

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 05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 6 & 7, 2015</p> <p>Facility number: 013264 Provider number: 013264 AIM number: N/A</p> <p>Census bed type: Residential: 73 Total: 73</p> <p>Census payor type: Other: 73 Total: 73</p> <p>Sample: 10</p> <p>These deficiencies reflect stae findings cited in accordance with 410 IAC 16.2-5.</p>	R 000	<p>This plan of correction is neither an agreement of wrong doing by this facility or its staff member. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of 5/12/15 and request paper compliance of this survey.</p>	
R 147 Bldg. 00	<p>410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities.</p> <p>Based on interview and record review, the facility failed to conduct a fire and disaster drill at least every six months in</p>	R 147	<p>Avon Fire Marshall was notified of ISDH regulation on 5/6/15 at 12:44pm. Drill was performed on 5/12/15 with Avon Fire</p>	05/12/2015

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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 A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/07/2015	
NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R 151	<p>conjunction with the local fire department. This deficient practice had the potential to affect 73 of 73 residents residing in the facility.</p> <p>Findings include:</p> <p>A document entitled, "Fire Drill Schedule," provided by the Clinical Consultant on 5/6/15 at 11:00 a.m., was reviewed on 5/6/15 at 11:12 a.m. The document did not include information that indicated the local fire department had been involved in the facilities fire drills over the last year.</p> <p>During an interview on 5/6/15 at 12:51 p.m., the Clinical Consultant indicated the facility did not involve the fire department in fire drills as required.</p> <p>A fire drill policy was requested on 5/6/15 at 12:51 p.m. The Clinical Consultant indicated the facility used the State guidelines as their policy related to fire safety.</p> <p>410 IAC 16.2-5-1.5(h)</p>		<p>Department. (See Attachment A) Fire Drill will be scheduled at a minimum of every 6 months with Avon Fire Department. Maintenance Director is responsible for scheduling.</p>				

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 05/07/2015	
NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123			
(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			
Bldg. 00	<p>Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.</p> <p>Based on record review and interview, the facility failed to ensure a resident's dog had a current Rabies vaccination for 1 of 3 pet vaccination records reviewed. (Resident #13).</p> <p>Findings include:</p> <p>The facility's pet vaccination records were reviewed on 5/6/15 at 1:00 p.m. The Rabies Vaccination Certificate, dated 4/21/14, indicated Resident #13's dog received a Rabies vaccine on 4/21/14 and the next vaccination was due by 4/21/15.</p> <p>During an interview on 5/7/15 at 11:12 a.m., the Director of Nursing (DON) indicated Resident #13's dog was in need of a current Rabies vaccination. The DON indicated the resident's dog currently resided in the facility and an appointment had been scheduled for the dog's vaccination.</p> <p>During an interview on 5/7/15 at 2:55 p.m., the General Manager (GM) indicated Resident #13's pet vaccination expired on 4/21/15. The GM indicated the resident's dog currently resided in the</p>	R 151	Appointment was scheduled 5/7/15 for pet vaccinations regarding pet belonging to Resident #13. Vaccinations were complete and updated records provided to business office. (See Attachment B) Vaccination book organized by month for pets residing in the community. Business Office Manager to maintain and monitor for upcoming vaccination deadlines. Vaccination due dates to be checked monthly throughout the year.	05/08/2015			

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 05/07/2015	
NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R 273 Bldg. 00	<p>facility and an appointment had been scheduled for the dog's vaccination.</p> <p>The corporate consultant provided the current pet policy on 5/6/15 at 12:00 p.m. The pet policy indicated the resident's pets were required to have annual vaccinations.</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure frozen foods were stored at zero degrees Fahrenheit or below for 2 of 2 observations. This deficient practice had the potential to affect 73 of 73 residents who consumed food from the facility kitchen.</p> <p>Findings include: On 5/6/15 at 10:05 a.m. and 11:31 a.m.,</p>	R 273	<p>Contacted service provider on 5/6/15. They came out that day and made adjustments to the thermostat. On 5/7/15, thermostat still registered an inappropriate temperature. Service provider was contacted again and they came out on 5/7/15 and replaced the thermostat. (See Attachment C) Food Service Director (Executive Chef) instructed on 5/21/15 on the need to call service providers immediately when temperatures are not within compliance. (See Attachment D) Temperatures are being</p>	05/08/2015			

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 05/07/2015	
NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123			
(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			
	<p>the executive chef (EC) indicated the temperature of the walk-in freezer was 10 degrees Fahrenheit according to the thermometer inside the freezer. The EC indicated the temperature of the walk-in freezer was 8 degrees Fahrenheit according to the thermometer on the outside of the freezer.</p> <p>On 5/6/15 at 1:20 p.m., the EC indicated the temperature of the walk-in freezer was 9 degrees Fahrenheit according to the thermometer inside the freezer. Frozen food was observed for solid frozen state including but not limited to the following: frozen French fries, frozen mixed vegetables, pork loin, individual beef patties, bagged ice, 2 pint sized ice cream containers, and individual serving ice creams. The 2 pint sized ice cream containers and the individual serving ice creams were observed to be soft to the touch.</p> <p>The Temperature Record for the walk-in freezer provided by the executive chef, on 5/6/15 at 12:51 p.m., indicated the walk-in freezer temperature was above zero degrees Fahrenheit on the following dates:</p> <ol style="list-style-type: none"> January 1 & 2, 2015 January 6 -11, 2015 January 13 -28, 2015 February 1 -28, 2015 		monitored daily and continue to remain in compliance. Daily monitoring to continue throughout the year by Food Service Director or designee. If temperature is not in compliance first thing in the morning, service provider to be contacted that day to service.				

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 05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123
---	--

(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
	<p>e. March 1-31, 2015 f. April 7-10, 2015 g. April 12-23, 2015</p> <p>During an interview on 5/6/15 at 11:32 a.m., the Executive Chef (EC) indicated the walk-in freezer temperature often read 10 degrees Fahrenheit.</p> <p>During an interview on 5/6/15 at 12:45 p.m., the EC indicated he was aware the walk-in freezer temperature had not been 0 degrees Fahrenheit or below consistently since January 2015. He indicated the walk-in freezer had not been serviced since January. He indicated he was aware the temperature was supposed to be 0 degrees Fahrenheit or below according to the state rules.</p> <p>On 5/6/15 at 1:40 p.m., the Corporate Consultant indicated the Temperature Record was the facility's current policy for freezer temperatures. The Temperature Record indicated the walk-in freezer temperature should be below negative 3 degrees Fahrenheit.</p> <p>Section 197 of the Indiana "Retail Food Establishment Sanitation Requirements," dated 11/13/04, indicated frozen food should remain frozen and be stored at a temperature of zero degrees Fahrenheit.</p>			

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

PRINTED: 06/01/2015
FORM APPROVED
OMB NO. 0938-0391

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 05/07/2015
NAME OF PROVIDER OR SUPPLIER REAGAN PARK SENIOR LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123		
(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	