STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135, GREENWOOD, , 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: November 8 and 9, 2021 Facility number: 005722 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on November 12, 2021.	R 0000	000 The submission of this Plan of Correction does not indicate an admission by Independence Village of Greenwood that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Independence Village of Greenwood. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the credible allegation of compliance with all sate requirements governing the operations of this community. Independence Village of Greenwood respectfully	

			requests a desk review for paper compliance.	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (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 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 interview and record review, the facility failed to	R 0092	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that other residents could have the potential to be affected by the alleged deficient practice. 3. The Executive Director reviewed with the Maintenance Director the Fire Drill Procedure that clearly delineates the required frequency of drills and the Responsibility to conduct the drills. In addition, a scheduled was developed for the remainder or 2021 and 2022 that ensures quarterly drills reflective on each shift. 4. The monthly Safety Committee will review all drills to ensure the schedule is being maintained and make any necessary recommendations/adjustments at that time.	11/23/2021

conduct quarterly fire drills for all three shifts at random times and locations quarterly to familiarize all facility personnel and residents with signals and emergency actions under varied conditions, for the previous twelve months.

Findings include:

On 11/9/21 at 9:45 a.m., the facility provided the following fire drill records for the previous 10-month period.

The following fire drills were conducted on the day shift and were completed in the service hallway which was located in a separate area of the facility, away from resident care areas:

10/22/21 at 1:00 p.m.

9/23/21 at 1:00 p.m.

8/26/21 at 1:00 p.m.

7/7/21 at 1"00 p.m.

6/28/21 at 1:00 p.m.

5/5/21 at 1:00 p.m.

4/26/21 at 1:00 p.m.

3/26/21 at 1:00 p.m.

2/26/21 at 1:00 p.m.

1/22/21 at 1:00 p.m.

12/18/20 at 1:00 p.m.

	The following fire drills were conducted on the night shift and were completed in the service hallway which was located in a separate area of the facility, away from resident care areas: 10/21/21 at 1:00 a.m. 9/22/21 at 1:00 a.m. 8/25/21 at 1:00 a.m. 7/8/21 at 1:00 a.m. 6/26/21 at 1:00 a.m. 5/6/21 at 1:00 a.m. 4/27/21 at 1:00 a.m. 3/27/21 at 1:00 a.m. 2/26/21 at 1:00 a.m. 1/23/21 at 1:00 a.m. 12/18/20 at 1:00 a.m. The facility fire drill documentation lacked quarterly drills for the evening shift. And lacked documentation of various times and locations for the drills to have occurred on a quarterly basis. During an interview, on 11/9/21 at 10:30 a.m., the Administrator indicated she was uncertain how often fire drills were to be conducted. During an interview, on 11/9/21 at 11:20 a.m., the			

Environmental Director (ED) indicated the facility was to conduct a fire drill once a month. He was unaware of the need to conduct one drill on each of the three shifts once quarterly with varied times and locations.

On 11/9/21 at 11:30 a.m., the Administrator provided a copy of their Fire Drill procedure, dated 9/22/17, and indicated it was the current policy being used by the facility. A review of the policy indicated, " ...Times, scenarios, and locations for drills should vary to achieve the purpose of evaluating functionality, readiness and capabilities in all conditions."

Based on interview and record review, the facility failed to conduct quarterly fire drills for all three shifts at random times and locations quarterly to familiarize all facility personnel and residents with signals and emergency actions under varied conditions, for the previous twelve months.

Findings include:

On 11/9/21 at 9:45 a.m., the facility provided the following fire drill records for the previous 10-month period.

The following fire drills were conducted on the day shift and were completed in the service hallway which was located in a

	separate area of the facility, away from resident care areas: 10/22/21 at 1:00 p.m. 9/23/21 at 1:00 p.m. 8/26/21 at 1:00 p.m. 7/7/21 at 1"00 p.m. 6/28/21 at 1:00 p.m. 5/5/21 at 1:00 p.m. 4/26/21 at 1:00 p.m. 3/26/21 at 1:00 p.m. 2/26/21 at 1:00 p.m. 1/22/21 at 1:00 p.m. 12/18/20 at 1:00 p.m. The following fire drills were conducted on the night shift and were completed in the service hallway which was located in a separate area of the facility, away from resident care areas: 10/21/21 at 1:00 a.m. 9/22/21 at 1:00 a.m. 8/25/21 at 1:00 a.m. 7/8/21 at 1:00 a.m. 6/26/21 at 1:00 a.m. 5/6/21 at 1:00 a.m.			

	4/27/21 at 1:00 a.m. 3/27/21 at 1:00 a.m. 2/26/21 at 1:00 a.m. 1/23/21 at 1:00 a.m. 12/18/20 at 1:00 a.m. The facility fire drill documentation lacked quarterly drills for the evening shift. And lacked documentation of various times and locations for the drills to have occurred on a quarterly basis. During an interview, on 11/9/21 at 10:30 a.m., the Administrator indicated she was uncertain how often fire drills were to be conducted. During an interview, on 11/9/21 at 11:20 a.m., the Environmental Director (ED) indicated the facility was to conduct a fire drill once a month. He was unaware of the need to conduct one drill on each of the three shifts once quarterly with varied times and locations. On 11/9/21 at 11:30 a.m., the Administrator provided a copy of their Fire Drill procedure, dated 9/22/17, and indicated it was the current policy being used by the facility. A review of the policy indicated, " ...Times, scenarios, and locations for drills should vary to achieve the purpose of			

	evaluating functionality, readiness and capabilities in all conditions."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (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	R 0121	1. No residents were affected by the alleged deficient practice. 1st and 2nd step TB testing has been completed for Culinary Aide #1. 2. The Community realizes that all residents could have been affected by the alleged deficient practice. 3. An audit of the employee files 1st and 2nd step TB testing has been completed at this time. 4. The Executive Director/designee will conduct an audit of new employees to ensure completion of TB testing weekly times 4 weeks; monthly times 5 months until compliance is achieved. All findings will be forwarded to the QA Committee.	11/23/2021

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 interview and record review, the facility failed to ensure an employee had completed a tuberculin (Tb) skin test prior to resident contact for 1 of 5 employees reviewed for pre-employment screening. (Dietary Server 1)

Findings include:

On 11/9/21 at 9:25 a.m., the employee record of Dietary Server 1 was reviewed. Dietary Server 1 was hired on 10/24/21. Dietary Server 1 had not completed a Tuberculin (Tb) skin test (tuberculosis is a highly contagious respiratory bacterial disease) prior to contact with the residents.

During an interview, on 11/9/21 at 12:02 p.m., the Administrator indicated this employee had not completed their pre-employment

Tb screen.

During an interview, on 11/9/21 at 12:05 p.m., the Administrator indicated the facility did not have a pre-employment screening policy.

On 11/9/21 at 2:30 p.m., reviewed of the updated guidance from 3/8/21, provided by the Centers of Disease Control and Prevention (CDC) website (CDC.GOV) , titled: Tb Screening and Testing of Health Care Personnel, specify, "...All U.S. health care personnel should be screened for Tb up on hire."

Based on interview and record review, the facility failed to ensure an employee had completed a tuberculin (Tb) skin test prior to resident contact for 1 of 5 employees reviewed for pre-employment screening. (Dietary Server 1)

Findings include:

On 11/9/21 at 9:25 a.m., the employee record of Dietary Server 1 was reviewed. Dietary Server 1 was hired on 10/24/21. Dietary Server 1 had not completed a Tuberculin (Tb) skin test (tuberculosis is a highly contagious respiratory bacterial disease) prior to contact with the residents.

During an interview, on 11/9/21 at 12:02 p.m., the Administrator

	indicated this employee had not completed their pre-employment Tb screen. During an interview, on 11/9/21 at 12:05 p.m., the Administrator indicated the facility did not have a pre-employment screening policy. On 11/9/21 at 2:30 p.m., reviewed of the updated guidance from 3/8/21, provided by the Centers of Disease Control and Prevention (CDC) website (CDC.GOV) , titled: Tb Screening and Testing of Health Care Personnel, specify, "...All U.S. health care personnel should be screened for Tb up on hire."			
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the ground surrounding the facility's dumpster area was free from rubbish and failed to ensure the dumpster lid was kept closed	R 0155	R 155 1.No residents were found to be affected by the alleged deficient practice. 2.The Community realizes that residents could have been affected by the alleged deficient practice. 3.Staff were educated as to the requirement to close the dumpster lids promptly after each use on November 23, 2021. The education included	11/23/2021

	when not in use. This had the potential to affect 66 of 66 residents residing in the facility. Findings include: On 11/8/21 from 10:35 a.m. to 10:40 a.m., observed the facility's trash dumpster area located adjacent to the kitchen's back door. There were 2 dumpsters, located next to each other, and each dumpster contained 2 separate top lids and 2 sliding side doors. The following was observed at the dumpster area: -The dumpster to the right side contained partially filled trash bags that were visible from within the dumpster. The top lid on the right side and both sliding doors were observed to not be closed. -On the ground near both dumpsters were used plastic gloves, partially filled trash bags, and 3 large mattresses. -No staff were observed near the area.		but was not limited to the requirement to close the lid. Each staff member taking waste to the dumpster is to ensure the closure of the lids and report any deviation from the proper waste disposal policy. 4.The Maintenance Director/designee will ensure the proper waste disposal program with daily checks by use of the 1440 Walk Checklist effective November 23, 2021. The Executive Director and all other Leaders will monitor and ensure compliance. November 23, 2021	

	On 11/9/21 from 9:00 a.m. to 9:05 a.m., observed the facility's trash dumpster area located adjacent to the kitchen's back door. There were 2 dumpsters, located next to each other, and each dumpster contained 2 separate top lids and 2 sliding side doors. The following was observed at the dumpster area: -The dumpster to the left side contained partially filled trash bags that were visible from within the dumpster. The top lid on the right side and the sliding door on the left side were observed to not be closed. -The dumpster to the right side contained partially filled trash bags that were visible from within the dumpster. The top lid on the left side was observed to not be closed. -On the ground near both dumpsters were 3 large mattresses. -No staff were observed near the area. During an interview, on 11/8/21 at 9:20 a.m., the Administrator indicated the facility census was 66. During an interview, on 11/8/21 at 10:45 a.m., the Dietary Manager (DM) indicated the dumpster lids were to be kept closed and the area was to be kept free of trash and other			

rubbish.

On 11/8/21 at 1:50 p.m., the Maintenance Director provided a copy of the Trash Removal policy, dated August 8, 2018, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the lids...the dumpsters are to be kept closed."

On 11/9/21 at 4:15 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..."

Based on observation, interview, and record review, the facility failed to ensure the ground surrounding the facility's dumpster area was free from rubbish and failed to ensure the dumpster lid was kept closed when not in use. This had the potential to affect 66 of 66 residents residing in the facility.

Findings include:

On 11/8/21 from 10:35 a.m. to 10:40 a.m., observed the facility's trash dumpster area located adjacent to the kitchen's back door. There were 2 dumpsters, located next to each other, and each dumpster

contained 2 separate top lids and 2 sliding side doors. The following was observed at the dumpster area:

-The dumpster to the right side contained partially filled trash bags that were visible from within the dumpster. The top lid on the right side and both sliding doors were observed to not be closed.

-On the ground near both dumpsters were used plastic gloves, partially filled trash bags, and 3 large mattresses.

-No staff were observed near the area.

On 11/9/21 from 9:00 a.m. to 9:05 a.m., observed the facility's trash dumpster area located adjacent to the kitchen's back door. There were 2 dumpsters, located next to each other, and each dumpster contained 2 separate top lids and 2 sliding side doors. The following was observed at the dumpster area:

-The dumpster to the left side contained partially filled trash bags that were visible from within the dumpster. The top lid on the right side and the sliding door on the left side were observed to not be closed.

-The dumpster to the right side contained partially filled trash bags that were visible from within the dumpster. The top lid

	on the left side was observed to not be closed. -On the ground near both dumpsters were 3 large mattresses. -No staff were observed near the area. During an interview, on 11/8/21 at 9:20 a.m., the Administrator indicated the facility census was 66. During an interview, on 11/8/21 at 10:45 a.m., the Dietary Manager (DM) indicated the dumpster lids were to be kept closed and the area was to be kept free of trash and other rubbish. On 11/8/21 at 1:50 p.m., the Maintenance Director provided a copy of the Trash Removal policy, dated August 8, 2018, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the lids...the dumpsters are to be kept closed."			

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R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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 dietary staff's hair was restrained and failed to ensure food items in the kitchen refrigerator were covered, dated, and perishable foods were discarded when no longer safe to consume. This had the potential to affect 66 of 66 residents residing in the facility who received food items from the kitchen. Findings include: 1. On 11/8/21, from 10:15 a.m. to 10:30 a.m., during the initial kitchen tour, observed	R 0273	R 273 1. No residents were affected by the alleged deficient practice. 2. The Community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. Staff were educated on November 23, 2021, regarding but not limited to the following: All food preparation and serving areas are maintained in accordance with State and local safe food handling standards. Dietary staff’s hair is to be restrained and food items in the kitchen refrigerator are to be covered and	11/23/2021

	Dishwasher 1 walking through the food preparation area and near the steam table where sandwiches were being prepared for the noon meal. Dishwasher 1's hair, ½ inch in length, was observed to not be covered. On 11/8/21, from 10:15 a.m. to 10:30 a.m., during the initial kitchen tour, observed the Dietary Manager (DM) walking through the food preparation area and near the steam table where he was preparing turkey sandwiches for the noon meal. The DM's hair, ½ inch in length, was observed to not be covered. On 11/8/21, from 11:20 a.m. to 11:30 a.m., observed Dishwasher 1 walking through the food preparation area and near the steam table which held the prepared foods for the noon meal. Dishwasher 1's hair, ½ inch in length, was observed to not be covered. On 11/8/21, from 11:20 a.m. to 11:30 a.m., observed the DM at the steam table taking and recording the food temperatures for the noon meal. The DM's hair, ½ inch in length, was observed to not be covered. On 11/8/21, from 1:05 p.m. to 1:09 p.m., observed the DM at the steam table taking and recording the food temperatures		dated, and perishable items are to be discarded when no longer safe to consume. 4. On-going frequent review of proper food storage will be maintained by observation, supervision and correction by the Executive chef/designee and monitored by the Executive Director.	

for the noon meal. The DM was wearing a white chef's hat that rested above his ears. The DM's hair from the ear level to the base of his neck, ½ inch in length, was observed to not be covered.

During an interview, on 11/8/21 at 9:20 a.m., the Administrator indicated the facility census was 66.

During an interview, on 11/8/21 at 11:35 a.m., the DM indicated kitchen staff's hair was to be covered when in the kitchen and all residents residing in the facility received food from the kitchen.

On 11/8/21 at 2:00 p.m., the Administrator provided a copy, of an undated document, and indicated it was the current procedure guide in use by the facility. A review of the document indicated, "ATTENTION Staff: You must have on a hairnet to enter the kitchen."

On 11/9/21 at 4:05 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints..."

2. On 11/8/21, from 10:15 a.m. to 10:30 a.m., during the initial kitchen tour, observed the

Dietary Manager (DM) enter the kitchen's walk in-refrigerator. The following food items were observed to have lacked the date to indicate when the item was placed into the refrigerator unit:

-15 small covered cups that was full of tarter sauce;

-Small covered container that was full of baby carrots; and

-Large tied plastic bag that was ¼ full of cilantro.

The following food items in the walk-in refrigerator unit were observed to have lacked a covering and a date in which the food items were placed into the refrigerator unit:

Small tray that was 1/4 full of cooked ham slices;

-Large stock pot that was 1/2 full of green beans;

-Large opened plastic bag that was ¾ full of lettuce; and

-Large tray that contained 12 cooked chicken breasts including 2 chicken breasts that were uncovered and were gray in color.

The following unopened perishable food items in the walk-in refrigerator unit were observed to have a white and black substance adhered to the

food items:

-2 medium sized containers of fresh strawberries.

During an interview, on 11/8/21 at 9:20 a.m., the Administrator indicated the facility census was 66.

During an interview, on 11/8/21 at 10:35 a.m., the DM indicated all food items in the walk-in refrigerator were to be covered and dated to indicate when the item was placed into the refrigerator. The strawberries should have been thrown away. All residents residing in the facility received food from the kitchen.

On 11/8/21 at 2:00 p.m., the Administrator provided a copy, of an undated document, and indicated it was the current procedure guide in use by the facility. A review of the document indicated, "Always Label & Date!!! Date prepared & 6 days after..."

On 11/8/21 at 2:00 p.m., the Administrator provided a copy, of an undated document, and indicated it was the current procedure guide in use by the facility. A review of the document indicated, "Date Marking Guidelines: When to date mark foods: anytime the original packaging is opened...How to date mark foods: apply masking tape or

label to the container...write today's date...write the date six days from today..."

On 11/9/21 at 4:15 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated "...refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded..."

Based on observation, interview, and record review, the facility failed to ensure dietary staff's hair was restrained and failed to ensure food items in the kitchen refrigerator were covered, dated, and perishable foods were discarded when no longer safe to consume. This had the potential to affect 66 of 66 residents residing in the facility who received food items from the kitchen.

Findings include:

1. On 11/8/21, from 10:15 a.m. to 10:30 a.m., during the initial kitchen tour, observed Dishwasher 1 walking through the food preparation area and near the steam table where sandwiches were being

prepared for the noon meal. Dishwasher 1's hair, ½ inch in length, was observed to not be covered.

On 11/8/21, from 10:15 a.m. to 10:30 a.m., during the initial kitchen tour, observed the Dietary Manager (DM) walking through the food preparation area and near the steam table where he was preparing turkey sandwiches for the noon meal. The DM's hair, ½ inch in length, was observed to not be covered.

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On 11/8/21, from 11:20 a.m. to 11:30 a.m., observed the DM at the steam table taking and recording the food temperatures for the noon meal. The DM's hair, ½ inch in length, was observed to not be covered.

On 11/8/21, from 1:05 p.m. to 1:09 p.m., observed the DM at the steam table taking and recording the food temperatures for the noon meal. The DM was wearing a white chef's hat that rested above his ears. The DM's hair from the ear level to the

base of his neck, ½ inch in length, was observed to not be covered.

During an interview, on 11/8/21 at 9:20 a.m., the Administrator indicated the facility census was 66.

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	date to indicate when the item was placed into the refrigerator unit: -15 small covered cups that was full of tarter sauce; -Small covered container that was full of baby carrots; and -Large tied plastic bag that was ¼ full of cilantro. The following food items in the walk-in refrigerator unit were observed to have lacked a covering and a date in which the food items were placed into the refrigerator unit: Small tray that was 1/4 full of cooked ham slices; -Large stock pot that was 1/2 full of green beans; -Large opened plastic bag that was ¾ full of lettuce; and -Large tray that contained 12 cooked chicken breasts including 2 chicken breasts that were uncovered and were gray in color. The following unopened perishable food items in the walk-in refrigerator unit were observed to have a white and black substance adhered to the food items:			

-2 medium sized containers of fresh strawberries.

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During an interview, on 11/8/21 at 10:35 a.m., the DM indicated all food items in the walk-in refrigerator were to be covered and dated to indicate when the item was placed into the refrigerator. The strawberries should have been thrown away. All residents residing in the facility received food from the kitchen.

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	today's date...write the date six days from today..." On 11/9/21 at 4:15 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated "...refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded..."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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