



Midwest Insurance Group, Inc
5875 Castle Creek Parkway N Dr.,
Suite 215
Indianapolis, IN 46250

MIDWEST INSURANCE GROUP
RENEWAL EXPOSURE
VERIFICATION FORM

A) APPLICANT INFORMATION:

- 1) Legal name: HI Jills House, LLC
- 2) Address: 751 E Tamarack Trail Bloomington, IN 47408

EXPOSURE INFORMATION:



No locations have been added or removed. The number of licensed beds being insured has not changed in the last twelve (12) months



The number of licensed beds being insured at any one location has changed in the last twelve (12) months or locations have been added or deleted. Changes are detailed below.

<u>Facility Name</u>	<u>Complete Address</u>	<u>SNF Beds</u>	<u>AL Beds</u>	<u>IL Beds</u>	<u>Change/Add/ Delete</u>

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THIS RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. ATTACH ADDITIONAL SHEETS IF NECESSARY.

PLEASE INCLUDE WITH THIS APPLICATION:

- 1) FIVE YEARS OF LOSS RUNS
- 2) MOST RECENT FINANCIAL STATEMENTS
- 3) MOST RECENT STATE SURVEY

Applicant (signature):

Michael Decker

Title: Member of Manager

Date: 9/6/2024

Note: This **Application** must be signed by an authorized agent of all individuals and entities proposed for this insurance.

HI Jill's House, LLC

Balance Sheet

As of July 31, 2024

	Jul 31, 24
ASSETS	
Current Assets	
Checking/Savings	
1020005 · Cash in Bank - Farmers	5,058.01
1020003 · Cash in Bank - Payroll	20,285.77
1020002 · Escrow Account	201,257.96
Total Checking/Savings	226,601.74
Accounts Receivable	
1100100 · Accounts Receivable	-1,885.88
Total Accounts Receivable	-1,885.88
Other Current Assets	
1103005 · Inventory - Dietary	6,991.15
1102015 · Due from Pre-School	929.00
1100110 · Prepaid Expenses	12,048.92
Total Other Current Assets	19,969.07
Total Current Assets	244,684.93
Fixed Assets	
1301000 · Land	200,000.00
1301500 · Building	4,625,619.71
1301505 · Site Improvements	13,545.00
1302500 · Kitchen Equipment	131,090.98
1303000 · Furniture and Fixtures	54,752.13
1303500 · Equipment	155,455.60
1309000 · Accumulated Depreciation	-1,118,183.25
1401000 · Intangible Costs	113,140.28
Total Fixed Assets	4,175,420.45
TOTAL ASSETS	4,420,105.38
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000000 · Accounts Payable	4,122.05
Total Accounts Payable	4,122.05
Credit Cards	
2101003 · Credit Card Payable	181.83
Total Credit Cards	181.83
Other Current Liabilities	
2101011 · Deposits	1,000.00
2101040 · Accrued Management Fee	2,752.19
2012010 · Advance Due to House Investment	134,950.00
2101000 · Accrued Interest Payable	19,524.11
2101030 · Accrued Real Estate Taxes	83,475.38
Total Other Current Liabilities	241,701.68
Total Current Liabilities	246,005.56
Long Term Liabilities	
2201505 · Note Payable - Equipment	21,528.94
2201000 · Note Payable - The Farmers Bank	4,415,076.00
Total Long Term Liabilities	4,436,604.94
Total Liabilities	4,682,610.50

HI Jill's House, LLC
Balance Sheet
As of July 31, 2024

	Jul 31, 24
Equity	
3000000 · Equity Investors	344,140.98
3040301 · Equity - HI Bloomington MC	84,031.15
3040314 · Syndication Costs	-900.00
3999999 · Retained Earnings	-471,814.31
Net Income	-217,962.94
Total Equity	-262,505.12
TOTAL LIABILITIES & EQUITY	4,420,105.38

HI Jill's House, LLC
Profit & Loss
January through July 2024

	Jan - Jul 24
Ordinary Income/Expense	
Income	
4010000 · Rental Income	
4010001 · Gross Rental Income	1,317,400.00
4010002 · Less Vacancy	-384,640.77
Total 4010000 · Rental Income	932,759.23
4020000 · Other Resident Income	
4020012 · Admittance Administration Fee	6,000.00
4020011 · Respite Care	7,820.00
4020010 · Private Companion	66.92
4020001 · Activity of Daily Living	28,248.67
4020002 · Continence Management	50,583.05
4020004 · Cardio-Pulmonary Care	1,501.64
Total 4020000 · Other Resident Income	94,220.28
4020050 · Adult Day Services	34,860.00
4020065 · Rent Income - Preschool	7,000.00
4020060 · Salon Services	7,825.20
4900000 · Miscellaneous Income	-343.38
Total Income	1,076,321.33
Expense	
5000000 · General and Administrative	
5000355 · Bank Fees	564.00
5000007 · Mileage	88.71
5000010 · Management Fee	20,762.34
5000020 · Office Supplies	1,432.75
5000350 · Supplies - General	118.86
5000040 · Dues & Subscriptions	925.20
5000050 · Postage	379.96
5000060 · Website	250.00
5000070 · IT Fees	3,814.81
5000090 · Admin Allocation	17,731.00
Total 5000000 · General and Administrative	46,067.63
5001000 · Advertising & Marketing	
5001025 · Network Marketing	1,915.65
5001010 · Advertising - Employment	21,289.91
5001020 · Advertising - Promotional	1,950.00
5001030 · Marketing Material	829.66
5001040 · Marketing Consultant	24,980.88
Total 5001000 · Advertising & Marketing	50,966.10
5002000 · Legal & Professional	
5002010 · Legal	1,209.00
5002040 · Other Professional Fees	2,900.00
Total 5002000 · Legal & Professional	4,109.00
5003000 · Employee Expenses	
5003010 · Salaries & Wages	
5003011 · Administrative Wages	55,650.17
5003012 · Wellness Wages	342,042.74
5003013 · Dietary Wages	65,220.29
5003014 · Development Wages	20,554.50
5003017 · Housekeeping Wages	10,167.26
5003015 · Vacation Wages	9,767.10
5003016 · Bonus Pay	20,089.26
Total 5003010 · Salaries & Wages	523,491.32

10:25 AM

09/06/24

Accrual Basis

HI Jill's House, LLC

Profit & Loss

January through July 2024

	Jan - Jul 24
5003020 · Payroll Taxes	42,254.88
5003025 · Workers Compensation	8,753.50
5003030 · Employee Insurance	58,075.24
5005032 · Employee Gifts	2,204.22
5003035 · Payroll Processing Fee	5,215.05
5003040 · Employee Physicals	48.00
5003050 · Employee Expenses	1,952.14
5003060 · Employee Continuing Education	67.77
5003065 · Consultant - Training	6,252.44
5003066 · Outside Labor - Agency	94,329.53
5003080 · Employee Uniform	289.77
5003090 · Mobile Phone	634.77
5003100 · Employee Meals	3,773.15
Total 5003000 · Employee Expenses	747,341.78
5004000 · Utility Expense	
5004055 · Internet	2,189.67
5004010 · Electric	20,540.96
5004020 · Gas	1,480.85
5004030 · Water & Sewer	7,534.65
5004040 · Telephone	2,598.80
5004050 · Cable	1,509.27
5004060 · Trash Removal	3,124.87
Total 5004000 · Utility Expense	38,979.07
5005000 · Resident Expenses	
5005072 · Medical Director	800.00
5005037 · Salon Services	8,182.00
5005073 · Pharmacy Consulting	1,401.00
5005010 · Dietary - Raw Food	56,022.91
5005015 · Dietary - Supplies	1,852.17
5005020 · Dietary Disposables	2,447.27
5005022 · Allocated Costs - Meals	-11,168.93
5005025 · Dietary - Consultant	2,254.90
5005028 · Fuel Surcharge	107.00
5005035 · Resident Services	63.60
5005050 · Activities - Supplies	478.74
5005055 · Activities - Meals	26.69
5005060 · Activities - Entertainment	684.01
5005070 · Medical Supplies	1,525.68
5005071 · PPE Supplies	1,061.15
5005080 · Travel	1,186.63
Total 5005000 · Resident Expenses	66,924.82
5006000 · Repairs and Maintenance	
5006010 · Housekeeping Supplies	4,139.09
5006015 · Maintenance Supplies	526.62
5006030 · Exterminating	1,703.14
5006035 · Landscaping	1,670.94
5006040 · Snow Removal	1,070.00
5006045 · Cleaning	5,750.00
5006055 · Laundry Chemicals	1,185.78
5006060 · R&M - Units	2,683.42
5006065 · R&M - HVAC	4,347.58
5006070 · R&M - Kitchen	3,288.33
5006075 · R&M - Building	4,913.88
5006080 · R&M - Plumbing	5,267.88
5006085 · R&M - Flooring	4,064.97
5006095 · R&M - Fire/Sprinkler	3,987.27
5006100 · R&M - Laundry	79.95
5006105 · R&M - Elevator	1,914.61
Total 5006000 · Repairs and Maintenance	46,593.46

HI Jill's House, LLC
Profit & Loss
January through July 2024

	Jan - Jul 24
5007000 · Property Expense	
5007010 · Real Estate Taxes	49,000.00
5007020 · Personal Property Taxes	991.59
5007030 · Insurance	8,121.75
Total 5007000 · Property Expense	58,113.34
5008000 · Depreciation & Amortization	
5008010 · Depreciation	84,875.00
5008020 · Amortization	15,169.00
Total 5008000 · Depreciation & Amortization	100,044.00
Total Expense	1,159,139.20
Net Ordinary Income	-82,817.87
Other Income/Expense	
Other Expense	
5009000 · Other Expense	
5009010 · Interest Expense	135,145.07
Total 5009000 · Other Expense	135,145.07
Total Other Expense	135,145.07
Net Other Income	-135,145.07
Net Income	-217,962.94

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

PRINTED: 05/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2024	
NAME OF PROVIDER OR SUPPLIER HI JILL'S HOUSE LLC				STREET ADDRESS, CITY, STATE, ZIP COD 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: April 2 and 3, 2024 Facility number: 013824 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 5, 2024.			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 April, 24,2024. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the POC and supporting documents submitted.		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Shonte Halliday

Director of Operations

04/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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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	occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to ensure a notice was posted of the availability of the most recent annual State survey, the survey book maintained the most recent annual survey and, the last two	R 0090	/p> Based on observation, interview, and record review, the facility failed to ensure a notice was posted of the availability of the most recent annual State	04/16/2024			

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	years of surveys for 1 of 2 days of the survey. Findings include: On 4/2/24 at 11:37 a.m., during an initial tour of the facility, the State survey book was located in the foyer area desk drawer. The survey book did not contain the most recent annual survey or the last two years of surveys. A sign alerting residents to where the most recent survey book was located was not observed. During an interview on 4/2/24 at 11:37 a.m., the Director of Operations (DOO) indicated there was no sign alerting residents to where the State survey book was located, the most recent annual survey was not in the book nor the last two years of surveys. She believed a resident may have gone through the book and removed some pages. During an interview on 4/3/24 at 11:20 a.m., the DOO indicated they facility did not have a policy related to a sign which indicated where the most recent State survey book was located or keeping the most recent annual survey and the last two years of surveys in the book. The DOO indicated the facility followed the State rules.				survey, the survey book maintained the most recent annual survey and, the last two years of surveys for 1 of 2 days of the survey. Findings include: On 4/2/24 at 11:37 a.m., during an initial tour of the facility, the State survey book was located in the foyer area desk drawer. The survey book did not contain the most recent annual survey or the last two years of surveys. A sign alerting residents to where the most recent survey book was located was not observed. During an interview on 4/2/24 at 11:37 a.m., the Director of Operations (DOO) indicated there was no sign alerting residents to where the State survey book was located, the most recent annual survey was not in the book nor the last two years of surveys. She believed a resident may have gone through the book and removed some pages. During an interview on 4/3/24 at 11:20 a.m., the DOO indicated		

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					they facility did not have a policy related to a sign which indicated where the most recent State survey book was located or keeping the most recent annual survey and the last two years of surveys in the book. The DOO indicated the facility followed the State rules. 1. Corrective action taken: Survey binder immediately updated and framed sign placed above drawer containing survey binder to notify all of it's location. 2. How other residents were identified: Survey binder corrected and replaced immediately and monitoring put into place. See attached monitoring form. 3. Measure in place/system changes: The Director of Operations or designee will monitor compliance of R 090 by auditing placement of survey binder weekly times 4 weeks and then monthly X 11 months. See attached monitoring tool. 4. Monitoring of Corrective actions		

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

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure staff disposed of expired foods by the expiration date in 1 of 2 kitchen observations. Findings include: On 4/2/24 at 10:20 a.m., initial kitchen tour was completed with Cook 1. Six cartons of heavy whipping cream were observed in the refrigerator with an expiration date of 3/26/24. Cook 1 indicated they were expired and they should have been thrown out. Cook 1 was observed to throw away the 6 cartons of heavy whipping cream. On 4/3/24 at 11:30 a.m., the Facility Director indicated the facility used the State Health Department regulations regarding food storage.			R 0273	taken: Compliance of R 090 will be reviewed during management meeting weekly X 4 weeks and then monthly X 11 months. 5. Date of compliance: 04/16/2024 ===== R 273 Food and Nutritional Services Based on observation and interview, the facility failed to ensure staff disposed of expired foods by the expiration date in 1 of 2 kitchen observations. Findings include: On 4/2/24 at 10:20 a.m., initial kitchen tour was completed with Cook 1. Six cartons of heavy whipping cream were observed in the refrigerator with an expiration date of 3/26/24. Cook 1 indicated they were expired and they should have been thrown out. Cook 1 was observed to throw away the 6 cartons of heavy whipping cream. On 4/3/24 at 11:30 a.m., the Facility Director indicated the facility used the State Health Department		05/07/2024

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					regulations regarding food storage. 1. Correction Action taken: Regarding the expired 6 cartons of heavy whipping cream found in the kitchen on 04/02/2024. Dietary staff immediately disposed of expired products. Dietary staff was inserviced on monitoring for and disposing of expired products. On 4/3/24 the facility director indicated the facility use the state health department regulations regarding food storage. See attached inservice, monitoring tool and policy 2. How other residents were identified: All refrigerated products in kitchen were inspected for expiration date on 4/2/24 with no other items noted to be expired. See attached inspection on 4/2/24. 3. Measures in place/system changes: The registered Dietitian, Certified Dietary Manager or designee will monitor compliance of R 273 by auditing 100% of refrigerated items in the facility kitchen monthly for 6 months and then quarterly for 6 months and random checks performed weekly X 4 weeks and then quarterly.. 4. Monitoring of corrective actions taken: Compliance of R 273 will be reviewed by the management meeting monthly. See attached monitoring tool and policy. 5. Date of Compliance: May 7, 2024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2024	
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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 infection control practices for 1 of 5 residents observed for medication administration. A staff member administered medication to a resident after it was dropped on the floor. (RN 1, Resident 9) Findings include: On 4/3/24 at 12:05 p.m., RN 1 was observed to prepare isosorbide dinitrate (a medication used to prevent chest pain) for Resident 9. RN 1 dropped the pill on the ground and the pill rolled approximately 5 feet before coming to a stop. RN 1 was observed to give the medication, which fell to the floor, and the resident swallowed the pill. During an interview on 4/3/24 at 12:10 p.m., RN 1 indicated she wondered if she should have given the pill to the resident. However, she indicated she would have to throw away a lot of medication if she disposed of every pill that fell to the ground. On 4/3/24 at 12:11 p.m., Resident 9's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and hypertension. A physician's order, dated 8/24/23, indicated the resident was prescribed isosorbide dinitrate 20 milligrams, three times a day.			R 0406	R 406 Infection Control-Offense Based on observation, interview, and record review, the facility failed to maintain infection control practices for 1 of 5 residents observed for medication administration. A staff member administered medication to a resident after it was dropped on the floor. (RN 1, Resident 9) Findings include: On 4/3/24 at 12:05 p.m., RN 1 was observed to prepare isosorbide dinitrate (a medication used to prevent chest pain) for Resident 9. RN 1 dropped the pill on the ground and the pill rolled approximately 5 feet before coming to a stop. RN 1 was observed to give the medication, which fell to the floor, and the resident swallowed the pill. During an interview on 4/3/24 at 12:10 p.m., RN 1 indicated she wondered if she should have given the pill to the resident. However, she indicated she would have to throw away a lot of medication if she disposed of every pill that fell to the ground. On 4/3/24 at 12:11 p.m., Resident 9's clinical record was reviewed. The diagnoses		05/07/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2024	
NAME OF PROVIDER OR SUPPLIER HI JILL'S HOUSE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 751 E TAMARACK TRAIL BLOOMINGTON, IN 47408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 4/3/24 at 12:12 p.m., the Director of Operations indicated RN 1 should have disposed of the medication and not administered it to the resident. She further indicated the facility did not have a policy in regard to disposal of medications dropped on the ground.				included, but were not limited to, dementia and hypertension. A physician's order, dated 8/24/23, indicated the resident was prescribed isosorbide dinitrate 20 milligrams, three times a day. During an interview on 4/3/24 at 12:12 p.m., the Director of Operations indicated RN 1 should have disposed of the medication and not administered it to the resident. She further indicated the facility did not have a policy in regard to disposal of medications dropped on the ground. 1: Corrective Action Taken: Regarding Resident 9, the Registered Nurse (RN) one (1) was in-serviced on the Infection Control policy and Medication Management policy. 2. How other residents were identified: There were no other residents identified. All registered and licensed nurses and QMA's were in-serviced on the facility Infectious Processes and Medication Management policies. See attached documentation if staff in-service and policies. 3. Measures in place/system changes: The Wellness Director/designee will monitor compliance of R 406 per the facility Medication Management Policy and Infectious Processes policy. Medication administration		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED
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 04/03/2024	
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					and management audits will be conducted weekly X 4 weeks on 4 residents and monthly X 4 months on 4 residents. See attached monitoring and audit tool. 4. Monitoring of corrective actions taken: Monitoring of R 406 will be reviewed by the management meeting weekly X 4 weeks and then monthly X 4 months. 5. Date of Compliance: 05/07/2024		



**Indiana
Department
of
Health**



Eric J. Holcomb
Governor

Lindsay M. Weaver, MD, FACEP
State Health Commissioner

May 3, 2024

Provider No:
State ID #: 013824

Shonte Halliday
Hi Jill's House Llc
751 E Tamarack Trail
Bloomington, IN 47408

RE: Hi Jill's House Llc - 751 E Tamarack Trail, Bloomington
Survey Event ID: 6NE511 - Re-Licensure

This letter is to notify you that the Plan of Correction (POC) for the survey completed on April 3, 2024, at subject facility, was approved on May 1, 2024. A revisit may be scheduled to verify correction of the deficiencies.

If you have any questions, please contact the following:

Area 9 Team B - Anna Baker
Surveyor Supervisor
Long Term Care Division
Indiana Department of Health
PHONE: 317/233-7442 or FAX: 317/233-7322

cc: 013824 File

To promote, protect, and improve the health and safety of all Hoosiers.

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R 090- Administration and Management

Based on observation, interview, and record review, the facility failed to ensure a notice was posted of the availability of the most recent annual State survey, the survey book maintained the most recent annual survey and, the last two years of surveys for 1 of 2 days of the survey.

Findings include:

On 4/2/24 at 11:37 a.m., during an initial tour of the facility, the State survey book was located in the foyer area desk drawer. The survey book did not contain the most recent annual survey or the last two years of surveys. A sign alerting residents to where the most recent survey book was located was not observed.

During an interview on 4/2/24 at 11:37 a.m., the Director of Operations (DOO) indicated there was no sign alerting residents to where the State survey book was located, the most recent annual survey was not in the book nor the last two years of surveys. She believed a resident may have gone through the book and removed some pages.

During an interview on 4/3/24 at 11:20 a.m., the DOO indicated they facility did not have a policy related to a sign which indicated where the most recent State survey book was located or keeping the most recent annual survey and the last two years of surveys in the book. The DOO indicated the facility followed the State rules.

1. Corrective action taken: Survey binder immediately updated and framed sign placed above drawer containing survey binder to notify all of it's location.

2. How other residents were identified: Survey binder corrected and replaced immediately and monitoring put into place. See attached monitoring form.

3. Measure in place/system changes: The Director of Operations or designee will monitor compliance of R 090 by auditing placement of survey binder weekly times 4 weeks and then monthly X 11 months. See attached monitoring tool.

4. Monitoring of Corrective actions taken: Compliance of R 090 will be reviewed during management meeting weekly X 4 weeks and then monthly X 11 months.

5. Date of compliance: 04/16/2024

R 273 - Food and Nutritional Services.

Based on observation and interview, the facility failed to ensure staff disposed of expired foods by the expiration date in 1 of 2 kitchen observations.

Findings include:

On 4/2/24 at 10:20 a.m., initial kitchen tour was completed with Cook 1. Six cartons of heavy whipping cream were observed in the refrigerator with an expiration date of 3/26/24. Cook 1 indicated they were expired and they should have been thrown out. Cook 1 was observed to throw away the 6 cartons of heavy whipping cream.

On 4/3/24 at 11:30 a.m., the Facility Director indicated the facility used the State Health Department regulations regarding food storage.

1. Correction Action taken: Regarding the expired 6 cartons of heavy whipping cream found in the kitchen on 04/02/2024. Dietary staff immediately disposed of expired products. Dietary staff was inservice on monitoring for and disposing of expired products. On 4/3/24 the facility director indicated the facility use the state health department regulations regarding food storage. See attached inservice, monitoring tool and policy

2. How other residents were identified: All refrigerated products in kitchen were inspected for expiration date on 4/2/24 with no other items noted to be expired. See attached inspection on 4/2/24.

3. Measures in place/system changes: The registered Dietitian, Certified Dietary Manager or designee will monitor compliance of R 273 by auditing 100% of refrigerated items in the facility kitchen monthly for 6 months and then quarterly for 6 months and random checks performed weekly X 4 weeks and then quarterly..

4. Monitoring of corrective actions taken: Compliance of R 273 will be reviewed by the management meeting monthly. See attached monitoring tool and policy.

5. Date of Compliance: May 7, 2024
R 406 Infection Control-Offense

Based on observation, interview, and record review, the facility failed to maintain infection control practices for 1 of 5 residents observed for medication administration. A staff member administered medication to a resident after it was dropped on the floor. (RN 1, Resident 9) Findings include: On 4/3/24 at 12:05 p.m., RN 1 was observed to prepare isosorbide dinitrate (a medication used to prevent chest pain) for Resident 9. RN 1 dropped the pill on the ground and the pill rolled approximately 5 feet before coming to a stop. RN 1 was observed to give the medication, which fell to the floor, and the resident swallowed the pill. During an interview on 4/3/24 at 12:10 p.m., RN 1 indicated she wondered if she should have given the pill to the resident. However, she indicated she would have to throw away a lot of medication if she disposed of every pill that fell to the ground. On 4/3/24 at 12:11 p.m., Resident 9's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and hypertension. A physician's order, dated 8/24/23, indicated the resident was prescribed isosorbide dinitrate 20 milligrams, three times a day. During an interview on 4/3/24 at 12:12 p.m., the Director of Operations indicated RN 1 should have disposed of the medication and not administered it to the resident. She further indicated the facility did not have a policy in regard to disposal of medications dropped on the ground.

1: Corrective Action Taken: Regarding Resident 9, the Registered Nurse (RN) one (1) was in-serviced on the Infection Control policy and Medication Management policy.

2. How other residents were identified: There were no other residents identified. All registered and licensed nurses and QMA's were in-serviced on the facility Infectious Processes and Medication Management policies. See attached documentation if staff in-service and policies.

3. Measures in place/system changes: The Wellness Director/designee will monitor compliance of R 406 per the facility Medication Management Policy and Infectious Processes policy. Medication administration and management audits will be conducted weekly X 4 weeks on 4 residents and monthly X 4 months on 4 residents. See attached monitoring and audit tool.

4. Monitoring of corrective actions taken: Monitoring of R 406 will be reviewed by the management meeting weekly X 4 weeks and then monthly X 4 months.

5. Date of Compliance: 05/07/2024