his medications, QMA 8 took the cup from Resident Q and placed it in the trash. QMA 8 shut Resident Q's door. QMA 8 did not perform hand hygiene prior to or after administering Resident Q's medications. Resident H approached the medication cart and asked for his medications. QMA 8 opened the drawer of the medication cart and removed Resident H's pill packet from the drawer, opened the pill pack and		**3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** a. DON or designee will do an audit of clinical staff during medication administration to ensure appropriate hand hygiene. b. DON or designee will educate new hire staff on hand hygiene during orientation. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a. The Director of Nursing or designee will audit hand hygiene and provide education to staff for six (6) weeks, then every other week for eight (8) weeks, and then as needed, to ensure compliance. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. **5. By what date will the systematic changes be completed** a. Education and in-service will be provided to all clinical staff between now and concluding on May 31, 2023	

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	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OASIS AT 56TH	4940 WEST 56TH STREET INDIANAPOLIS, IN 46254

(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
	poured the medication into a plastic cup. QMA 8 then removed a wrist blood pressure cuff from the top drawer of the medication cart and placed it on Resident H's wrist to take his blood pressure, removing the cuff from Resident H's wrist after the blood pressure had been obtained. QMA 8 then handed the medications to Resident H. Resident H inquired if his pain pill was in the cup and QMA 8 indicated it was. Resident H took his medications and handed the cup back to QMA 8, who took it and threw it away. QMA 8 did not perform hand hygiene prior to handling Resident H's medication or after administering the medications. During an interview on 4/18/23 at 9:40 a.m., QMA 8 indicated he normally performed hand hygiene with alcohol-based hand gel. He had ran out of alcohol-based hand gel for his medication cart. QMA 8 normally performed hand hygiene after administering medications to each person. On 4/18/23 at 2:03 p.m., the Regional Director of Health Services provided the Hand Hygiene policy, last revised on 9/30/2019, which read "...Alcohol-Based Hand Rubs...In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub containing 60 to 95% ethanol or isopropanol for the following situations... before and after direct contact with residents...before preparing or handling medications...after handling contaminated equipment...after contact with inanimate objects [e.g., medical equipment] in immediate vicinity of the resident...."			

Comments for Prairie Winds Urbana WY23 Annual Review

146.220 Resident Participation Requirements a) The SLP setting may admit or retain whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLP setting.

2) Be screened by the appropriate Department on Aging contracted Care Coordination Unit (DoA CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care. A new Determination of Need (DON), or successor tool, screen is not needed for a resident who is transferring between SLP providers or comes from a nursing facility with no break in service. It is the admitting SLP provider's responsibility to ensure that a screening document is received from the transferring SLP setting or nursing facility. If the individual is transferring directly from a nursing facility and has a history of a developmental disability or serious mental illness, as evidenced in the medical history accompanying the individual, the SLP provider must submit a referral for a specialized evaluation to be completed by the DHS Division of Developmental Disabilities (DHS-DDD) Independent Service Coordination (ISC) agency or the Division of Mental Health (DHS-SMH) Preadmission Screening Resident Review (PASRR) agency to evaluate for need for active treatment or the existence of serious functional risk and needs associated with the diagnosis to determine if they exceed the capacity of the SLP setting. Private pay individuals may choose to be admitted into the SLP setting when the screening assessment does not justify nursing facility level of care.

R-5 did not have DON screen. Per E-28," R-5 moved from a different state and did not have one completed". R-5 was admitted 1/6/22. A DON screen was requested 11/23/22.

R-33, R-35, R-36 and R-37 had an initial DON screen completed but did not have a conversion screen completed. Appointment was made per E-28 to get screens done.

Comment: A DON screen should be completed prior to admission unless there is an allowable post screen, the resident transferred directly from another SLP provider or a Nursing facility, <60 days break from a Nursing facility or the resident received a Medicaid conversion screening. Please follow the rule as noted above.

146.245 Assessment and Service Plan and Quarterly Evaluation h) The SLP manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, the reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLP staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

R-31, no evidence of designated representative notification for hospital send-out on 4/1/22.

Comment: As stated in the rule above, whenever a change in a resident's mental or physical status is observed, the SLP manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative. Please follow the rule as noted above.]

RESPONSE TO ON-SITE REVIEW FINDINGS **Page 2 of 14**

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

[redacted]

5-16-23
Date

5/16/23
Date

Signature of Bureau of Long Term Care Regional Supervisor

Date

Signature of Bureau of Long Term Care Area Manager

Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _3___ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.215 SLF Participation Requirements o) The SLF shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests. The SLF shall provide all residents with information about advance directives, including the Durable Power of Attorney for Health Care, Statement of Illinois Law on Advance Directives, Living Will, Declaration for Mental Health Treatment and Do Not Resuscitate Advance Directive. The SLF shall maintain in a resident's file any of these documents authorized by the resident. This requirement is not met as evidenced by: No evidence of resident's being informed of Advance Directives. R-4, R-6, R-7, R-12, R-13, R-14, R-15, R-16, R-17, R-18, R-19, R-23, R-25, R-28, R-29, R-34, R-39, R-40, R-41, R-42, R-43, R-44 and R-46 did not have evidence of being informed of Advance Directives.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.220 Resident Participation Requirements a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission 4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to an SLF. This requirement is not met as evidenced by: Inmate search was checked instead of the parolee site requirements to be checked. late or missing sex offender checks, other late background checks. R-1, R-2, R-3, R-4, R-5, R-7, R-8, R-9, R-10, R-11, R-12, R-13, R-14, R-17, R-19, R-34, R-37, R-38, R-39, R-40, R-41, R-42, R-43, R-44, and R-45 did not have the Parolee website checked prior to admit, an inmate search was checked. Parolee site checked 11/16/22 (late). R-26 was admitted 4/8/21, checks completed 7/8/21 (late) R-39 was admitted 6/1/19 and had the National sex offender site checked late on 7/7/21. R-42 did not have the three required sex offender checks prior to admission.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _5A__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control pf tuberculosis Code (77 iLL. Adm. Code 696) This requirement is not met as evidenced by: late/untimely/incomplete/missing resident TB tests and /or S/S checklist. R-1 was admitted per facility's admit date 2/12/22, CO admit date 2/10/22. TB test was not given until 5/31/22 read 6/3/22, 2nd step given 6/6/22 read 6/8/22. TB test was given late. R-2's checklist of S/S was not completed until 5/31/22. R-2 was admitted 2/11/22. R-3's TB test was not given until 7/1/22 read 7/4/22, 2nd step given 7/11/22/read 7/14/22. S/S checklist not completed until 5/31/22. R-3 was admitted 6/25/21. R-4's TB test and S/S checklist was not completed within 7 days after admit. R-4 took possession financially 8/30/21, move in 9/2/21. TB test was given 7/5/22 read 7/7/22, 2nd step given 7/14/22 read 7/21/22. 2nd step was read late. R-5 did not have a S/S checklist within 7 days of admit. R-6's TB screening test not documented/completed until 6.1.22: TB signs and symptoms checklist not completed until 5.31.22. R-7's TB screening test not performed until 6.13.22-6.15.22 & 6.22.22-6.24.22. TB signs and symptoms checklist not completed/documented until 6.13.22. R-8's TB signs & symptoms checklist not completed within 7 days after admission.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control pf tuberculosis Code (77 ILL. Adm. Code 696). This requirement is not met as evidenced by: late/untimely/incomplete/missing resident TB tests and /or S/S checklist. R-9's TB screening test not performed or documented in accordance with the Control of Tuberculosis Code-admit date 11.20.21-TB screening initiated 5.31.21, TB signs & symptoms checklist not completed within 7 days after admission. R-10's TB screening test not performed in accordance with the Control of Tuberculosis Code-Not initiated until 6.1.22-admitted 1.28.22. Signs & Symptoms Checklist not completed within 7 days after admission. Signs & Symptoms checklist completed 5.31.22. R-11's TB screening test not performed with accordance with the Control of Tuberculosis Code-initiated 7.4.22-admit date 8.20.21 checklist date 5.31.22. R-12's TB signs and symptoms checklist not completed within 7 days after admission. R-13 did not have documentation of TB signs and symptoms checklist. R-14's Checklist of signs and symptoms of TB not completed within 7 days after admission-admit date 6.1.22. S/S checklist 6.13.22. R-24's screening series was completed late, R-24 admitted 10/11/19, series started 5/31/22.		

Signature of SLF Representative [redacted] Date 5/30/23

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _5C__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.220 Resident Participation Requirements d) Each prospective resident shall have a tuberculin skin test in accordance with the Control pf tuberculosis Code (77 ILL. Adm. Code 696). This requirement is not met as evidenced by: late/untimely/incomplete/missing resident TB tests and /or S/S checklist. R-27's TB screening process not completed within regulation. Started 3/20/21 read too soon 3/21/21 (admitted 3/20/21) restarted series 5/31/22, entire series completed per regulation at that time. R-40, no documentation of TB screening or signs/symptoms checklist for the 5/1/21 admit date. TB test for admit date of 4/22/22, 1st step given 5/31/22 read 6/1/22. 2nd step given 6/3/22 read 6/8/22. Signs/symptoms checklist completed 5/31/22. TB test and signs/symptoms checklist were done late. R-41 was admitted 5/13/22. TB test, 1st step given 5/13/22 read 5/15/22, 2nd step given too soon on 5/18/22 read 5/21/22. Signs/symptoms checklist was done late on 5/31/22. R-43 did not have documentation of a signs/symptoms checklist. R-44 was admitted 7/10/21. TB test, 1st step was given 5/31/22 read 6/3/22, 2nd step given 6/6/22 read 6/8/22. Signs/symptoms checklist was completed on 5/31/22. Both were completed late. R-46 was admitted 7/8/21. TB, test, 1st step given 5/31/22 read 6/3/22, 2nd step given 6/8/22 read 6/10/22. Signs/symptoms checklist done 5/31/22. Both were completed late.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.235 Staffing c) Staff Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLF shall make changes in the training materials 1) 1) The SLF shall provide staff and subcontractors who provide direct care with A) Training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment; B) Training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control and reporting; and encouraging independence; potential resident inquiry and admission application policy; and non-discrimination policy (these subjects shall be trained as part of staff orientation and at least annually thereafter). This requirement is not met as evidenced by: late or missing 30 day training/semi-annual training. R-1, R-2, R-3, R-4, R-5, R-7, R-8, R-9, R-10, R-11, R-12, R-13, R-14, R-17, R-19, R-34, R-37, R-38, R-39, R-40, R-41, R-42, R-43, R-44 and R-45 did not have the Parolee website checked prior to admit, an inmate search was checked. Parolee site checked 11/16/22. R-26 admitted 4/8/21, Background checks were completed late on 7/8/21. R-39 admitted 6/1/19 and had the National sex offender site checked late on 7/7/21. R-42 did not have the three required sex offender checks prior to admission.		

Signature of SLF Representative [redacted] Date 5/30/23

1108

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.235 Staffing I) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check. This requirement is not met as evidenced by: HCWB check not checked within 30 days of employment. 33 staff did not have the Registry Employment Verification checked within 30 days of employment. E-1, E-2, E-3, E-4, E-5, E-6, E-7, E-8, E-9, E-10, E-11, E-12, E-13, E-14, E-15, E-16, E-17, E-18, E-20, E-21, E-22, E-23, E-24, E-25, E-26, E-27, E-28, E-29, E-30, E-31, E-32, and E-33.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _8__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.235 Staffing m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). This requirement is not met as evidenced by: late/missing/incomplete staff TB test. 3 staff did not have a 2nd step TB test completed. E-17, E-23, and E-34. 1 staff had the 1st step initiated but not read. No 2nd step. E-18. 4 staff had their TB test given late, E-9, E-14, E-22 and E-36.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

1110

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _9__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation a) Interview: The SLP provider shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy but not before the DON, or successor tool, and other required PAS assessments are completed and determinations provided to the SLP provider. This requirement is not met as evidenced by: missing or incomplete Standardized interviews. R-6 did not have a standardized interview for admission. R-11 and R-12 did not have documentation of a Standardized interview being completed. R-19 had pages 6 & 7 missing of the 9 pages of the standardized interview. R-40, no documentation of a Standardized interview for admit date of 5/1/21.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

1111

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _10__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse. This requirement is not met as evidenced by: missing/incomplete/untimely Initial Assessment. R-4's initial assessment was not completed within 24 hours after admit. QA audit noted, missing signature and signed 8/10/22/ R-6, no Initial Assessment & Service Plan completed for this admission. See above under 245 a). R-10's Initial assessment and Service Plan not signed or dated. R-12, no documentation of Initial Assessment & Service Plan being completed. R-14, no nurse signature for initial Assessment and Service Plan completion. R-19, initial assessment & service plan missing pages 6 & & of 9 pages. R-40, no documentation of an initial assessment and service plan being completed for the admit dates of 5/1/21 or 4/22/22. R-42 was admitted 5/25/22. Initial Assessment was completed late on 8/17/22. R-46 was admitted 7/8/21. Standardized/initial interview completed late on 8/10/22.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

1112

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _11A__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. This requirement is not met as evidenced by: R-1 admitted 2/12/22. RAI not completed until 11/6/22. RAI is not thoroughly complete, section AA.4 was blank. RAI is not accurate. ISS shows R-1 receives assistance from family with finances. RAI is scored "0". R-2's RAI was not completed within 7-14 days after admit of 2/11/22. Assessment was completed 5/6/22 by the LPN and co-signed by the RN the same day. R-3, no RAI completed or signed by the RN within 7-14 days after admit. RAI completed 10/2/21. RAI of 10/2/21 was not thoroughly completed, Section AA.4 & 5 were blank. R-4's RAI of 10/2/21 was not signed by the RN within 7-14 days after admit. R-4 was admitted per facility's admit date 8/30/21, CO admit date 9/2/21. R-4's RAI was not thoroughly completed. Section AA.4 & 5 was blank. R-5's RAI was completed by the LPN 4/5/22 and co-signed by the RN 4/13/22. R-7's RAI was not signed by the RN within 7-14 days after admission. Admit date 8.27.21-RAI date signed 10/2/21. R-8's RAI was not completed within 7-14 days after admit. R-9's RAI not completed within 7-14 days after admission, admit date 11.20.21-Assessment date 4.6.22.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. This requirement is not met as evidenced by: R-10's RAI was not signed/co-signed by an RN within 7-14 days after admit, admit date 1.28 22-assessment date 5.6.22. R-11's RAI was not completed within 7-14 days after admission, admit 8.20.21, Assessment 9.30.21. R-12's RAI was not signed by an RN within 7-14 days after admission. R-13's RAI was not signed/co-signed by an RN within 7-14 days after admission. R-14, no RN signature on the RAI. R-15's RAI of 3/8/2020 was completed by the LPN, but not signed or co-signed by the RN. RAI not thoroughly completed, Section F.2A Mods of locomotion) was blank. R-16 did not have a update RAI. Updated ISP noted for 9/29/2020. R-17's RAI was not signed by the RN within 7-14 days after admit, signed 7/14/22. R-19's RAI was not completed within 7-14 days after admission. R-20's RAI was not completed within 7-14 days after admission-admission date 9.11.21-assessment date 10.2.21. R-21's RAI was not completed, was not signed by the RN within 366 days of the previous assessment-RAI dates 4.11.22 previous date 12.29.2020. R-22's 12.9.21 RAI was not completed by or co-signed by an RN. r-23's RAI was not completed within 7-14 days after admission. Admitted 4/27/22, RAI completed 5/12/22.		

Signature of SLF Representative [redacted] Date 5/30/23

1114

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. This requirement is not met as evidenced by: R-25's RAI was completed by the LPN 9/21/22, no RN signature until 10/8/22 (late. admitted 9/2/22). R-26's RAI was not thoroughly complete, Section AA.4(race/ethnicity) blank, no RN signature present. R-29 admitted 4/29/22, RAI late completion by LPN on 5/19/22. RN signature 5/24/22. R-30's most recent RAI not completed within 366 days of the last assessment (5/27/21, 5/31/22. R-32's most recent RAI not completed within 366 days of the last RAI (8/16/21, 9/12/22). R-33, unable to determine if most recent RAI was completed within 366 days of the last assessment, none completed for 2021 (One completed 4/8/22. RAI completed by LPN 3/28/22, no RN signature until 4/8/22. R-34's RAI not co-signed by RN within 7-14 days after admit. R-47's RAI was completed by an LPN 9/9/22 and co-signed by an RN 10/2/22. R-48's RAI was not completed within 366 days of the previous Assessment. Previous Assessment was completed 2/23/21. Current Assessment completed 4/28/22 by an LPN and not signed or co-signed by an RN.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse. This requirement is not met as evidenced by: R-40 was admitted 5/1/21, RAI was completed late on 9/16/21. RAI was not completed thoroughly, Section AA.4 & 5 was blank. R-41's RAI not completed within 7-14 days of admit. Facility's admit date 5/13/22, CO admit date 5/16/22. RAI completed 5/31/22 by the RN. R-42 was admitted 5/25/22. RAI was not signed by the RN until 6/22/22. R-43 was admitted 7/19/22. RAI was completed and signed by RN 8/15/22. R-44 was admitted 7/10/21, RAI was not completed until 10/2/22. R-46 was admitted 7/8/21 and did not have an RAI completed.		

Signature of SLF Representative [redacted] Date 5/30/23

1116

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _12A__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input form the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches frequency and duration of services provided and whether the services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. This requirement is not met as evidenced by: R-1 did not have an ISP, ISS completed after R-1 converted to MCO 4/1/22. R-1 should have had ISP completed after admit of 2/12/22. R-4 did not sign the ISP. Remediated on-site. R-6, no ISP/ISS completed. R-9, no ISP completed. R-9 was FFs on admission (11.20.21), then switched to MCO over a month later (01.01.22)-RAI not completed when an ISS was also completed. R-11's ISP did not have R-11's signatures on the ISP. Remediated on-site. R-12, did not sign the ISP. Remediated on-site		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. This requirement is not met as evidenced by: R-13's ISP was not signed by the R-13/designated representative for reviewing ISP. R-14 did not have an RN signature on the ISP. R-18's ISP was not signed/co-signed by an RN within 7 days of completing the RAI. R-20's ISP was not signed by R-20. Remediated on-site. R-25's ISP late, LPN completion 9/21/22, RN signature 10/18/22. R-28's ISS completed late on 10/23/2020 (8 days after completion of RAI). R-33's ISP completed 3/28/22 has LPN signature but no RN signature. R-34's ISP for Goals (What is important to me) was blank. R-37's ISS of 10/3/22 was completed by an LPN 9/9/22 and not co-signed by an RN until 10/3/22.		

Signature of SLF Representative [redacted] Date 5/30/23

10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF thar are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. This requirement is not met as evidenced by: R-40 did not have an ISP completed. An ISS was completed 9/16/21. Admit date 5/1/21. No ISP or ISS completed for 4/22/22 admit date. An ISS was completed 10/11/22. R-42's ISP was signed by RN on 10/18/22. RAI done 6/22/22. R-46 did not have an ISP or ISS done.		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. This requirement is not met as evidenced by: missing/unsigned/untimely quarterly assessments. R-1, no RN signature for quarterlies of 7/13/22 and 10/12/22. R-2's quarterly evaluations of 8/5/22 was completed by the LPN and not co-signed by the RN. 11/8/22 quarterly is > 92 days from the 8/5/22 quarterly and co-signed by the RN late. R-3, no quarterlies at this time. R-4's quarterly of 1/18/22 completed by LPN but not co-signed by RN. R-5's quarterlies of 7/13/22 and 10/12/22 were not signed by an RN. R-10's quarterly evals-RAI not completed timely, should have been done in February 2022, was not done until 5.6.22, if done timely-quarterly would have been due in May 2022-R-10 then went to MCO on 6.1.22. R-11's quarterly eval not completed by or co-signed by an RN, also not completed every 92 days. R-4's quarterly evals not completed every 92 days and not completed by or co-signed by an RN.		

Signature of SLF Representative [redacted] Date 8/13/23
10/1/22

1120

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _13B__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse. This requirement is not met as evidenced by: missing/unsigned/untimely quarterly assessments. R-16's quarterly evals not completed every 92 days. No August quarterly due to R-16 was at a SNF. R-16 returned from SNF 9/9/2020. Assessment schedule reset due to R-16 being out greater than 30 days. R-17's quarterly of 10/18/22 not signed or co-signed by the RN and not completed timely. R20's quarterly evals not signed/co-signed by an RN-1.18.22, 4.14.22 and 7.13.22; also completed every 92 days-1.18.22 quarterly-late. R-21, no quarterly evaluation since 10.1.21 R-30's quarterlies > 92 days between RAI of 5/27/21 and quarterly assessment 9/30/21. R-31's quarterlies > 92 days between quarterly assessments (8/15/22, next 11/8/22) target completion date 11/4/22.. R-33's quarterly did not have an RN signature on last (3) completed quarterly assessments. > 92 days between assessments. R-41's quarterly of 8/24/22 was not signed/co-signed by an RN. R-42's quarterly was completed by the LPN, but not c[redacted]		

Signature of SLF Representative [redacted] Date 5/30/23
10/1/22

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE _14__ OF _14__**

SLF NAME: Prairie Winds of Urbana REFERRAL DATE: _____
First Follow-up ( ) Second Follow-up ( )

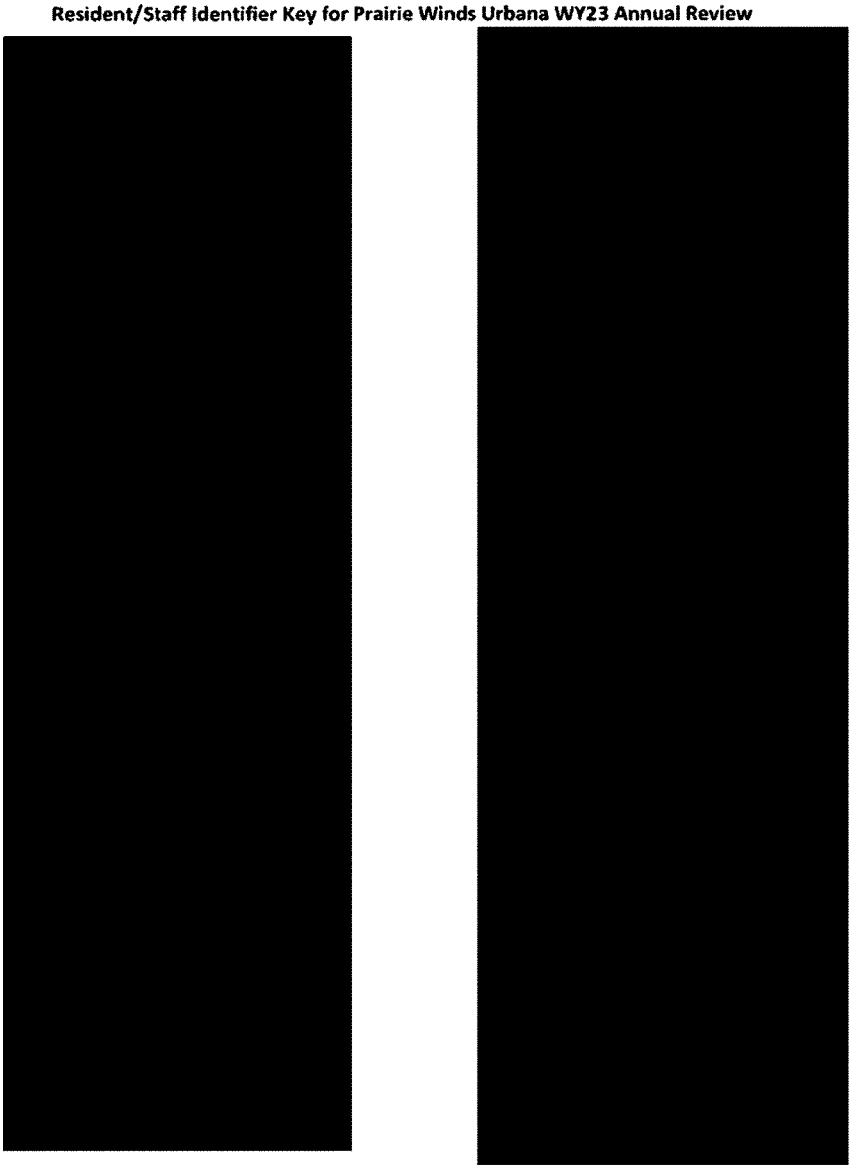
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Based on Section 146.295 Emergency Contingency Plan e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. This requirement is not met as evidenced by: R-1, R-4, R-6, R-7, R-10, R-12, R-13, R-14, R-15, R-16, R-17, R-18, R-19, R-23, R-25, R-28, R-29, R-40, R-41, R-42, R-43, R-44 and R-46 was not oriented to the emergency plans within ten days after admission.		

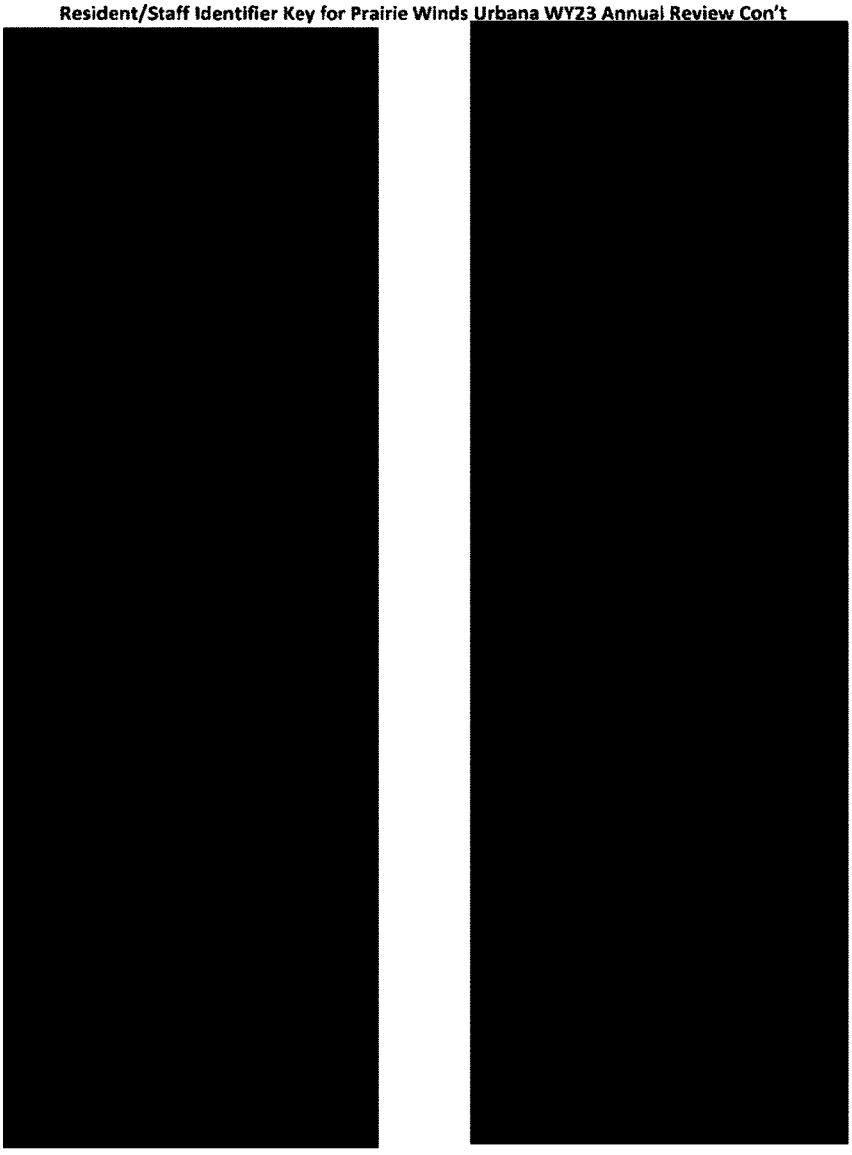
Signature of SLF Representative [redacted] Date 5/30/23

10/1/22

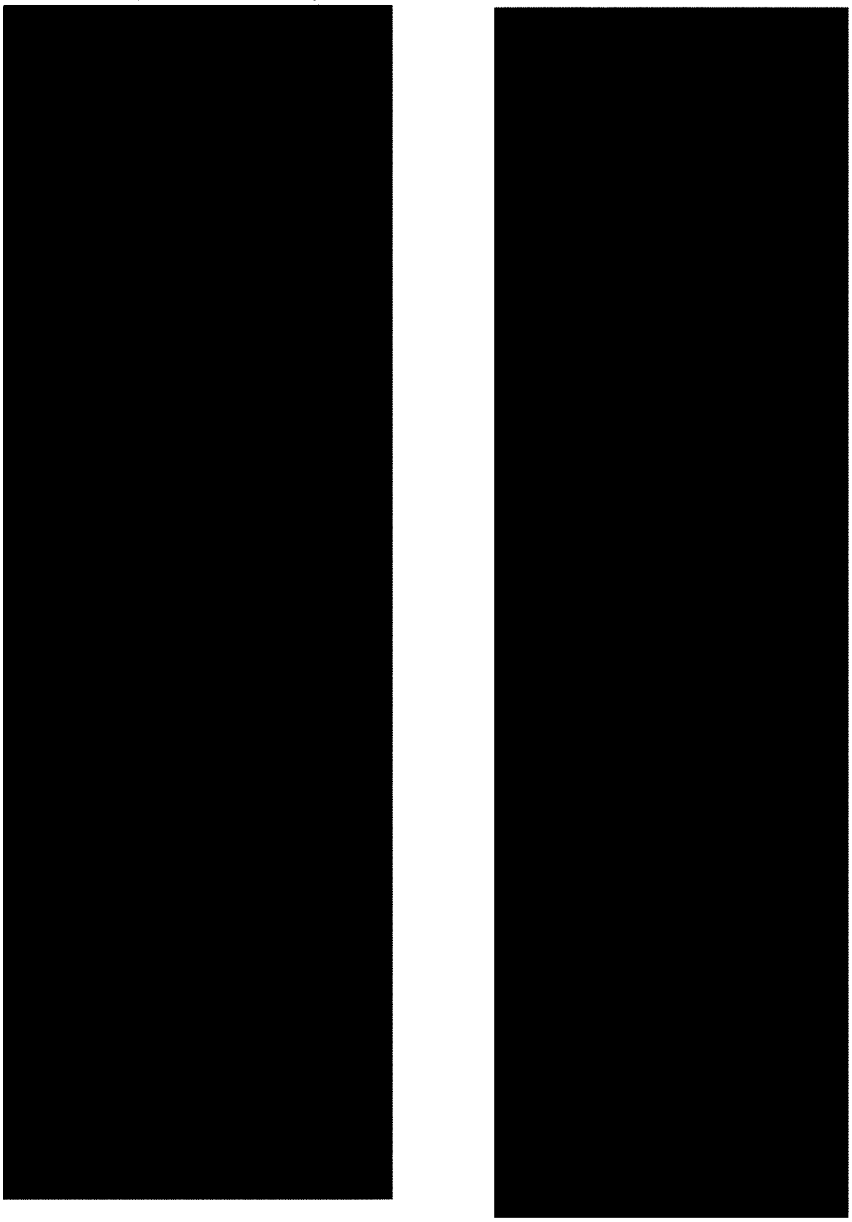
Resident/Staff Identifier Key for Prairie Winds Urbana WY23 Annual Review



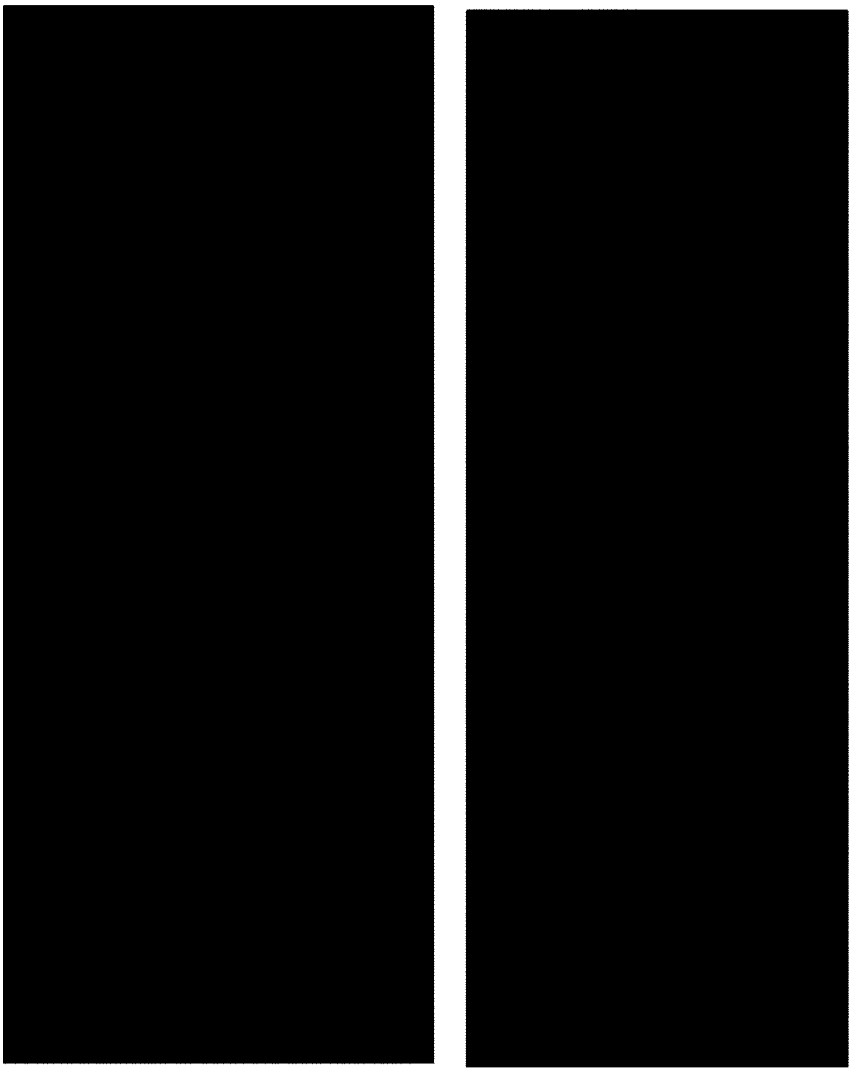
Resident/Staff Identifier Key for Prairie Winds Urbana WY23 Annual Review Con't



Resident/Staff Identifier Key for Prairie Winds Urbana WY23 Annual Review



Resident/Staff Key for Prairie Winds Urbana WY23 Annual Review Con't



Resident/Staff Identifier Key for Prairie Winds Urbana WY23 Annual Review Con't

[redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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	Initial Comments Total Capacity: 58 Total Census: 30 County: Fairfield Administrator: [redacted] Survey Type: Annual The facility remains out of compliance from the surveys dated 08/05/23, 12/01/22, 09/09/20, and 12/28/18.	R 0000		
R 0559	O.A.C. 3701-16-10 (H)(1) Dietary services; supervision of therapeutic O.A.C. 3701-16-10 (H)(1) Each residential care facility that provides meals: (1) Shall procure, store, prepare, distribute, and serve all food in a manner that protects it against contamination and spoilage; This STANDARD is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure food was stored and prepared in a manner to prevent contamination and spoilage. This had the potential to affect all 30 residents in the facility who received meals from the kitchen. The census was 30. Findings include: 1. Observations on 12/12/23 from 11:25 A.M. to 11:35 A.M. revealed Cook #125 was wearing gloves and was preparing to serve food behind the steam table. When	R 0559		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0559	Continued From page 1 it was time to start serving food, she began by touching the bowls used for the soup as well as the ladle to serve the soup. There were portions of the soup that touched her gloved hands while she was serving the soup. After pouring approximately 12 bowls of soup, she reached in the bag of shredded mozzarella cheese and sprinkled some on each bowl of soup. After completing the first tray of soup to be served, she filled a second tray with 12 more bowls of soup and cheese; following the same process. She did not change her gloves at any point during the soup pouring process. Then, at approximately 11:32 A.M., she removed her dirty gloves and threw them in the trash can, and used a non-gloved hand to lift the trash can lid. She did not wash her hands prior to putting on a new pair of gloves. After putting on a new pair of gloves, she started preparing other portions of the lunch meal. She touched plates, plastic wrap, tongs, bread for the peanut butter and jelly as well as turkey sandwiches, cheese slices, the paper menu for each resident's order, buns for the hot dogs, and chips from the bag. At no point during this portion of the meal service did she change her gloves or wash her hands. Interview with Cook #125 on 12/12/23 at 11:35 A.M. confirmed she does not change her gloves until she switched between tasks and food items. She revealed that she doesn't normally change her gloves until she was done serving one portion of the meal or unless	R 0559		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0559	Continued From page 2 her gloves become contaminated/dirty. Review of facility Personal Hygiene guidelines, undated, revealed handwashing is to be completed before putting on clean, single-use gloves for working with food, and between glove changes. Also, bare hand contact with ready to eat food, such as sandwiches and salads, can result in contamination of food and contribute to foodborne illness outbreaks. Therefore, food employees should always use suitable utensils such as spatulas, tongs, single-use gloves, or dispensing equipment when handling ready to eat foods. Single use gloves used along with handwashing can be an effective barrier to decrease the transfer of microorganisms from the hand to food. However, gloves are not total barriers to microbial transmission, and will not be an effective barrier alone for food workers without education on proper glove use and handwashing requirements. 2. Observation of the facility kitchen on 12/12/23 from 8:30 A.M. to 8:50 A.M., revealed there were three opened bags of frozen food in the walk-in freezer with no label or date. The bags were twisted closed. Interview with Dietary Manager #115 at the time of the observation revealed she identified the unlabeled bags as frozen meatballs. Dietary Manager #115 confirmed there were no labels or dates on the bags of meatballs and further confirmed the opened bags should have had been dated when they were opened.	R 0559		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0559	Continued From page 3 Review of the facility's policy titled "Ready-to-Eat Hazardous Food, Date Marking" revealed ready-to-eat potentially hazardous foods prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in the kitchen and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises or discarded. This violation is an example of continued non-compliance from the surveys dated 08/05/23, 12/01/22, 09/09/20, and 12/28/18.	R 0559		
R 0614	O.A.C. 3701-16-13 (K)(1) Building, plumbing, fire & CO safety requirem O.A.C. 3701-16-13 (K)(1) Each residential care facility shall conduct the following drills unless the state fire marshal allows a home to vary from this requirement and the residential care facility has written documentation to this effect from the state fire marshal: (1) Twelve fire exit drills, one conducted on each shift at least every three months to familiarize staff members and residents with signals, evacuation procedures and emergency action required under varied times and conditions. Fire exit drills shall include the transmission of a fire alarm signal to the appropriate fire department or monitoring station, verification of receipt of that signal, and simulation of emergency fire conditions except that the movement of infirm and bedridden	R 0614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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 0614	Continued From page 4 residents to safe areas or to the exterior of the structure is not required. Drills conducted between nine p.m. and six a.m. may use a coded announcement instead of an audible alarm. Residential care facilities that have an alarm system that is not capable of sending a fire alarm signal if an audible alarm is not used shall transmit a fire alarm signal and verify receipt of that signal no more than twelve hours after the coded announcement. Fire drills shall meet the following requirements. (a) Each staff member shall participate in at least one fire drill annually. (b) One staff member with knowledge of the disaster preparedness plan and the fire evacuation routes shall be designated to observe and evaluate each drill and shall not participate in that drill. (c) Residents capable of self-evacuation shall be actually evacuated to safe areas or to the exterior of the residential care facility in at least two fire drills a year on each shift. Movement of non-ambulatory residents to safe areas or to the exterior of the facility is not required. This STANDARD is not met as evidenced by: Based on review of facility fire drills, staff interview, and facility policy review, the facility failed to ensure fire drills were performed on each shift at least every	R 0614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0614	Continued From page 5 three months and residents who were capable of self-evacuation were evacuated to safe areas or to the exterior of the building in at least two fire drills a year on each shift. This had the potential to affect all 30 residents residing in the facility. The census was 30. Findings include: 1. Review of facility fire drills dated August 2023 through November 2023 revealed a fire drill was conducted on second shift in August 2023, a fire drill was conducted on third shift in September 2023, a fire drill was conducted on first shift in October 2023, and no fire drill was conducted in November 2023. Review of the fire drills revealed no fire drill was conducted on second shift during the months of September 2023, October 2023, and November 2023. Interview with Executive Director #112 on 12/12/23 at 10:50 A.M. confirmed there was no fire drill performed on second shift in November 2023. 2. Review of the facility fire drills, dated January 2023 to November 2023, revealed no evidence to support residents who were capable of self-evacuating to outside the facility or to a safe area, was completed on two shifts during at least two drills a year on each shift. Interview with Executive Director #112 on 12/12/23 at 10:50 A.M. confirmed they have no evidence to support residents	R 0614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2635R	A. BUILDING _____ B. WING _____	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	2750 WEST FAIR AVENUE LANCASTER OH, 43130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0614	Continued From page 6 who were independent with ambulation and independent with transferring to a mobility device, were evacuated or moved to a safe area at least twice a year on each shift in the last 12 months. Review of the facility Fire Safety Training and Drills policy, undated, revealed the facility will conduct appropriate and timely training and fire drills on safety procedures in accordance with state regulations, local fire codes, and Fire Marshal requirements. The executive director (or designee) will conduct periodic fire drills, in compliance with state regulations and local fire codes, rotating the timing of the drills so that all staff has the opportunity to participate.	R 0614		
R 0615	O.A.C. 3701-16-13 (K)(2) Building, plumbing, fire & CO safety requirem O.A.C. 3701-16-13 (K)(2) Each residential care facility shall conduct the following drills unless the state fire marshal allows a home to vary from this requirement and the residential care facility has written documentation to this effect from the state fire marshal: At least two disaster preparedness drills per year, one of which shall be a tornado drill which shall occur during the months of March through July. This STANDARD is not met as evidenced by:	R 0615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2635R	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS RETIREMENT COMMUNITY	**2750 WEST FAIR AVENUE LANCASTER OH, 43130**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED 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 0615	Continued From page 7 Based on review of facility disaster drills and staff interview, the facility failed to ensure a tornado drill was completed during the months of March through July. This had the potential to affect all 30 residents residing in the facility. The census was 30. Findings include: Review of the facility disaster drills, dated February 2023 and May 2023, revealed two elopement drills were conducted. Review of all fire and disaster drills, dated January 2023 to October 2023, revealed the facility had not perform a tornado drill during the months of March through July. Interview with Executive Director #112 on 12/12/23 at 10:50 A.M. confirmed the facility did not perform a tornado drill during the months of March through July.	R 0615		

St. Anthony of Lansing
Response to Findings
Referral Date: 7/29/2022

Section 146.220 Resident Participation Requirements

a) The SLF may admit or retain residents whose needs can be met through services described in Section 146.230. The following criteria shall be met prior to admission to a SLE.

4) Have name checked against the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov, the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to a SLF.

Alleged findings:

- R-3: Admit date 11/5/20. Three required Sex offender searches completed on 11/6/20 1 day late.
- R-6: Admit date 10/19/20. IL sex offender and national sex offender search completed on 7/26/21 and parolee search on 12/20/21-done after admission.
- R7: Admit date 12/30/20. IL and national sex offender search completed on 7/26/21 -almost 7months later.
- R20: Admit date 5/30/20. Three required Sex offender search completed on 4/11/21 -late.

Administrator or Assistant Administrator will in-service the MIC and Marketing Director on the community background check policy for residents prior to admission.

Administrator, Assistant Administrator or MIC will assure all new residents names are checked against the United States Department of Justice Dru Sjodin National Offender Public Website at 222.nsopr.gov,, The Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us.

Administrator or Assistant Administrator will conduct Quality Assurance monthly to ensure compliance of this regulation.
Completion date systemic changes will be completed: August 30, 2022

[redacted]

Assure any new resident has background checks prior to admission:

Topic: Resident Background Checks Important Points for Successful Implementation.

- admission. Include websites of the United States Department of Justice Dru Sjodin National Offender Public Website at www.nsopr.gov,the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections registered sex offender database at www.idoc.state.il.us. Refer to Section 146.215 for facility requirements if a person whose name appears on either registry is admitted to the community.
- Pay special attention to assure the Illinois Department of corrections registered sex offender database is run and not the inmate search.
- Assure documents are kept together and filed promptly in the Resident Background Check Binder.
- Add the resident name, date of admission and date of checks to the log for QA purposes.
- Assure the Resident Background check binder remains up to date and available for review. All background checks should be promptly filed.
- Any questions or concerns about the results or inactivity of the system should be promptly discussed with the Administrator and Regional Director.

St. Anthony of Lansing
Response to Findings
Referral Date: 7/29/2022

Section 146.220 Resident Participation Requirements

a) The SLF may admit or retain residents whose needs can be met through the services described in Section 146.230. The following criteria shall be met prior to admission to the SLF:

1) Be screened by the Department or other State agency screening entity and found to be in need of nursing facility level of care and that SLF placement is appropriate to meet the needs of the individual. A new screen is not needed for a resident who is transferring between SLFs or comes from a nursing facility with no break in service. It is the admitting SLF's responsibility to ensure that a screening document is received from the transferring SLF or nursing facility. Private pay individuals may choose to be admitted into the SLF when the screening assessment does not justify nursing facility level of care; and

2) Be without a primary or secondary diagnosis of developmental disability or serious and persistent mental illness. The developmental disability or mental illness must be determined by a qualified Department of Human Services screening agent; and

Administrator or Assistant Administrator will in-service the MIC and Marketing Director on DON screenings policy and regulation (146.220) for all new residents.

Administrator or Assistant Administrator will assure all new residents names be screened by the appropriate Department on Aging contracted Care Coordination Unit (D0A CCU) or the Department of Human Services Division of Rehabilitation Services (DHS-DRS) screening agency and found to be in need of nursing facility level of care.

Administrator or Assistant Administrator will conduct Quality Assurance monthly to ensure compliance of this regulation.

Completion date systemic changes will be completed: August 30, 2022

[redacted]

St. Anthony of Lansing
PLAN OF CORRECTION
Referral Date: 7/29/2022

Community Response

Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

Section 146.245 Assessment and Service Plan and Quarterly Evaluation
a) Interview: The SLP provider shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy but not before the DON, or successor tool, and other required PAS assessments are completed, and determinations provided to the SLP provider.

1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**
- R5-Resident a re-admit on 1-16-19. No standardized interview on record to review. Reviewer requested for one, facility unable to provide
- Admit date 6-5-19. No standardized interview on record to review. Reviewer requested for one, facility unable to provide.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
   - All residents of the facility have the potential to be affected by the same alleged deficient practice. Clinical nurses will be in-serviced on completing the standardized interview prior to admission and for residents out of the community more than 30 days.

3. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**
   - The Director of Nursing will include completing the standardized interview in the QA Plan for St. Anthony of Lansing.

4. **How the corrections will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
   - Administrator/DON/Designee will develop, monitor, and conduct routine as well as Quality Assurance monthly audits for one month to ensure compliance of the standardized interview. The audits will be discussed during our monthly QI meetings

for trends, patterns, and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.

Completion date systemic changes will be completed: August 30, 2022

[redacted]
Regional Director of Health Services

St. Anthony of Lansing
PLAN OF CORRECTION
Referral Date: 8/1/2022

Community Response

Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

Section 146.245 Assessment and Service Plan and Quarterly Evaluation
b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse.

1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**

- R3: Date of admission 11-5-20. Initial assessment and service plan completed on 11-8-20 was 3 days late.
- R5: Date of admission 1-16-19. No Initial assessment and service plan on record. Reviewer requested for one, facility unable to provide.
- R7: Date of admission 12-30-20. Initial assessment and service plan completed on 12-29-20-completed before admission. Per rule to be completed within 24 hours after admission.
- R8: Admit date 6-5-19. No Initial assessment and service plan on record. Reviewer requested for one, facility unable to provide.
- R9: Admit date 6-16-19. Initial assessment and service plan completed 6-26-19 was 10 days late.
- R27: Admit date 4-2-19, initial assessment completed on 12-16-19, over 8 months.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**

- All residents of the facility have the potential to be affected by the same alleged deficient practice. Clinical nurses will be in-serviced on completing the initial assessment within 24 hours of admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse.

3. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**
   The Director of Nursing will include completing the initial assessment in the QA Plan for St. Anthony of Lansing.

4. **How the corrections will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
5. Administrator/DON/Designee will develop, monitor, and conduct routine as well as Quality Assurance monthly audits for one month to ensure compliance of the Initial assessment. The audits will be discussed during our monthly QI meetings for trends, patterns, and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.

Completion date systemic changes will be completed: August 30, 2022

[redacted]
Regional Director of Health Services

St. Anthony of Lansing
PLAN OF CORRECTION
Referral Date: 8/1/2022

Community Response

Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

Section 146.245 Assessment and Service Plan and Quarterly Evaluation
c)Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually, and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.

1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**
   - R7: Date of admission 12-30-20. RAI completed and signed by the RN onl-13-20. RAI late.
   - R9: Date of admission 6-16-19. RAI was completed and signed by the RN on 7-9-19. RAI 10 days late.
   - R10: Date of admission 9-11-20. RAI completed and dated 9-11-20, RAI completed the same date of admission. Per Rule, RAI to be completed within 7- 14 days after admission.
- R11: Date of admission 9-1-20. RAI was completed and signed by the RN on 9-6-20. RAI 1 day early. RAI to be completed within 7-I 4 days after admission.
- R12: Date of admission 7-7-20. RAI completed and signed by the RN 0117-22-20. RAI was 2 days late.
- R13: Date of admission 3-10-20. RAI completed and signed by the RN on 4-3-20. RAI was due on 3- 23-20-late.
- R15: Date of admission 3-12-20. RAI completed and signed by the RN on 4-4-20. RAI due on 3-25-20 -late.
- R17: Date of admission 2-28-20. RAI completed and signed by the RN on 3-16-20. RAI 3 days late.
- R18: Date of admission 12-28-20. RAI completed and signed by the RN on 1-13-21. RAI was 3 days late.
- R27: Admit date 4-2-19, RAI completed on 12-26- 19, over 8 months late.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**

- All residents of the facility have the potential to be affected by the same alleged deficient practice. Clinical nurses will be in-serviced on the Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually, and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.

3. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**
   - The Director of Nursing will include completing the Comprehensive RAI in the QA Plan for St. Anthony of Lansing.

4. **How the corrections will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
   - Administrator/DON/Designee will develop, monitor, and conduct routine as well as Quality Assurance monthly audits for one month to ensure compliance of the comprehensive RAI. The audits will be discussed during our monthly QI meetings for trends, patterns, and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.

Completion date systemic changes will be completed: August 30, 2022

[redacted]
Regional Director of Health Services

St. Anthony of Lansing
PLAN OF CORRECTION
Referral Date: 8/1/2022

Community Response

Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

d.) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by filling outside entity. The service plan shall include a description of expected outcomes, approaches, frequency md duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plm1 must be individualized to address the health m1d behavior needs of each resident. The service plan shall document the services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed md updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**
   - R4: RAI completed md signed by the RN on 1-17-21, ISP completed md signed by the RN on 3-19-21. ISP almost 3 months late, ISP due on 1-23-21.
   - Rl9: RAI completed and signed by the RN on 1-27-20, ISP completed and signed by the RN on 2-11-20. ISP late; due on 2-2- 20.Per SLF rules, ISP to be completed within 7 days of completing the RAI.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
   - All residents of the facility have the potential to be affected by the same alleged deficient practice. Clinical nurses will be in-serviced on completing the service plan within 7 days of the completion of the RAI.

3. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**

- The Director of Nursing will include completing the completion of the service plan in the QA Plan for St. Anthony of Lansing.

4. **How the corrections will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
   - Administrator/DON/Designee will develop, monitor, and conduct routine as well as Quality Assurance monthly audits for one month to ensure compliance of the service plan. The audits will be discussed during our monthly QI meetings for trends, patterns, and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.

Completion date systemic changes will be completed: August 30, 2022

[redacted]
Regional Director of Health Services

St. Anthony of Lansing
PLAN OF CORRECTION
Referral Date: 7/29/2022

Community Response

Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

e.) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.

1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**

   - Rl: Based on quarterly dated 4-22-21, quarterly dated 7- 25-21 was late. Due on 7-22-21.
   - R2: Based on quarterly assessment dated 3-10-21, quarterly assessment dated 6-10-21 was 1 day late.
   - R3: Based on quarterly dated 2-6-21, quarterly dated 5-9- 21 was I day late. 3rd quarterly due on 8-7-21 was not completed. Reviewer requested for quarterly, facility unable to provide quarterly.
   - R4: RAI completed on 1-17-21, 1" quarterly dated 4-20-21 was 2 days late, due on 4-18-21.
   - R5: Admit date 1-16-19, Most recent Quarterly dates as follows 10-9-20, 4-21-21 and 7-2-21. RAI was completed 1-8-21, Quarterly dated 4-12-21 was 3 days late. Due 4-9-21.
   - R11: 1st quarterly dated and signed by the RN on 12-7-20 was 1 day late. Per RAI dated 9-6-20, 1st Quarterly was due on 12-6-20.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
   - All residents of the facility have the potential to be affected by the same alleged deficient practice. Clinical nurses will be in-serviced on completing the quarterly assessments on time per HFS regulations.
   -

3. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**
   - The Director of Nursing will include completing the Quarterly assessments in the QA Plan for St. Anthony of Lansing.

4. **How the corrections will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
   - Administrator/DON/Designee will develop, monitor, and conduct routine as well as Quality Assurance monthly audits for one month to ensure compliance of the Quarterly assessment. The audits will be discussed during our monthly QI meetings for trends, patterns, and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.

Completion date systemic changes will be completed: August 30, 2022

[redacted]
Regional Director of Health Services

St. Anthony of Lansing
Response to Findings
Referral Date: 7/29/2022

Community Response

Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

Section 146.245 Assessment and Service Plan and Quarterly Evaluation
a) Interview: The SLP provider shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy but not before the DON, or successor tool, and other required PAS assessments are completed, and determinations provided to the SLP provider.

5. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:**
- R5-Resident a re-admit on 1-16-19. No standardized interview on record to review. Reviewer requested for one, facility unable to provide
- Admit date 6-5-19. No standardized interview on record to review. Reviewer requested for one, facility unable to provide.

6. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
   - All residents of the facility have the potential to be affected by the same alleged deficient practice. Clinical nurses will be in-serviced on completing the standardized interview prior to admission and for residents out of the community more than 30 days.

7. **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**
   - The Director of Nursing will include completing the standardized interview in the QA Plan for St. Anthony of Lansing.

8. **How the corrections will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
   - Administrator/DON/Designee will develop, monitor, and conduct routine as well as Quality Assurance monthly audits for one month to ensure compliance of the

standardized interview. The audits will be discussed during our monthly QI meetings for trends, patterns, and areas of concern. QI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated.

Completion date systemic changes will be completed: August 30, 2022

[redacted]
Regional Director of Health Services

St. Anthony of Lansing
Response to Findings
Referral Date 7/29/2022

Community Response

Regulation 146.235 Staffing e) Staffing Training. All staff training materials shall be available for review by the Department. If required by the Department, the SLF shall make changes in the training materials. 1)the SLF shall provide staff and subcontractors who provide direct care with A) training that takes place no later than 30 days after beginning employment and semi-annual training in areas related to their employment. B) training that covers resident rights; infection control; crisis intervention; prevention and notification of abuse, neglect, and financial exploitation; behavioral intervention; tuberculosis identification, prevention, control, and reporting, and encouraging independence (these subjects shall be trained as part of staff orientation and at least annually thereafter).

Findings: This requirement is not met as evidence by nine employees did not have 30-day training after beginning employment. Eighteen employees did not have semi-annual training. Eight employees did not have annual training.

Response: St. Anthony of Lansing will provide training to employees no later than 30 days after beginning employment and employees have completed semi-annual training in areas related to their employment. A monthly audit to ensure compliance will be conducted by the Administrator or Assistant Administrator and monthly; thereafter, for the next three months.

Correction Date

- The first audit will be completed by August 30, 2022, to review employees have completed training no later than 30 days from date of employment and that employees have completed semi-annual training (as appropriate). This audit will continue to occur monthly for the next three months.
- An in-service on the Staff Training Policy and Procedure was completed by the Administrator, Assistant Administrator and D.O.N. on July 28, 29, 2022 and August 3rd and August 4th, 2022. This will be documented and located in the Quality Assurance binder.
- E-1 completed department specific training on 10/30/2019-1/18/2020 and 3/5/2020 an employee HCWR and registry was late completed on 10/1/19.
- E-2 is no longer employed at the community termed 6/16/22.
- E-3 2/9/20, no training on record within 30 days of employment.
- E-4 completed annual training annual was completed on 7/28/2021, HCWR and registry was completed late on 10/12/19.
- E-8 Hire date 1/8/20, no trainings completed on Behavior intervention; Crisis intervention; Infection control was completed on 9/11/20; TB; encouraging

independence; Non-discrimination policy; and Resident inquiry and APP were not completed within 30 days of employment.

- E-9 hire date 3/22/19, no trainings completed on Behavior intervention; Crisis intervention; Infection control; TB: Encouraging independence; Residents rights; Abuse and neglect; Non-discrimination policy; and Resident inquiry and APP: emergency plan; fire Extinguisher within 30 days of employment.
- E-13 Hire date: 6/26/17 Trainings on record were dated 6/26/17 and 1/29/20, no training on non-discrimination and resident inquiry for training dated 1/29/20 on record, certificates of completion for semi-annual training was completed on 7/28/17, Resident Abuse 9/20/17, residents rights 11/17/17.
- E-5, E-6, E-7, E-10, E-11, E-12, E-14, E-16, E-18, E-19, E-20, E-21 are no longer employed at the community.
- E-15 Hire Date: 8/31/13, trainings on record were dated semi-annual completed on 1/26/18, semi-annual completed 7/27/18, semi-annual 1/21/21 and 7/28/21. certificates of completion attached.
- E-17 Hire Date: 9/5/17, trainings on record were dated semi-annual 7/27/18, semi-annual 1/26/18 , semi-annual 1/31/19, semi-annual 7/31/19, semi-annual 1/29/20, semi-annual 7/28/20 and semi-annual 7/28/21 were completed certificates of completion attached.
- E-28 Hire date: 9/10/18 no training on record for 2019 and 202. Training was completed on semi-annual 1/31/19 and 7/21/19 certificates of completion are attached.

St. Anthony of Lansing

Response to Findings
Referral Date 7/29/2022

Community Response:

Section 146.295 Emergency Contingency Plan

Each resident shall be oriented to the emergency plans WITHIN ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.

Community Response:

- The Regional Director of Environmental Services or the Regional Director of Operations will in-service the Administrator and all staff and residents on the community Emergency Contingency Plan 146.295 to ensure compliance.

- Administrator will conduct routine as well as Quality Assurance monthly to ensure compliance to notify HFS when loss of electrical power or other utilities for more than an hour occurs in the community.

- The Administrator shall monitor the above to assure compliance of regulation by 8/30/2022.

Findings:

The following actions were taken :

- R4-admitted 1/4/21 no longer resides at the community.
- R5: admitted 1/16/19 – Maintenance Director and Regional Director of Healthcare completed in-service training on the emergency contingency plan with R5on 8/8/2022.

Completion date systemic changes will be completed: August 30, 2022

[redacted]

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 11 and 12, 2023 Facility number: 014706 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 16, 2023.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Sweet Galilee at the Wigwam desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective: 6/16/23 Sweet Galilee respectfully asks for Paper Compliance	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging.			

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

[redacted] | Administrator | 05/30/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 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.

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	(E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to post contact information for advocacy and regulatory agencies. This deficient practice had the potential to impact 70 of 70 residents. Findings include: During an observation and tour of the facility on 5/11/22 from 10:08 a.m. to 10:45 a.m., a posting of contact information for advocacy and regulatory agencies was not located anywhere in the facility. During an observation of the lobby/entrance common area on 5/12/23 at 10:28 a.m., no posting of contact information for advocacy and regulatory agencies was locating in the common entrance area. During an interview on 5/12/23 at 10:30 a.m., the Receptionist indicated she did not know where a posting of contact information for advocacy and regulatory agencies was located. During an interview on 5/12/23 at 10:35 a.m., the Administrator made a tour of the lobby common area and could not locate a posting of advocacy and government regulatory agencies contact information. She made a phone call and queried the Activity Director. The Administrator then indicated the facility could not locate any posted contact information for the following: a. The Indiana Department of Health. b. The office of the secretary of family and social	R 0033	· *All residents have the potential to be affected by this deficient practice. A posting of mandated offices was hung in the lobby, consisting of: The ISDH, APS, The local Ombudsman, local Area on Aging, Office of FSSA and local Mental Health agency. * All residents will be made aware of the posting and familiar with the contents at the next resident council meeting. · *All residents will be provided with a copy of the posting, via memo delivered to apartment door. · *A posting shall be displayed at all times, in the common area of the lobby, in an area that is visible to residents and guests. The Administrator will include in monthly QA meeting for 3 months. · *The Administrator or designee will ensure the posting is available and visible by monitoring daily x's 3 weeks, then weekly x's 4 weeks and then monthly thereafter. · 5/31/23	05/31/2023

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	services. c. The area agency on aging. d. The local mental health center. e. Adult protective services.			
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure the residents had access to examine the results of the most recent annual survey of the facility conducted by the state surveyors and the plan of correction in effect with respect to the facility, and any subsequent surveys. This deficient practice had the potential to impact 70 of 70 residents who resided in the facility. Findings include: During an observation and tour of the facility on 5/11/22 from 10:08 a.m. to 10:45 a.m., no copy of the most current Indiana Department of Health annual survey results or plan of correction was posted anywhere within the facility. There was no signage indicating the location of the survey report. During observation of the lobby/entrance common area on 5/12/23 at 10:28 a.m., no copy of the most current Indiana Department of Health annual survey results or plan of correction was posted anywhere in the common area. There was no signage indicating the location of the survey report.	R 0042	· *All residents have the potential to be affected by this deficient practice. All residents will be made aware of the survey binder whereabouts and familiar with the contents at the next resident council meeting. · *All residents will be inserviced monthly, via Resident Council and monthly newsletter as to the whereabouts of the survey binder. · *The survey binder will be readily available at the reception desk or other designated location, at all times, for residents and guests of Sweet Galilee. The Administrator will include in monthly QA meetings for 3 months. · *The Administrator or designee will ensure that the binder is located in the designated location, daily x's 3 weeks, then weekly x's 4 weeks and then monthly thereafter.	06/05/2023

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	During an interview on 5/12/23 at 10:30 a.m., the Receptionist indicated the state survey results report was in a binder behind the counter and available upon request. During an interview on 5/12/23 at 10:35 a.m., the Administrator indicated the binder with the state survey results and was available upon request. The binder had frequently gotten lost when it was located in the common area. There was no sign telling the location of the survey results.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	Based on interview and record review, the facility failed to ensure one employee with First Aid Certification was on duty each shift for 18 of 21 shifts reviewed. This deficient practice had the potential to impact 70 of 70 residents who resided in the facility. Findings include: Review of the facility staffing schedule for 5/5/23 to 5/11/23 indicated 21 shifts were worked during this seven (7) day period. The facility provided a certification of "Standard First Aid" training for one (1) employ who worked three shifts during this seven day period. This resulted in 18 uncovered shifts as follows: 5/5/23- first, second, and third shifts, 5/6/23- second and third shifts, 5/7/23- second and third shifts, 5/8/23- first, second, and third shifts, 5/9/23- first, second, and third shifts, 5/10/23- first, second, and third shifts, 5/11/23- second, and third shifts. During an interview on 5/12/23 at 10:40 a.m., the Administrator indicated the facility did not have a record of any other employees, who had worked during the past week, having First Aid training. The facility was currently enrolling staff in both CPR and First Aid training.	R 0117	· *All residents have the potential to be affected by this deficient practice. Sweet Galilee had identified and already had classes scheduled. · *There will be at least one person per shift, daily, to be CPR as well as First Aid Certified. Sweet Galilee will continue to offer classes until standards are met or exceeded. · *Sweet Galilee will offer free CPR/First Aid classes to all of its employees, to ensure at minimum, one CPR and First Aid certified staff member per shift. · *The DON or designee will audit nursing employees monthly, to ensure they are first aid certified or attend a class. Include in monthly QA meetings x's 6 months or until 100% compliance is met.	06/16/2023
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community.			

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	(2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to coordinate service plans related to mental health needs with the resident's mental health care provider for 2 of 2 residents reviewed for mental health services (Residents 48 and 54). Findings include: 1. During an interview on 5/12/23 at 11:53 a.m., Resident 48 indicated she had never been asked to participate, either in person or on the phone, in any type of meeting which involved the facility and her mental health provider in order to develop a plan to address her mental health needs. Resident 48's clinical record was reviewed on 5/11/23 at 2:30 p.m. Current diagnoses included schizoaffective disorder-bipolar type, anxiety and major depressive disorder. The resident received Medicaid services. The resident received psychiatric services at a community - based provider. The resident had a current, signed 9/6/22, Service Plan document. The service plan lacked a plan of care developed in cooperation with their mental health services provider to include the following: (1) Psychosocial rehabilitation services that are to be provided within the community.	R 0383	· *All residents with mental health diagnoses have the potential to be affected by this deficient practice. · *An audit will be conducted on all Residents to identify those with mental health diagnoses and to ensure they have appropriate service plans in place. Any missing mental health service plans will be corrected with the resident and resident's mental health provider. · *Monthly Service Plan meetings to audit resident service plans will be implemented to ensure compliance is met, ongoing. · *DON or designee will audit any new admits and include in monthly QA meetings for 6 months	06/16/2023

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	(2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. 2. Resident 54's clinical record was reviewed on 5/11/23 at 2:10 p.m. Current diagnoses included schizoafffective disorder and legal blindness. The resident received Medicaid services. The resident received psychiatric services at a community - based provider. The resident had a current, signed 3/31/23, Service Plan document. The service plan lacked a plan of care developed in cooperation with their mental health services provider to include the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. During an interview on 5/122/23 at 10:37 a.m., the Administrator indicated the facility had not developed plans of care in cooperation with residents mental health care providers for Residents 48 and 54. An undated, current, facility document titled			

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	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET ANDERSON, IN 46016

(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
	"Residents with major mental illness,", provided by the Administrator on 5/11/23 at 11:48 a.m. indicated the facility provided services to 13 residents with identified mental health needs. Residents 48 and 54 were included on the list. A current, 6/22/23, facility policy titled "Service Plans", provided by the Administrator on 5/12/23 at 10:37 a.m., indicated the following: "...C. The scope and content of the evaluation includes: 1. The resident's physical, cognitive, and mental status.... The services offered to the resident shall be appropriate to the scope, frequency, need, and preference of the resident...."			

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE 1 OF 4**

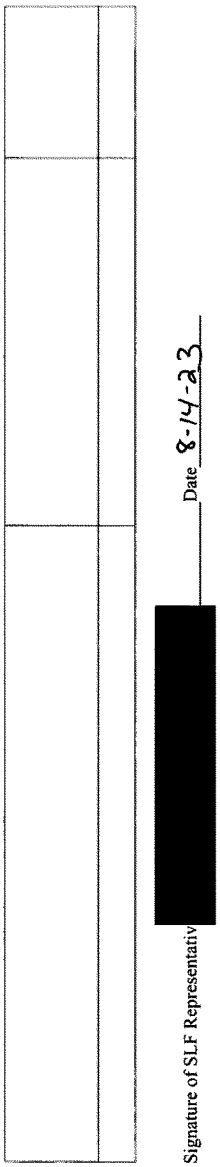
SLF NAME: **Timberlake SL** REFERRAL DATE: **4.4.2023**
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLF Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
146.235 Staffing **(l) The SLP provider shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLP provider shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLP provider may conditionally employ an applicant for up to three months pending the results of the criminal history record check.** This requirement was not met as evidenced by: HCWR checks completed late for E1, E5, E6, E9	An In-service will be completed with the BOM and ED on the proper steps to completing Health Care worker Background checks by the Regional Director of Operations. The ED or Designee will audit all employee files to make sure all background checks have been completed on all current staff in the building. We will then complete a monthly QA to make sure that all Health Care worker background checks have been completed and in the correct time frames on all new hire employees. To be completed by the ED or receptionist.	09/16/2023 for all findings

146.235 Staffing **(m) Each employee and volunteer shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** This requirement was not met as evidenced by: TB late/2nd step not given or late/read and given same day-E1, E2, E3, E4, E5, E6, E7, **Section 146.230 Services** **(n)** Daily Check The SLF shall implement a system to check on the welfare of each resident daily. This requirement was not met as evidenced by: missing well-being checks for R20, R26, R28 **Section 146.220 Resident Participation Requirements** **(d) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).** This requirement was not met as evidenced by: TB late/2nd step not given or late/read and given same day/no s/s checklist for R3, R6, R7, R8, R16, R19, R20, R21, R23, R25, R26, R27, R28, R29	(m) Our Regional Director of Nursing will complete an in-service with all nursing staff on the proper steps to completing TB testing. The Director of Nursing will audit all employee files to see if TB testing has been completed correctly. And if not she will complete the testing again. The ED or Designee will then complete monthly QA checks to ensure that any new hires coming into the building have been completed correctly and on time. --- (n) The Regional Director of Nursing will complete an in-service with all CNA staff about completing the daily welfare checks. The DON or Designee will do an audit on all Daily check sheets. If not completed, they will speak with the CNA that worked to get it completed. The Executive Director or Designee will check the sheets every morning to ensure they have been completed. If they have not been completed disciplinary action with begin. --- (d) The Regional Director of Nursing will complete an in-service with the DON and LPN's on giving TB testing to the residents. All resident charts will be audited to make sure they are in compliance with TB regulations. The ED and Designee will do monthly QA checks to ensure the compliance of TB testing for any new residents that move into the building.	

Section 146.245 Assessment and Service Plan and Quarterly Evaluation **(a) Interview: The SLP provider shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy but not before the DON, or successor tool, and other required PAS assessments are completed and determinations provided to the SLP provider.** **This requirement was not met as evidenced by:** Standardized assess not completed-R6, R16, R19, R22, R24, R25 **(b) Initial Assessment: The SLP provider shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered professional nurse.** This requirement was not met as evidenced by: 24hour assessment and service plan not completed for R6, R19, R23 **(c) Comprehensive Resident Assessment: The SLP provider shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered professional nurse.** **This requirement was not met as evidenced by:** RAI late/incomplete/missing signature for R2, R4, R5, R6, R10, R11, R12, R13, R16, R17, R18, R19, R20, R25, R26, R28, R29	(a)The Regional Director of Nursing will complete an in-service with nursing staff and the Executive Director about completing the assessment. The nursing staff will check all resident charts to make sure that they have all had the assessment completed. The ED or Designee will do a QA check that the assessment is completed before move in on all new residents. --- (b) The Regional Director of Nursing will complete an in-service with the nursing staff on the guidelines for completing the initial assessment and service plan with-in 24 hours of move in. All resident charts will be checked to make sure they all have the 24 hour assessments and the service plans completed. This will be done by the nursing staff. The ED or Designee will do a QA check within 24 hours of any new move-ins that these have been completed. --- (c) Our Regional Director of Nursing will complete an in-service with nursing staff on doing the RAI within 14 days of admission. All resident charts will be checked to make sure an RAI has been completed by nursing staff. The ED or Designee will check twice a month to see if we had any new move ins and to make sure the RAI has been completed.	

(d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered professional nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLP provider that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. This requirement was not met as evidenced by: ISP late/missing signature/date- R2, R5, R9, R10, R14, R15, R16, R18, R20, R24, R25 **(e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered professional nurse.** This requirement was not met as evidenced by: Quarterlies late/missing- R2, R7, R8, R17, R18, R20, R22, R23 **146.295 Emergency Contingency Plan** **(e) Each resident shall be oriented to the emergency plans within ten days after the resident's admission. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.** This requirement was not met as evidenced by: No documentation of orientation to emergency plans for R3, R4, R5, R8, R24	(d) An in-service will be completed by our Regional Director of Nursing to any nurse staff on this process. An audit will be completed to be sure that all residents have their Service plan completed by Nurse staff or Designee. A monthly QA will be done to ensure that we are staying in compliance with the Service plans by the ED or Designee. (E) Our Regional Director of Nursing will in-service the DON on how to properly complete the Quarterly evaluations. The Nursing staff will audit all resident files to make sure a quarterly evaluation was completed and if there was not one we will complete one. The ED or Designee will do quarterly monitoring so make sure that all evaluations are being completed.	


Date 8-14-23
Signature of SLF Representativ

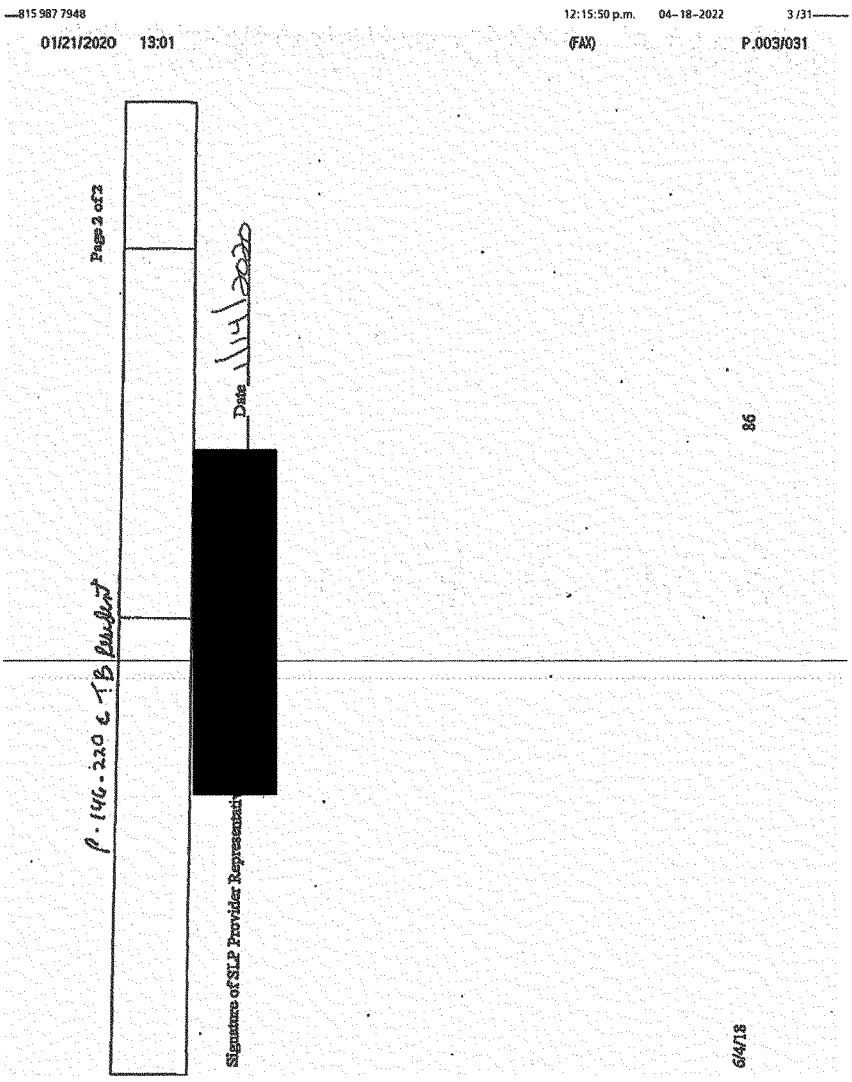
Page 1 of 2

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: 10-25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)		SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements This requirement is not met e) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R2- No documentation that TB screening test was performed. Documentation requested but facility stated there was no documentation available. R2-No documentation provided checklist of signs & symptoms of TB disease completed. This form was requested but not provided. 6/4/18		SLF Response: Complaint/finding Withdrawn January 8, 2020	Correction Date: N/A


815 987 7948
12:15:50 p.m. 04-18-2022 3 /31
01/21/2020 13:01
(FAX)
P.003/031
Page 2 of 2
Date 1/14/2020
86
P. 146-220 c 1B Bowlus
Signature of SLP Provider Representati
6/4/18

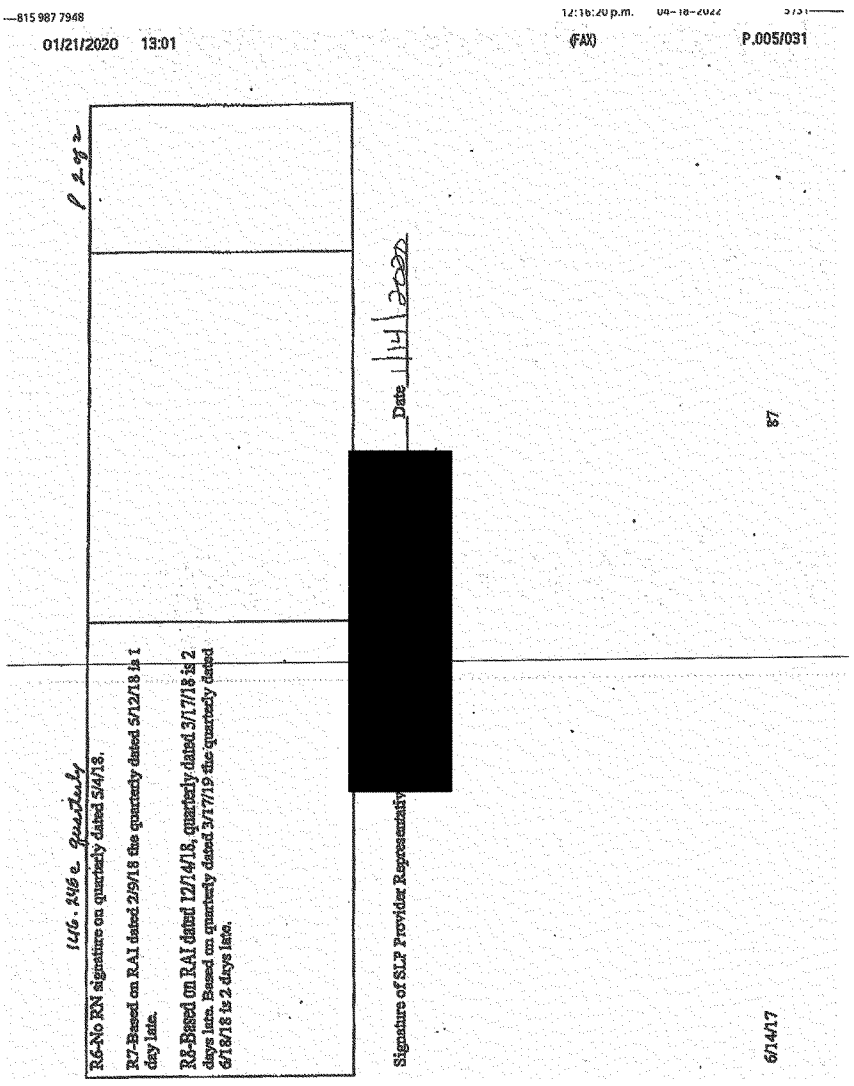
RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 2

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: JQ25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLF RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse. This requirement is not met: R1- Based on quarterly dated 9/17/18 another quarterly was due 12/17/18 and facility was unable to provide a December 2018 quarterly. R3-RAI dated 1/24/18, the next quarterly was due 4/25/18; the quarterly was dated 5/12/18, approximately 17 days late.	SLF Response: • A quarterly evaluation of the health and behavior status of each resident will be completed quarterly no later than 92 days from the initial Assessment date and the previous quarterly evaluation. Each quarterly evaluation will be signed by a registered nurse. • New Wellness Manager was hired during the 2019 annual state review and was oriented to Admin Code Section 146.245. Wellness Manager will be re-orientated to address all state findings and create a quality assurance plan to ensure accurate completion.	Correction Date: 2/19/2020

6/14/17



—815 987 7948 12:16:20 p.m. 04-18-2022 3/31

01/21/2020 13:01 (FAX) P.005/031

1 of 2

R6-No RN signature on quarterly dated 5/4/18.
R7-Based on RAI dated 2/9/18 the quarterly dated 5/12/18 is 1 day late.
R8-Based on RAI dated 12/14/18, quarterly dated 3/17/18 is 2 days late. Based on quarterly dated 3/17/19 the quarterly dated 6/18/18 is 2 days late.

146. 146 e quarterly

Date 1/4/2022

[redacted]

Signature of SLP Provider Representative

87

6/14/17

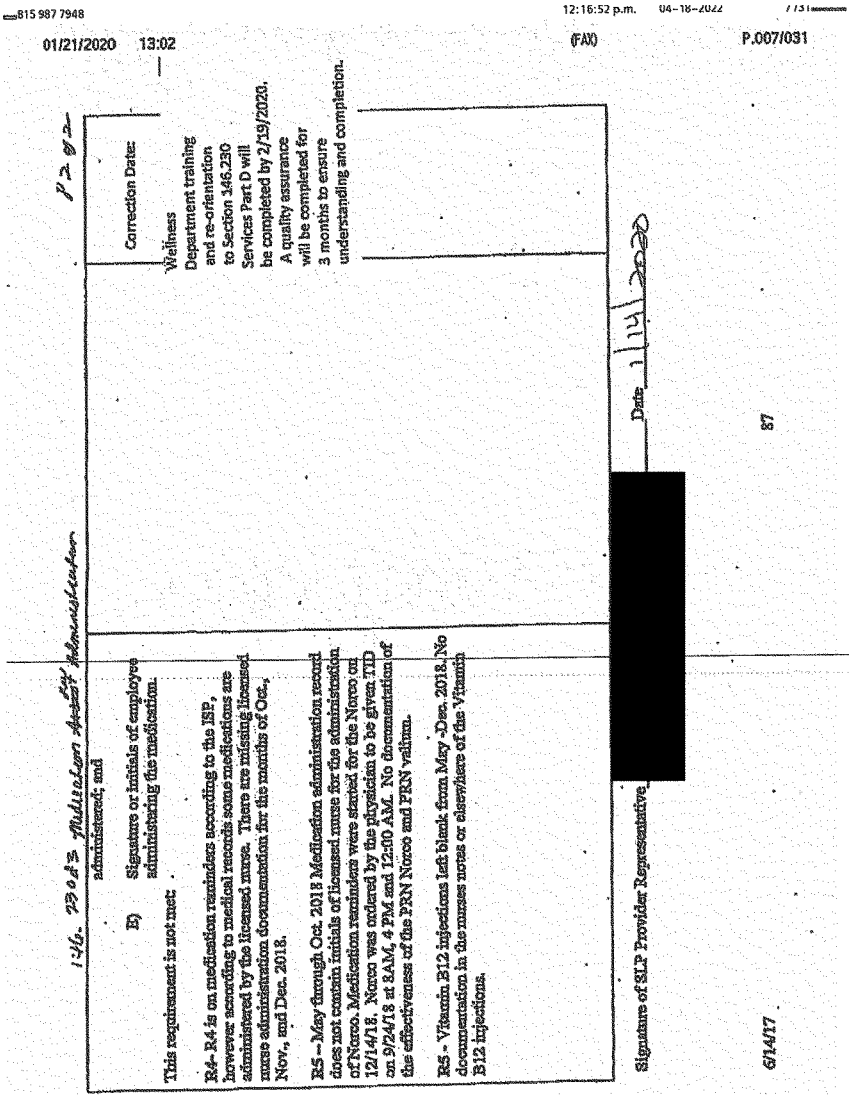
RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 2

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: 10-25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not be limited to, the following: A) Name of resident; B) Name of medication, dosage, directions and route of administration; C) Date and time medication is scheduled to be administered; D) Date and time medication was	SLF Response: • R4 – Nurse administration documentation was present for October 2018. • R5 – Medication administration record which contains initials of a licensed nurse for the administration of Norco June through September 2018 was present. • R5 – Vitamin B12 injection documentation was present for May – July 2018 and September 2018. • All medication reminders, assistance and nurse administration will be documented according to the guidelines of Section 146.230 Services Part D • All CNA's, LPN's, and Wellness Manager will be re-orientated and retrained to Section 146.230 Section D.	

6/14/17 87


815 987 7948
12:16:52 p.m.
01/21/2020 13:02
(FAX)
P.007/031
administered; and
E) Signature or initials of employee administering the medication.
Correction Date:
Wellness Department training and re-orientation to Section 146.230 Services Part D will be completed by 2/19/2020. A quality assurance will be completed for 3 months to ensure understanding and completion.
This requirement is not met
R4- R4 is on medication reminders according to the ISP, however according to medical records some medications are administered by the licensed nurse. There are missing licensed nurse administration documentation for the months of Oct., Nov., and Dec. 2018.
R5 -- May through Oct. 2018 Medication administration record does not contain initials of licensed nurse for the administration of Norco. Medication reminders were started for the Norco on 12/14/18. Norco was ordered by the physician to be given TID on 9/24/18 at 8AM, 4 PM and 12:00 AM. No documentation of the effectiveness of the PRN Norco and PRN valium.
R5 - Vitamin B12 injections left blank from May -Dec. 2018. No documentation in the nurses notes or elsewhere of the Vitamin B12 injections.
Signature of SLP Provider Representative
Date 1/14/2020
6/14/17
87

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 3

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE 10-25-19
First Follow-up (x) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees).

Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to, the following: A) Name of resident; B) Name of medication, dosage, directions and route of administration; C) Type of oversight needed; i.e., reminders, assisting with opening container, etc.;	SLF Response: • All medication reminders, assistance and nurse administration will be documented according to the needs of each resident and within the guidelines of Section 146.230 Services Part D. • All CNA's, LPN's and Wellness Manager will be re-orientated and re-trained to Section 146.230 Services Part D which includes but not limited to: A. medication assist record B. Following the Physician Order Sheet (POS) C. Medication assist times • A quality assurance plan will be created to ensure accurate completion of the above stated.	

614417

1/16-23rd & 31st Absent			p 2 of 3
D) Date and time medication is scheduled to be taken; E) Documentation showing that resident has taken, or refused to take, the medication; and F) Signature or initials of employee providing oversight. This requirement is not met.			Correction Date: Wellness Department training and re-orientation to Section 146.230 Services Part D will be completed by 2/19/2020. A quality assurance will be completed for 3 months to ensure understanding and completion.

R4 – R4 medication reminders not documented on 11/20/18 and 11/27/18 (4PM and 8:00 PM).

R5 – R5 is a medication assist and a nurse administer for medications. There are multiple missing initials on the medication assist record for Oct., Nov., and Dec. 2018. There are also missing medication assist initials for Jan 2019. Medication assistance times are also not according to the Nov. 2018 Physician's order sheet (POS). There is no medication time listed for 9:00 AM. There is also a change from a 12:00 AM medication to an 11:00 AM medication with no noted order change in Nov. 2018.

R5 - December POS does not coincide with the December medication assist record. There are December 2018 order changes and the times on the medication assist record are scratched out and illegible.

R5 – Medication assist records (Oct., Nov., and Dec. 2018) indicate the nurse did not leave out the medication or they were not in the cabinet.

R6 – R6 is a medication reminder but nurse gives insulin and does accu-checks. There is missing medication assist initials multiple times for November and Dec 2018 and Jan 2019. In

6/1417

P 3 83

addition, there is no staff initials for 4 pm time for medicated lotion that was ordered on 12-14-19.

R7- There are no staff initials on the medication reminder sheet on 11/20/18 at 8am, 12pm, 4pm and 8pm. On 11/27/18 at 4pm & 8pm. On 11/28/18 at 8am & 12pm; 12/29/18 at 8am; 1/1/19 at 8am &12pm; 1/2/19 at 12pm; 1/6/19 at 4pm & 8pm; 1/9/19 8am 1/13/19 no staff initials at 8am, 12pm, 4pm and 8pm.

R9- Nurse administers fluoxetine 7.5 mg po at 8am and risperidone 1 mg po at 8am. R9 is a medication reminder for the rest of his medications. There are no staff initials on medication reminder sheet on 1/5/19 at 8pm; 1/9/19 at 8am, 1/10/19 at 8pm; 1/11/19 at 8am & 8pm; 12/14/18 at 8pm; 12/16/18 at 8am; 11/12/18 at 8am, 11/14/18 at 8am and 11/28/18 at 8am.

Signature of SLP Provider Representative [redacted] Date 1/14/2020

87

6/14/17

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: 10-25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior	No plan of correction required. Remediate only	

815 987 7948 12:18:26 p.m. 04-18-2022 12/31

01/21/2020 13:03 (FAX) P.012/031

Page 2 of 2

146.245d ISP (Remediate)

needs of each resident. This service plan shall document any services recommended by the SLP that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences. REMEDIATE the Following:	No plan of correction required. Remediate only	
R5 – No ISP completed only and RSP 2/20/18. RAI has phone scored a "7" and this is not on the RSP/ISP. No documentation that resident initialed he/she chose SLP services. No documentation R5 received a copy of resident rights. No documentation of goals, interests, preferences or choice. No identification of safety concerns that impact the resident. Medication management not completely accurate on the RSP. R6- The ISP dated 10/31/18, bathing, mode of locomotion/ambulation, dressing, transportation, shopping, laundry and steps to achieve section was blank. Per Executive Director, facility unable to remediate this section on the ISP. R7- RAI coded pain as a 2 but wasn't addressed on the ISP, resident had Tylenol for pain.		

Signature of SLP Provider Representative [redacted] Date 1/14/2020

6/4/18

86

RESPONSE TO ON-SITE REVIEW FINDINGS

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: 10-25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements This requirement is not met: c) Each prospective resident shall have a tuberculin skin test in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). R2- No documentation that TB screening test was performed. Documentation requested but facility stated there was no documentation available. R2-No documentation provided checklist of signs & symptoms of TB disease completed. This form was requested but not provided.	SLF Response: Complaint/Finding Withdrawn January 8, 2020	Correction Date: N/A

P. 146.220 & TB Resident

Signature of SLP Provider Representativ [redacted] Date 1/14/2020

RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 2

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: 10-25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.245 Assessment and Service Plan and Quarterly Evaluation e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse. This requirement is not met: R1- Based on quarterly dated 9/17/18 another quarterly was due 12/17/18 and facility was unable to provide a December 2018 quarterly. R3-RAI dated 1/24/18, the next quarterly was due 4/25/18; the quarterly was dated 5/12/18, approximately 17 days late.	SLF Response: • A quarterly evaluation of the health and behavior status of each resident will be completed quarterly no later than 92 days from the Initial Assessment date and the previous quarterly evaluation. Each quarterly evaluation will be signed by a registered nurse. • New Wellness Manager was hired during the 2019 annual state review and was oriented to Admin Code Section 146.245. Wellness Manager will be re-orientated to address all state findings and create a quality assurance plan to ensure accurate completion.	Correction Date: 2/19/2020

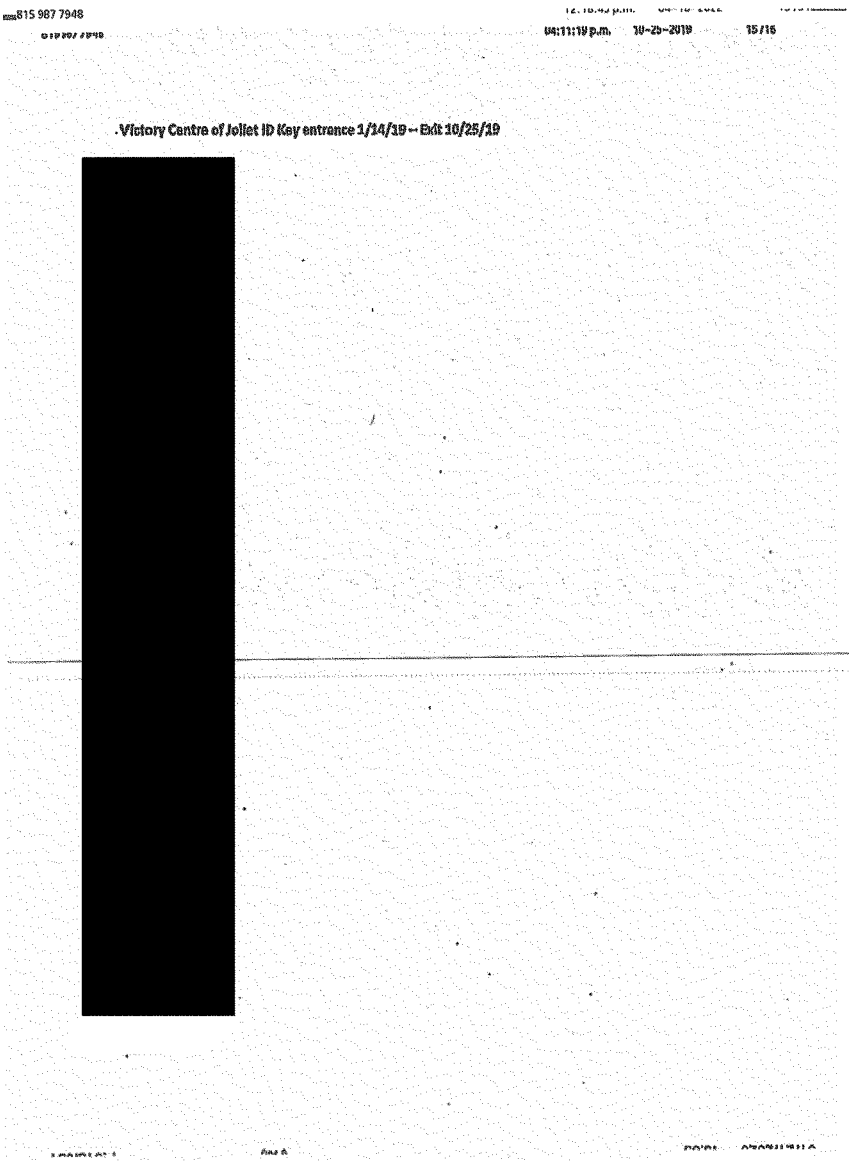
R6-No RN signature on quarterly dated 5/4/18. R7-Based on RAI dated 2/9/18 the quarterly dated 5/12/18 is 1 day late. R8-Based on RAI dated 12/14/18, quarterly dated 3/17/18 is 2 days late. Based on quarterly dated 3/17/19 the quarterly dated 6/18/18 is 2 days late.		

Signature of SLP Provider Representative [redacted] Date 1/14/2020

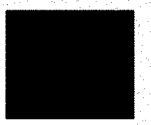
RESPONSE TO ON-SITE REVIEW FINDINGS PAGE 1 OF 2

PROVIDER NAME: Victory Centre of Joliet REFERRAL DATE: 10-25-19
First Follow-up ( ) Second Follow-up ( )
Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	SLP RESPONSE	CORRECTION DATE
Section 146.230 Services d) Medication Administration, Oversight and Assistance in Self-Administration 3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not be limited to, the following: A) Name of resident; B) Name of medication, dosage, directions and route of administration; C) Date and time medication is scheduled to be administered; D) Date and time medication was	SLF Response: • R4 – Nurse administration documentation was present for October 2018. The record is attached. • R5 – Medication administration record which contains initials of a licensed nurse for the administration of Norco June through September 2018 was present. The record is attached. • R5 – Vitamin B12 injection documentation was present for May – July 2018 and September 2018. • All medication reminders, assistance and nurse administration will be documented according to the guidelines of Section 146.230 Services Part D • All CNA's, LPN's, and Wellness Manager will be re-orientated and retrained to Section 146.230 Section D.	


815 987 7948
04:11:19 p.m. 10-25-2019 15/16
Victory Centre of Joliet ID Key entrance 1/14/19 -- Exit 10/25/19

Victory Centre of Joliet ID Key entrance 1/14/19 (continued)



Presenter: Ava Mitchell

Date: January 17, 2020

In-Service Topic: **PROFESSIONS, OCCUPATIONS, AND BUSINESS OPERATIONS (226 ILCS 65/) Nurse Practice Act.**

By signing below it is understood that you have a clear understanding and working knowledge of the above stated Nurse Practice Act.

[redacted]

Presenter: Ava Mitchell, Executive Director

Date: December 27, 2019

In-Service Topics:

Section 146.245 Assessment and Services Plan and Quarterly Evaluation

e) Quarterly Evaluation: A quarterly evaluation o the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

Section 146.230 Services

d) Medication Administration, Oversight and Assistance in Self – Administration

3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not limited to, the following:
A) Name of resident
B) Name of medication, dosage, directions and route of administration;
C) Date and time medication is scheduled to be administered;
D) Date and time medication was administered; and
E) Signature or initials of employee administering the medication

4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not limited to, the following:
A) Name of resident;
B) Name of medication, dosage, directions and route of administration;
C) Type of oversight needed; i.e., reminders, assisting with opening container, etc.;
D) Date and time medication is scheduled to be taken;
E) Documentation showing that resident has taken, or refused to take, the medication; and
F) Signature or initials of employee providing oversight.

By signing below it is understood that you have a clear understanding and working knowledge of the above stated policy and procedures.

[redacted]

Section 146.245 Assessment and Service Plan and Quarterly Evaluation

a) Interview: The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy.

b) Initial Assessment: The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems. Each assessment shall be completed by, or co-signed by, a licensed practical nurse or a registered nurse.

c) Comprehensive Resident Assessment: The SLF shall complete a Comprehensive Resident Assessment Instrument (RAI) within 14 days after admission, annually and upon a significant change in the resident's mental or physical status. Each RAI shall be completed by, or co-signed by, a registered nurse.

d) Service Plan: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse, with input from the resident and his or her designated representative. This includes coordination and inclusion of services being delivered to a resident by an outside entity. The service plan shall include a description of expected outcomes, approaches, frequency and duration of services provided and whether the services will be provided by licensed or unlicensed staff. The service plan must be individualized to address the health and behavior needs of each resident. The service plan shall document any services recommended by the SLF that are refused by the resident. The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences.

e) Quarterly Evaluation: A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed by, or co-signed by, a registered nurse.

f) Service Plan for Identified Sex Offenders: Within seven days after completion of the RAI, a written service plan shall be developed by, or co-signed by, a registered nurse that addresses the following:

1) the amount of supervision required by the individual to ensure the safety of all residents, staff and visitors; and

2) determination of approaches developed in the service plan are appropriate and effective in dealing with any behaviors specific to the identified offender.

g) Progress Notes: Progress notes shall be completed at least monthly to document

decline or improvement in resident status. A progress note does not have to be completed if there is no change in resident status. Any SLF staff may write progress notes.

h) The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

Section 146.230 Services

a) An SLF must combine housing, personal and health related services in response to the individual needs of residents who need help in activities of daily living. Supportive services shall be available 24 hours per day to meet scheduled and unscheduled needs in a way that promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and autonomy in a residential setting.

b) Nursing Services

1) The SLF shall conduct a comprehensive resident assessment and service plan for each SLF resident as required under Section 146.245.

2) When a resident is unable to administer his or her own medications, a licensed nurse shall administer the medications.

3) Nursing services shall include medication set-up (such as preparing weekly pill caddies with that week's medication) and follow-up care, and shall be conducted by a licensed nurse.

4) Other nursing services include episodic and intermittent health promotion or disease prevention counseling and teaching self-care in meeting routine and special health care needs that can be done by other staff under the supervision of a registered nurse.

5) All nursing services shall be provided in accordance with the Nurse Practice Act [225 ILCS 65].

c) Personal Care

1) The SLF shall provide personal care services for residents, including but not limited to assistance with bathing, eating, dressing, personal hygiene, grooming, toileting, ambulation and transfer.

2) Personal care services shall be delivered by certified nursing assistants who meet the qualifications described in Section 146.235(f)(1).

d) Medication Administration, Oversight and Assistance in Self-Administration

1) The SLF shall provide the following:

A) Reminding the resident to take his or her medications;

B) Taking medication from where it is stored in the apartment and handing it to the resident when requested to do so by the resident;

C) Opening or uncapping medication containers for residents; and

D) Assisting residents in the removal of the medication from the container and assisting the resident in consuming or applying the medication when requested to do so by the resident (i.e., placing a dose in a container and placing the container to the mouth of the resident).

2) The services identified in subsection (d)(1)(D) shall only be delivered by a licensed nurse.

3) Medication administration shall be documented according to the needs of each resident. Documentation for medication administration shall include, but not be limited to, the following:

A) Name of resident;

B) Name of medication, dosage, directions and route of administration;

C) Date and time medication is scheduled to be administered;

D) Date and time medication was administered; and

E) Signature or initials of employee administering the medication.

4) Medication oversight shall be documented according to the needs of each resident. Documentation for medication oversight shall include, but not be limited to, the following:

A) Name of resident;

B) Name of medication, dosage, directions and route of administration;

C) Type of oversight needed; i.e., reminders, assisting with opening container, etc.;

D) Date and time medication is scheduled to be taken;

E) Documentation showing that resident has taken, or refused to take, the medication; and

F) Signature or initials of employee providing oversight.

e) Meals

1) The SLF shall provide three meals per day, or two meals per day (noon and evening meals) and a breakfast bar. The menu shall include food choices that allow a resident to choose foods that will meet the requirements of a therapeutic diet as ordered by a resident's physician. The menu for each resident shall meet the basic food pattern for a general diet for an adult following the recommendations of the Food and Nutrition Board, National Academy of Sciences.

2) The SLF shall make available beverages, including coffee, fruit juice and snack foods, at no cost to the residents.

3) The SLF shall offer the same menu options to all residents regardless of payment source.

4) The SLF shall keep all menus served on file for not less than six months.

5) The SLF shall maintain on the premises supplies of staple foods for a minimum of a one week period and of perishable foods for a minimum of a two day period. Supplies shall be appropriate to meet the requirements of the menu.

6) The SLF shall keep records of all food purchased on file for not less than six months.

7) The SLF shall store, prepare, distribute and serve food in a manner to protect against contaminants and spoilage and to insure the preparation and serving of food at safe and palatable temperatures.

8) The SLF shall provide and maintain clean and sanitary central kitchen and dining areas. The SLF shall ensure a sanitary and adequate supply of eating and drinking utensils and pots and pans for preparing food in the central kitchen and dining areas.

9) The SLF shall provide residents with written information about menu plans. Menu cycles shall not be repeated within a one week time frame. There shall be an established mechanism for residents to provide input

into the selection and preparation of food served.

10) The SLF shall allow residents to obtain, prepare and store food in residential apartments if doing so does not represent a health or safety hazard to others.

11) The SLF shall provide residents with meal service in their apartments as a time limited service during periods of documented illness.

f) Laundry

1) If requested by a resident, the SLF shall provide laundry services at least weekly at no charge to the resident.

2) The SLF shall provide for the appropriate handling, cleaning, and storage of routine personal laundry, laundry soiled with body secretions and all other laundry. This includes all detergent and fabric softeners required to perform normal routine laundry service at no cost to the resident.

3) The SLF shall provide on-site laundry equipment for resident use in accordance with Section 146.210.

4) Laundry service does not include dry cleaning services.

g) Housekeeping

1) The SLF shall provide for general housekeeping services at least weekly (house cleaning, bed making, changing of linens, dusting and vacuuming).

2) The SLF shall take into account individual habits and lifestyle preferences when providing all housekeeping services in residential apartments.

3) The SLF shall maintain all public areas in a clean and orderly condition.

4) The SLF shall maintain all common bathing rooms in a clean and orderly condition.

h) Maintenance

1) The SLF shall maintain all residential apartments in good repair.

2) The SLF shall keep the building and grounds clean and free of hazards, with all systems maintained in good working order.

i) Social and Recreational Programming

1) The SLF shall facilitate the involvement of individual and community volunteer activities with and for residents.

2) The SLF shall provide programs at least twice weekly, which include on-site programs as well as off-site trips, allowing for social and recreational programs for the residents. Transportation shall be provided or arranged at no cost to the resident by the SLF for scheduled activities off-site.

3) The SLF shall provide access to opportunities for scheduled and unscheduled individual and group socialization within the SLF and in the larger community.

4) The SLF shall make available to each resident information about community resources and make community integration part of the SLF's recreational, socialization and vocational activities.

j) Ancillary Services

1) The SLF shall provide or arrange transportation, at no charge to the residents, for scheduled shopping, community and social activities. The community outings shall reflect the interests, choices and needs of the residents and be scheduled on a regular basis and be reflected in the residents' calendar.

2) The SLF shall assist a resident in obtaining needed and preferred services offered outside the SLF at his or her request. Upon request by a resident, the SLF shall assist in making medical appointments and arranging for transportation to and from the source of medical treatment (payment for medical transportation shall be made in accordance with 89 Ill. Adm. Code 140.490 through 140.492).

3) The SLF shall provide shopping assistance when a resident is temporarily unable to shop.

k) 24 Hour Response/Security Staff

1) The SLF shall have response/security staff awake and available on the premises 24 hours a day to respond to scheduled or unpredictable needs and emergency calls from residents. Staff shall possess certification in emergency resuscitation. The SLF shall provide no fewer than one staff person for facilities with one to 75 residents, a second staff person for

facilities with 76 to 150 residents, and a third staff person for facilities with 151 or more residents. In determining the number of staff, the SLF shall consider the number of floors in the building, and the medical needs of the residents. At least one certified nursing assistant shall be on-site 24 hours a day to respond to resident needs.

2) The SLF shall provide security 24 hours a day, including lockable entrances (accessibility controlled by SLF staff for security purposes during overnight hours) and on-site personnel. All residents shall have 24 hour access.

3) Rehabilitated nursing facilities shall have separate staff on-site in the SLF.

l) Health Promotion and Exercise Programming

1) The SLF shall offer and encourage the use of health promotion and exercise programs for its residents.

2) The SLF shall develop programs to be held not less frequently than three times per week geared toward promoting better health and fitness of the residents. These programs are in addition to the social and recreational programming described in this Section.

m) Emergency Call System

1) The SLF shall ensure that at least two electronic devices are available in each apartment to enable the resident to secure help in an emergency. At least one device shall be located in each bathroom. The requirement for additional devices shall be met with a device located in each bedroom or through a portable emergency home response system.

2) The SLF shall have electronic devices available in each common area, each public restroom, each common bathing room and each resident laundry room to enable residents to secure help in an emergency.

3) The emergency call system shall be capable of direct and immediate notification to staff or shall be manned by personnel 24 hours a day for transmission to available staff for assistance.

n) Daily Check
The SLF shall implement a system to check on the welfare of each resident daily.

(Source: Amended at 33 Ill. Reg. 11803, effective August 1, 2009)

Policies and Procedures
Pathway Management

Policy and Procedure: QUARTERLY ASSESSMENT OF RESIDENTS
Policy Number: WN 207
Issue Date: CURRENT 03/17

PURPOSE

Quarterly assessments will detect any changes in the condition of a resident that may require medical attention or changes in the Resident Service Plan.

POLICY

Nurses will conduct a thorough assessment of each resident each quarter or upon change of condition.

PROCEDURE

1. Obtain the resident's record for reference for previous assessments, physician orders, notes, etc.

2. Review all information included in the resident's record since the prior assessment (new orders, progress notes, labs, medication and treatment records, etc.). Make a notation of any special assessments or questions that need to be explored during the visit with the resident.

3. Meet with the resident and explain the assessment process. Ask the resident about any specific concerns and make notations as appropriate.

4. Review monthly vital signs and weight for the quarter. Compare vital signs and weight to previous records for any significant changes and make notations as appropriate.

5. Complete the items on the quarterly assessment form make notations of any changes in condition.

6. Review the assessment form with the resident and with the family if appropriate. Provide an opportunity for the resident to ask questions and voice concerns.

7. Provide health teaching, suggestions, and/or recommendations as appropriate.

8. Share the assessment information with the team and coordinate any modifications to the Resident Service Plan.

9. Notify physician of any pertinent information.

10. Review the Quarterly Assessment form to make sure all documentation is complete.

11. Record any other additional pertinent information in the Resident Record.

Policies and Procedures
Pathway Management

Policy and Procedure: MEDICATION MANAGEMENT
Policy Number: WN 501 A (IL)
Issue Date: CURRENT 01/17

PURPOSE

To ensure that the right resident receives the right medication, in the right dosage, at the right time, via the right route, with the right documentation.

POLICY

Medications will be managed to ensure proper administration.

PROCEDURE

1. The pharmacy distributes the medication in a multi dose packet that is labeled with the resident's name, date and time the medication should be taken. The label also has the name and dose of each medication in the packet.

2. A nurse will be responsible to check the delivered medication against the Physicians Order Sheet. The nurse will then deliver the medication to the resident's apartment locking in the secured storage area or will store the medications in the wellness center medication secured storage areas.

Assessment

All residents must have a Self-Medication Assessment completed by the nurse upon admission to ensure that the proper service level is provided to allow safe medication management. The determined service level will be documented on the Resident Service plan and reviewed quarterly and as needed with a change in status.

Three levels of medication assistance

1. Independent, this means that the resident has been assessed and the conclusion is that the resident may self-administer his or her own medication.

2. Reminders with observation. This means that a LEA will go to the resident's apartment and remind them it is time to take their medication.

   a. The Life Enrichment Aid (LEA) will unlock the medication drawer.

   b. The LEA will check the medication packet for the resident name, date and time.

   c. The LEA will then observe the resident taking the medication and document on the Care Schedule/EHR.

3. Medication assistance. This means that the LEA will provide assistance to the resident by verbally cueing or by physically assisting the resident to open the package.

   a. The LEA will unlock the medication drawer.

Policies and Procedures
Pathway Management

b. The LEA will check the medication packet for the resident's name, date and time.

c. The LEA will verbally direct the resident to open the packet and take the medication if the resident requires cueing only.

d. The LEA will open the packet for the resident and hand the packet to the resident if this is required.

e. The LEA will then observe the resident taking the medication and document on the Care Schedule/EHR.

4. If at any time a resident is unavailable to take a medication the nurse should be notified to give direction on managing the situation. If there is no nurse on duty in the community, the Resident Care Manager or Wellness Manager should be called and informed of the situation to provide direction.

5. If a resident refuses a medication the nurse should be notified to allow intervention. If no nurse is in the community, the LEA should document the refusal on the refusal form and on the care schedule. The LEA should ensure that the refusal is reported to the nurse at the earliest opportunity to allow for follow up by the nurse.

Policies and Procedures
Pathway Management

Policy and Procedure: MEDICATION ADMINISTRATION
Policy Number: WN 502 A (IL)
Issue Date: CURRENT 03/17

PURPOSE

To maintain the well being of residents by ensuring proper medication administration.

POLICY

The right resident will receive the right medication, in the right dosage, at the right time, via the right route with the right documentation.

PROCEDURE

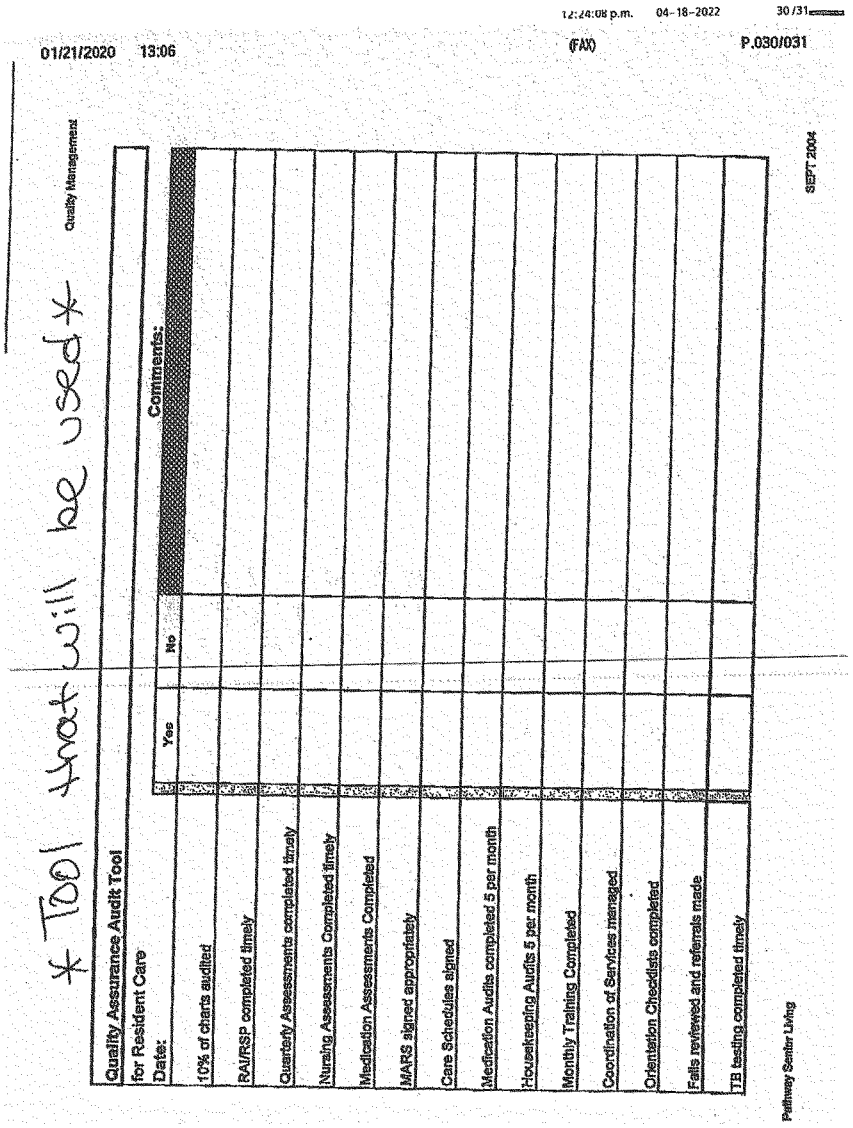
1. The pharmacy distributes the medication in a multi-dose packet that is labeled with the resident's name, date and time the medication should be taken. The label also has the name and dose of each medication in the packet.
2. A nurse will be responsible to check the delivered medication against the Physicians Order Sheet and administer the medication to the resident as prescribed.
3. The medication will be locked in a secured storage area in the wellness center. Residents will be required to come to the wellness center to receive medications. However when a resident is unable to come to this desired location the nurse must go to the apartment and assess the resident's status. The LEA may escort the resident as needed.

Medication Administration:

1. Only Licensed nurses will provide medication administration. Any time a judgment must be made regarding the medication such as what day, time, or dose a licensed nurse will be responsible for the decision. Any time a change must be made in the medication only a licensed nurse will make the change.
2. Medications such as eye drops, ear drops, patches, inhalers, nebulizer treatments, accuchecks, or insulin must be administered by a nurse, for residents who are not deemed capable of self-administration.
3. When the level of medication management service requires, the removal of medication from container and assisting resident in consuming or applying medication may be performed. **(This must be done by a licensed nurse)**
4. Nurses will assist the residents with blood glucose monitoring when they are unable to perform the task without hands-on assistance. When the resident can perform the task, they must do so in the presence of a nurse if the results will require insulin management by the nurse.

Policies and Procedures
Pathway Management

5. All team members will follow the Nurse Practice Act and Pharmacy Practice Act in relation to medications. Medications are prescribed to each resident individually. Medications prescribed for one resident may not be administered to a different resident.



12:24:08 p.m. 04-18-2022 30/31

01/21/2020 13:06 (FAX) P.030/031

* Tool that will be used *

Quality Management

Quality Assurance Audit Tool

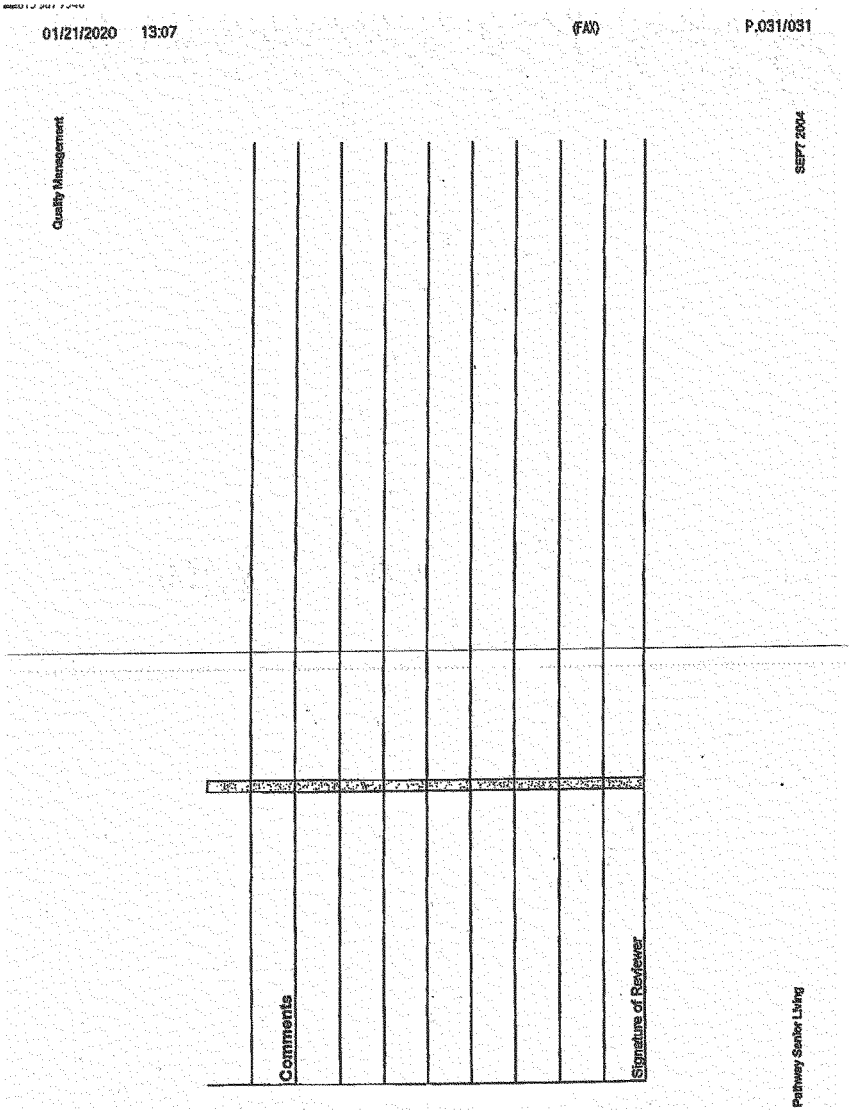
for Resident Care

Date:

	Yes	No	Comments:
10% of charts audited			
RAI/RSP completed timely			
Quarterly Assessments completed timely			
Nursing Assessments Completed timely			
Medication Assessments Completed			
MARS signed appropriately			
Care Schedules signed			
Medication Audits completed 5 per month			
Housekeeping Audits 5 per month			
Monthly Training Completed			
Coordination of Services managed			
Orientation Checklists completed			
Falls reviewed and referrals made			
TB testing completed timely			

SEPT 2004

Pathway Senior Living


01/21/2020 13:07
(FAX)
P.031/031
Quality Management
SEPT 2004
Comments
Signature of Reviewer
Pathway Senior Living

PRINTED: 06/30/2023
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	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VIVERA SENIOR LIVING OF COLUMBUS	1971 STATE STREET COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 1 and 2, 2023 Facility number: 014519 Residential Census: 110 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on June 7, 2023.	R 0000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
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, interview, and record review, the facility failed to store food and provide a clean kitchen for 4 of 4 kitchen observations. This deficient practice had the potential to affect all 110 residents that resided in the facility. Findings include: During an observation and interview on 06/01/23 at 9:55 A.M., the walk-in cooler contained 10	R 0273	With regards to finding R273 Food& Nutritional Services Vivera Senior Living Columbus will; **-What corrective actions will be accomplished for those residents found to have been affected by the finding:** No negative outcome identified for those residents affected.	07/05/2023

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

[redacted] | Administrator | 06/21/2023

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 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.

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	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VIVERA SENIOR LIVING OF COLUMBUS	1971 STATE STREET COLUMBUS, IN 47201

(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
	unopened gallons of whole milk that had a use by date of 05/30/23. A small reach-in refrigerator contained a gallon of milk that was 1/4 full with a use by date of 05/30/23. Cook 2 indicated the milk had been used for breakfast that morning and should have been thrown out. During an observation on 06/01/23 at 11:40 A.M., the plate warmer was observed. The bottom of the warmer contained scattered food crumbs, a piece of hard looking bread, and a pair of tongs. During an observation, interview, and record review on 06/01/23 at 1:50 P.M., Cook 3 indicated the plate warmer was cleaned by the cooks but he wasn't sure it was on the cleaning schedule. The Dietary Manager was on vacation and Cook 2 was in charge. Cook 3 provided the clip board that contained the cleaning schedules for review. There was no cleaning schedule for 06/01/23. The last cleaning schedules were dated daily for 04/09/23 through 04/15/23 and the weekly schedule was dated for April 2023. During an observation and interview on 06/01/23 at 3:01 P.M., the walk-in cooler had a large pan that contained both an unopened tube of pork sausage and a previously opened package of deli ham. The ham had been cut and a portion was missing. The pork sausage was thawing out. There was no blood present, but there was water in the pan. There was no date that indicated when the pork sausage or ham was removed from the freezer. A tube of hamburger was thawed in a tray with no date that indicated when it was removed from the freezer. Cook 2 indicated the pork sausage was pulled from the freezer on Saturday and should not have been on the same tray as the ham and the hamburger was pulled from the freezer on Sunday. The meats should have had a		**-How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:** All residents had the potential to be affected. No resident was adversely affected. An audit was completed to further identify any concerns, none noted. **-What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Culinary Manager or Designee will audit refrigerator & dry stock daily to ensure compliance with expiration dates. Culinary Manager or Designee will train dietary staff on proper cleaning and the use of cleaning logs. Culinary Manager or Designee will provide training on proper food storage, handling & labeling. **-How the corrective action(s) will be monitored to ensure the finding will not recur:** Executive Director or Designee will monitor Dietary Managers audit tool and cleaning schedules weekly X 1 month, monthly x 2 months and random audits ongoing. By what date the systemic changes will be completed: July 5th, 2023	

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	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VIVERA SENIOR LIVING OF COLUMBUS	1971 STATE STREET COLUMBUS, IN 47201

(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
	date of when they came out of the freezer. There were dry food particles under the dry storage racks. Cook 2 indicated she was unsure on how to clean the plate warmer. She had never cleaned it before, and the Dietary Manager had never told her it needed to be cleaned. She had been working in the building for 6 months. She also wasn't sure where the cleaning schedules were located, and she had never checked off daily or weekly cleaning. The current, undated facility policy titled, "Ready-to-Eat Hazardous Food, Date Marking" was provided by the Administrator of 06/01/23 at 3:32 P.M. The policy indicated, "...All ready-to-eat potentially hazardous foods...shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, discarded..." The current, undated facility policy titled, "Cleaning Frequency" was provided by the Administrator on 06/01/23 at 3:03 P.M. The policy indicated, "...Non-food contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation dust, dirt, food particles, and other debris...The approved...cleaning schedule shall be utilized. Task will be assigned on the Assignment Sheets for the Cooks and Dietary Aides..." The current, undated facility policy titled, "Refrigerated Storage" was provided by the Administrator on 06/01/23 at 3:01 P.M. The policy indicated, "...Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation..."			

`ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM
RESPONSE TO ON-SITE REVIEW FINDINGS **Page 1 of 13**

SLP NAME: **White Oaks**
CHECK ONE:

() INTERIM **CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

() FINAL **CERTIFICATION** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

(X) ANNUAL CERTIFICATION **REVIEW FINDINGS: YES, X** NO ☐

ENTRANCE DATE: 2/14/2023 EXIT DATE: 2/17/2023

() CHANGE **OF OWNERSHIP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

() INCIDENT **FOLLOW UP** **REVIEW FINDINGS:** YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

() GENERAL **FINDINGS (Use for findings noted during informal visits to SLP)**
Findings should be written under this section for non-compliance of rules that impact the health and safety of residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

() COMPLAINT **REVIEW** **DATE OF COMPLAINT:** _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

() FIRST **FOLLOW-UP REVIEW** () SECOND **FOLLOW-UP REVIEW**

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the SLP provider is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

Signature of SLP Provider Representative — Date

[redacted] — Date 4/21/2023

Signature of Bureau of Long-Term Care Regional Supervisor — Date

Signature of Bureau of Long-Term Care Area Manager — Date

PROVIDER NAME: **White oaks** **REFERRAL DATE: 4/14/2023**

First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
Section 146.220 Resident Participation Requirements: **3) If further evaluation is necessary due to the suspicion of a developmental disability or serious mental illness, the developmental disability or serious mental illness must be determined by a qualified DHS-DDD ISC agent.** **This requirement has not been met as evidenced by:** R-3 was admitted to the SLP on 8/12/2022. Resident did not have a SLP Initial Screen completed, as required, to determine that the resident can have their needs met in the SLP setting R-5 was admitted to the SLP on 8/4/2022. Resident did not have a SLP Initial Screen completed, as required, to determine that the resident can have their needs met in the SLP setting **R-7** re-admitted to SLP from SNF on 6/23/22 and R-7 did not have a SLP initial Screen assessment not completed.		

PROVIDER NAME: **White Oaks** **REFERRAL DATE: 4/14/2023**

First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.235 l) The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position, with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check. **This requirement has not been met as evidenced by:**		

PROVIDER NAME: **White Oaks** **REFERRAL DATE: 4/14/2023**

First Follow-up () Second Follow-up (

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.235 I) continues: E-1 start date 6/16/22 and the HCW Registry and the Registry Websites checks done late on 2/13/23. E-2 start date 5/24/22 and the HCW Registry and the Registry Websites checks done late on 2/14/23. E-3 start date 5/3/22 and the HCW Registry and the Registry Websites checks done late on 2/13/23. E-4 start date 3/11/22 and the HCW Registry and the Registry Websites checks done late on 2/13/23. E-5 start date 11/9/21 and the HCW Registry and the Registry Websites checks done late on 1/24/23.		

PROVIDER NAME: WHITE OAKS REFERRAL DATE: 4/21/23

FIRST FOLLOW-UP () SECOND FOLLOW-UP ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.60 staffing e) All staff who work on the unit (e.g., nurses, CNAs, housekeepers, activities staff) shall have four hours of training specific to working with persons with Alzheimer's disease or related dementia within seven days after working on the unit. The training shall include, but not be limited to, the following: 1) Information about the causes, nature, progression and management of Alzheimer's disease and another dementia. 2) Techniques for successful communication. 3) Handling behavior. 4) Planning activities. 5) Techniques for creating an environment that minimizes behavior. 6) Identifying and minimizing safety risks. 7) Delivering personal care; and 8) How to partner with families and the community. **This requirement has not been met as evidenced by:**		

PROVIDER NAME: WHITRE OAKS **REFERRAL DATE: 4/21/23**

First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.60 staffing e) continuous: E-2 was hired by the SLP on 5/25/2022 as a CNA. E-2 did not complete all required training on the following topics: Activities. E2 completed all required training late (not within the required 7 days of employment): Dementia 6/7/2022, Communication 6/6/2022, Techniques for creating an environment that minimizes behavior 6/8/2022, Identifying and minimizing safety risks 6/8/2022, Personal Care 11/21/2022, and Partnering with Others 11/14/2022. E-6 was hired on 5/3/2022 as a CNA. E-6 did not complete all required training on the following topics: Activities and Personal Care. E-6 completed the Partnering with Others training on 7/22/2022 not within 7 days of beginning employment.		

PROVIDER NAME: WHITE OAKS **REFERRAL DATE: 4/21/23**

First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.60 staffing e) continuous: E-7 was hired by the SLP on 9/20/2022. E-7 did not complete all required training on the following topics: Partnering with Others. E-7 completed the following required training late (not within the required 7 days of employment): Dementia 11/29/2022, Communication 11/30/2022, Activities 12/6/2022, Techniques for creating an environment that minimizes behavior 11/30/2022, Identifying and minimizing safety risks 12/2/2022. E-8 was hired by the SLP on 6/22/2022. E-8 did not complete all required training on the following topics: Activities, Personal Care, and Partnering with Others. E-8 completed the following required training late (not within the required 7 days of employment): Dementia 7/9/2022, Communication 7/10/2022, Techniques for creating an environment that minimizes behavior 7/10/2022, Identifying and minimizing safety risks 7/11/2022. E-9 was hired by the SLP on 12/5/2022. E-9 did not complete all required training on the following topics: Activities, Personal Care, and Partnering with Others.		

PROVIDER NAME: WHITE OAKS **REFERRAL DATE: 4/21/23**

First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.60 Staffing e) continuous: E-10 was hired by the SLP on 6/16/2022. E-10 completed the following required training late (not within the required 7 days of employment): Activities 10/27/2022, Personal Care 10/27/2022, and Partnering with Others 7/8/2022. E-11 was hired by the SLP on 6/22/2022. E-11 did not complete all required training on the following topics: Activities and Personal Care. E-11 completed the following required training late (not with the required 7 days of employment): Dementia 7/30/2022, Communication 7/30/2022, Behavior 7/30/2022, Identifying and minimizing safety risks 7/30/2022, and Partnering with Others 8/10/2022. E-12 was hired by the SLP on 9/5/2022. E-12 did not complete all required training on the following topics: Activities, Personal Care, and Partnering with Others.		

PROVIDER NAME: WHITE OKS **REFERRAL DATE: 4/21/23**

FIRST FOLLOW-UP () **SECOND FOLLOW-UP ()**

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.60 staffing e) continuous: E-13 was hired by the SLP on 8/2/2022. E-13 did not complete all required training on the following topics: Partnering with Others. E-13 completed the following required training late (not with the required 7 days of employment): Dementia 8/19/2022, Communication 8/27/2022, Behavior 9/15/2022, Activities 10/10/2022, Identifying and minimizing safety risks 9/16/2022, Personal Care 9/20/2022. E-14 was hired by the SLP on 8/15/2022. E-14 did not complete all required training on the following topics: Partnering with Others. E-14 completed the following required training late (not with the required 7 days of employment): Dementia 12/30/2022, Communication 2/8/2023, behavior 2/8/2023, Activities 2/11/2023, Identifying and minimizing safety risks 2/8/2023, and Personal Care 1/10/2023.		

PROVIDER NAME: WHITE OAKS REFERRAL DATE: 4/21/23

FIRST FOLLOW-UP () SECOND FOLLOW-UP ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	**SLP RESPONSE**	**CORRECTION DATE**
146.60 Staffing Continuous: This requirement has not been met as evidenced by: E-15 was hired by the SLP on 5/15/2022. E-15 completed the following required training late (not with the required 7 days of employment): Dementia 7/29/2022, Communication 7/29/2022, Behavior 7/29/2022, Activities 11/14/2022, Identifying and minimizing safety risks 7/29/2022, and Personal Care 7/30/2022. E-16 was hired by the SLP on 5/24/2022. E-16 did not complete all required training on the following topics: Activities, Personal Care, and Partnering with Others.		

PROVIDER NAME: WHITE OAKS **REFERRAL DATE: 4/21/2023**

First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
12 hours of in-service training regarding Alzheimer's disease and another related dementia. Training topics may include the following: 146.60 f) All staff as indicated in subsection (e) of this Section shall annually complete at least 12 hours of in-service training regarding Alzheimer's disease and other related dementia. Training topics may include the following: **This requirement has not been met as evidenced by:** E-17 was hired by the SLP on 3/18/2021. E-17 completed 9 hours of dementia training annually and did not complete at least 12 hours of training regarding Alzheimer's disease and another related dementia. E17 did not complete all required training annually on the following topics: Activities and Partnering with Others. E-18 was hired by the SLP on 6/15/2016. E-18 did not complete all required training annually on the following topics: Personal care.		

PROVIDER NAME: WHITE OAKS **REFERRAL DATE: 4/21/23**

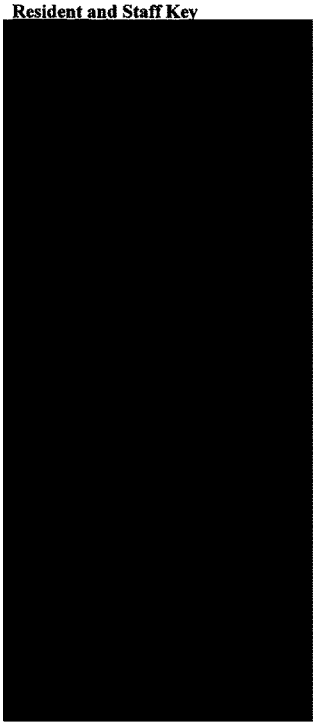
First Follow-up () Second Follow-up ()

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP provider response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (MUST INCLUDE RULE CITE)	SLP RESPONSE	CORRECTION DATE
146.60 Staffing continuous: This requirement has not been met as evidenced by: E-19 was hired by the SLP on 8/24/2021. E-19 did not complete all required training annually on the following topics: Partnering with Others. E-20 was hired by the SLP on 7/23/2019. E-20 completed 10 hours of dementia training annually and did not complete at least 12 hours of training regarding Alzheimer's disease and another related dementia. E20 did not complete all required training annually on the following topics: Activities, Personal Care, and Partnering with Others.		

Signature of SLP Provider Representative_____ Date_____

Resident and Staff Key



White Oaks at Spring Street
1300 W. Spring Street
South Elgin, IL. 60177
Phone: 847-717-3187
Fax: 847-717-3248

Date: 7/7/2023

Division of Assisted Living
Illinois Department of Public Health
525-535 West Jefferson Street
Springfield, IL. 62761-0001

[redacted]

Please accept this correspondence as the Licensee's Statement of Correction in response to Statement of Finding/Violation- Type 3 Violation (Section 295.4060) for annual survey completed on June 26, 2023.

Type 3 Violation
Section 295.4060 Alzheimer's and Dementia Programs

a) *In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act.* (Section 150(a) of the Act)

8) *Require the* manager *and direct care staff to complete sufficient comprehensive and ongoing dementia and cognitive deficit training* as set forth in subsection (i) of this Section;

11) Have a supervisor of the program with training as outlined in subsection (i)(1) of this Section.

i) Training requirements for individuals working in a special program:

1) Manager qualifications and training:

A) The manager of an establishment providing Alzheimer care or the supervisor of an Alzheimer program must be 21 years of age and have:

i) a college degree with documented course work in dementia care, plus one year of experience working with persons with dementia; or

ii) at least two years of management experience with persons with dementia.

B) The manager or supervisor must complete, in addition to the training required in subsection (i)(2) of this Section and in Section 295.3020, six hours of annual continuing education regarding dementia care.

What is the specific corrective action the establishment is taking?

E2 will maintain required dementia specific training and working towards obtaining Certified Dementia Practitioner certification. E1 will hold title of Executive Director and Memory Care Director. E1 will oversee day to day operations and E2 will directly report to E1. An in-service was conducted by Regional Director of Operations on manager qualifications and training requirements.

What are the steps that will be taken to avoid future reoccurrences?

- Regional Director of Operations to provide in-service related to IDPH regulations on manager's qualifications and training requirements.
- E1 will now hold title of Executive Director and Memory Care Director until E2 meets the qualifications as a Memory Care Director per IDPH regulations.
- E2 to continue comprehensive and ongoing dementia and cognitive deficit training including working towards obtaining Certified Dementia Practitioner certification.
- Ongoing monitoring and report through quality assurance meeting.

Specific date when the corrective action has been/will be completed.
July 28, 2023.

Sincerely,

[redacted]