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 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN	98 NORTH 10TH STREET GREENCASTLE, IN 46135

(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 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Date of survey: 11/19/15 Facility number: 013322 Provider number: 013322 AIM number: N/A Census bed type Residential: 48 Total: 48 Census payor type: Other: 48 Total: 48 Sample: 16 These state findings are cited in accordance with IAC 16.2-5. Quality review completed November 23, 2015 by 29479.	R 0000		
R 0055 Bldg. 00	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	(2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on observation, interview, and record review, the facility failed to ensure privacy when administering medications for 6 of 7 residents reviewed for privacy during medication administration (Residents #7, #8,#9,#10,#11, and #12). Finding includes: On 11/19/15 during the noon medication pass the following was observed: a). LPN #1 administered three tablets to Resident #8 in the dining room while she was seated at the dining room table with other residents. b). LPN #1 administered one tablet to Resident # 9 in the dining room as she was seated at her table during noon meal time. c). LPN #1 administered two tablets and an eye drop to Resident #10 in the dining room as she was seated at the table during noon meal time. d). LPN #1 administered four tablets to Resident #7 in the dining room as he was seated at the table during noon meal time. e). LPN #1 administered four tablets to	R 0055	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Autumn Glen as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. R 055 Residents' Rights**	12/18/2015

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	Resident #11 in the dining room as she was seated at the table during noon meal time. f). LPN #1 administered two tablets to Resident #12 in the dining room as he was seated at the table during noon meal time. During an interview on 11/19/15 at 2:10 p.m., Resident #13 indicated the nurses administer medications in the dining room daily. A undated policy, identified as current, titled, "Residential Residents Rights", provided by the Director of Nursing on 11/19/15 at 1:36 p.m., indicated,"...Privacy shall be afforded for bathing, personal care, physical examinations, and treatments, and visitations, at a minimum...."		**Deficiency** 1. All residents with **oral** medication(s) prescribed during general meal times will be visited and offered to sign a MEAL—TIME MEDICATION PRIVACY WAIVER or cease to receive **oral** medication in the main dining room. Per facility Medication Administration Policy, all residents who wish to not receive medications in the main dining room at meal time shall receive them in their apartment prior to or following meal time, pending individual preference. 2. Upon admission, an Autumn Glen employee will review this policy with the new resident and/or his/her responsible party to educate him/her on his/her right to privacy and the availability of meal-time medications being provided in his/her apartment. He/she will also be educated on his/her right to waive said privacy by completing a MEAL-TIME MEDICATION PRIVACY WAIVER, **which pertains only to oral, meal-time medications**, should he/she wish to do so. 3. Implement new Medication Administration Policy. A review of the facility Medication Administration Policy will become part of the clinical admission process with applicable form presented upon resident's request. All nursing personnel will be in-serviced on new practice. 4. The Director of Nursing or designee will complete	

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			audit of med pass administration in the dining room weekly for four (4) weeks and then monthly until the next survey. 5. Date of systematic change complete: 12-18-15	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure 1 of 5 employees' files reviewed had criminal background screening upon hire. This deficient practice had the potential to affect 48 out of 48 residents residing in the facility. Finding includes: Employee records were reviewed on 11/19/15 at 1:30 p.m. Certified Nurse Aide (CNA) #2 ' s employee file did not indicate a criminal background screen was completed prior to her employment which began on 7/23/15. On 11/19/15 at 3:10 p.m., the daily nursing schedules from 11/08/15 to 11/19/15 were reviewed. The schedule indicated CNA #2 had worked on	R 0116	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Autumn Glen as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any**	12/02/2015

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	November 9, 11, 13, 14, 15, and 16, 2015. During an interview, on 11/19/15 at 2:45 p.m., the Business Director indicated she did not have a record of CNA #2's background screening prior to employment or since hire. She further indicated employees were to have background screening upon hire per the State regulations. The Business Director indicated the employee background screening task had been overlooked. The Business Director indicated she had ordered a background screening as of 11/19/15 at 2:04 p.m. An undated policy, identified as current, titled, "Background Investigation Policy," provided by the Business Director on 11/19/15 at 3:00 p.m., indicated, " ...each applicant or employee selected for employment will have a criminal background check performed .... "		**corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.** **R 116 Personnel - Noncompliance** 1. The one (1) employee in question has now been screened according to our normal procedure and found to have a clear criminal record. This employee did not report to work between the time of the finding and the completion of the background screen. 2. All employee files have been audited and found to be in compliance with State Regulations. 3. Criminal background screen and drug screen will be added to facility orientation checklist. 4. Administrator will audit all new employee files to ensure compliance until next survey. 5. Date of systematic change complete: 12-2-15	
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			

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	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 interview and record review, the facility failed to ensure transfer information was completed for 1 of 1 closed record reviewed for discharge information (Resident #6). Finding includes: Resident #6's closed clinical record was reviewed on 11/19/15 at 1:15 p.m. The record included information that the resident had discharged to another Assisted Living facility. Documentation of where the resident went or information regarding assessments of the resident, medical conditions, or physician's orders was not included. The Director of Nursing (DON) was interviewed on 11/19/15 at 1:30 p.m., She indicated she was not aware of what information had been sent with the	R 0354	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Autumn Glen as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding**	12/18/2015

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	resident, or where she had transferred to. On 11/19/15 at 1:36 p.m., the DON provided a document, dated 2/2013 and titled, "Notice of Transfer or Discharge." She indicated this was the form used to provide information to residents upon discharge. The document identified where residents were discharged to, the reason for transfer or discharge, and the facility's bed hold policy and appellate rights. The DON indicated she was unable to locate a "Notice of Transfer or Discharge" document for Resident #6.		**on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. R 354 Clinical Records - Noncompliance** 1. Administrator will contact resident's family and resident to ensure all belongings arrived at new domicile and resident is happily situated and not in emotional distress. 2. Director of Nursing or designee will audit resident charts to ensure all other resident transfers were conducted in a compliant manner. **Using the TRANSFER OF RESIDENT WORKSHEET, the transferring nurse on duty at the time of the transfer will certify all pertinent information was communicated to resident's new domicile and document the same in the resident's chart.** 3. Administrator will implement new *Resident Inventory* tool, to be completed by new residents or responsible parties upon admission and as needed during residency. All nursing personnel will be in-serviced on the process of resident transfers from the facility, regardless of new location and/or resident level of	

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			independence. 4. Director of Nursing will audit all resident transfers until next survey, **certifying by signing off on TRANSFER OF A RESIDENT WORKSHEET.** 5. Date of systematic change complete: 12-18-15	