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	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HI JILL'S HOUSE LLC	751 E TAMARACK TRAIL BLOOMINGTON, IN 47408

(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: January 16 and 17, 2025 Facility number: 013824 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 21, 2025.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective February 28,2025. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC and supporting documents submitted.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a minimum of one employee with a current cardiopulmonary resuscitation (CPR) and First Aid (FA) certification on each shift for 5 of 7 days reviewed . Findings include: On 1/17/25 at 10:00 a.m., the Wellness Director provided the schedule and copies of the CPR and FA certifications for the week of 1/10/25 through 1/16/25.	R 0117	=”” p=””> =”” p=””> =”” p=””> CPR and first aid class held on January 28th 2025, resulting in 22 of 25 employees being certified. Class set for March of 2025 to ensure 100% compliance. CPR and first aid classes will be scheduled every six months and PRN. The Wellness Director or designee will monitor the CPR/first	01/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shonte Halliday	Director of Operations	02/13/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The schedule indicated the following: - On 1/10/25, there were no staff members on day shift with FA. - On 1/11/25, there were no staff members on day, evening, and night shift with FA, and no staff members on evening and night shift with CPR. - On 1/12/25, there were no staff members on day, evening, and night shift with FA, and no staff members on evening and night shift with CPR. - On 1/15/25, there were no staff members on evening and night shift with FA and CPR. - On 1/16/25, there were no staff members on evening and night shift with FA and CPR. During an interview on 1/17/25 at 10:30 a.m., the Wellness Director indicated the shifts lacked any staff members with FA and CPR. On 2/8/23 at 11:10 a.m., the Wellness Director indicated they did not have a CPR and FA policy. The facility followed the state regulations.		aid binder monthly for six months and then quarterly for six months to ensure compliance with federal regulations. ="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on record review and interview, the facility failed to complete the semi-annual functional assessments/evaluations for 3 of 7 residents reviewed. (Residents 3, Resident 4, Resident 7) Findings include: 1. On 1/16/25 at 11:00 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but	R 0214	Upon audit 100% of residents were without semiannual functional assessments. 100% of semiannual functional assessment / evaluation forms completed for all residents. Auditing tool put in place for service plans/functional assessments to be monitored by	02/07/2025

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	not limited to, Alzheimer's (a brain disorder that gradually destroys memory and thinking skills) and hypertension (high blood pressure). Upon review of the clinical record, the last functional assessment/evaluation completed was on 12/8/23. The record lacked any additional functional assessments/evaluations. During an interview with the Director of Wellness on 1/17/25 at 9:18 a.m., she indicated there were no other functional assessments/evaluations for Resident 3. 2. On 1/16/25 at 11:30 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, dementia (a decline in mental abilities that affects a person's ability to perform everyday activities). Upon review of the clinical record, the last functional assessment/evaluation completed was on 9/24/24, the assessment prior was dated 9/25/23. The record lacked any additional functional assessments/evaluations. During an interview with the Director of Wellness on 1/17/25 at 9:18 a.m., she indicated there were no other functional assessments/evaluations on Resident 4.3. On 1/16/25 at 11:28 a.m., Resident 7's clinical record was reviewed. The diagnoses included, but were not limited to, coronary artery disease and hypertension. The Service/Functional Evaluation, dated 3/4/24, indicated it was an annual evaluation. The clinical record lacked a Service/Functional Evaluation semiannually.		Wellness Director or designee on a monthly basis for six months followed by quarterly for six months..	

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	During an interview on 1/17/25 at 10:44 a.m., the Wellness Director indicated clinical record lacked a Service/Functional Evaluation semiannually. On 1/17/25 at 11:30 a.m., the Wellness Director provided the facility's policy, "Resident Functional Assessment," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated ..."An evaluation of the individual needs of each resident shall be initiated prior to admission, completed post-admission and updated at least semiannually, or upon a know substantial change in the resident's condition ..."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed for 1 of 7 residents reviewed. (Resident 1) Findings include: On 1/16/25 at 10:50 a.m., Resident 1's clinical record was reviewed. The diagnosis included, but was not limited to dementia. The current service plan, dated 10/10/24, and had not been signed by the resident nor the resident's representative. During an interview on 1/16/25 at 12:00 p.m., the Wellness Director indicated the service plan for Resident 1 had not been signed. On 1/17/25 at 9:17 a.m., the Wellness Director provided the policy, "Resident Service Plan," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 7. The resident will sign and date his or her Service Plan after review and discussion,	R 0217	Upon review of all residents charts, two other charts were found without signatures. Service plan meetings continue with families 100% compliance anticipated by February 7th 2025. Auditing tool in place for signature compliance to be monitored by Wellness Director or designee on a monthly basis for six months followed by quarterly for six months.	02/28/2025

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	indicating his or her agreement with the plan ..."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure a first step tuberculin skin test was completed prior to or upon admission and a second step tuberculin skin test was completed within one to three weeks after the first step tuberculin skin test for 1 of 7 residents reviewed. (Resident 1) Finding includes: On 1/16/25 at 10:50 a.m., Resident 1's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 9/9/24. The clinical record lacked documentation of the resident's first step tuberculin skin test having been completed or documented upon admission or the second step tuberculin skin test having been completed or documented within one to three weeks after the first step tuberculin skin test. The first documented tuberculin skin test was 9/23/24. During an interview on 1/16/25 at 12:00 p.m., the Wellness Director indicated Resident 1's first step tuberculin skin test was done late and there had not been a second step done. The facility started the series over on 12/16/24, after realizing they had not completed the first and second step tuberculin skin test correctly. On 1/17/25 at 9:17 a.m., the Wellness Director provided the policy, "Resident Tuberculosis Screening," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 2. All residents	R 0410	Upon review of all residents charts, two other charts were found without signatures. Service plan meetings continue with families 100% compliance anticipated by February 7th 2025. Auditing tool in place for signature compliance to be monitored by Wellness Director or designee on a monthly basis for six months followed by quarterly for six months.	02/07/2025

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	will have a tuberculin skin test ... at the time of admission within three weeks prior to admission ... 9. If the initial Mantoux test reaction is negative, the second will be given one week to three weeks after the first test ..."			