STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST, CHARLESTOWN, , 47111

(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 the Investigation of Complaints IN00370738, IN00371778, and IN00378118. Complaint IN00370738 - Substantiated. State deficiency related to the allegations is cited at R0029. Complaint IN00371778 - Substantiated. State deficiencies related to the allegations are cited at R0029 and R0154. Complaint IN00378118 - Substantiated. State deficiencies related to the allegations are cited at R0029 and R0036. Survey date: May 1, 2, and 3, 2022 Facility number: 012007 Residential Census: 87 These State Residential Findings are cited in accordance	R 0000		

	with 410 IAC 16.2-5.			
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure education was provided to a Resident (Resident F) in private for 2 of 3 residents reviewed for resident rights. Findings include The clinical record for Resident F was reviewed on 5/2/22 at 10:20 a.m. Diagnoses included, but were not limited to, chronic pain, anxiety, and diabetes. The nurse's note, dated 3/22/22 at 3:56 p.m., indicated the Wellness Director spoke with the resident on her porch about appearing to be under the influence of alcohol and how important it was to make sure she was safe. During an interview of 5/2/22 at 11:17 a.m., Resident K indicated he had been out on his patio when he heard the Wellness Director (WD) approach Resident F and told her loudly, that she had been drinking. Resident F told her she	R 0029	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. IDR has been requested for this tag. The Community is disputing the R029 tag regarding dignity and would like this tag to be removed altogether. Resident B requires assistance with ADLs, but this assistance is not usually provided by Community staff. Since this resident is a Medicaid waiver resident, she has a Purpose Home Health Aid that provides ADL care to resident. The Purpose Home Health Plan of Care for Resident B is attached as Exhibit D, which states that ADL care is provided for	06/30/2022

	would take a breathalyzer test. It was shameful the way she talked to her and should have taken her inside to talk in private instead of outside where everybody could hear. During an interview on 5/2/22 at 1:35 p.m., Resident L indicated he had been sitting on his patio when he heard the WD approach Resident F. It was so disrespectful the way Resident F was spoken to. The WD told Resident F she had been drinking too much. Resident F told the WD she would take a breathalyzer test and the WD told her they don't do those but knew she had been drinking. It was just disrespectful for the WD to talk with her around other residents. During an interview on 5/3/22 at 11:33 a.m., the WD indicated the resident had been drinking alcohol, alcohol was found in her room, and her eyes were glassy. She spoke with the resident on her porch with regards to her drinking. She had spoken in a low voice or thought she did. There was no reason why she did not speak with the resident in her apartment rather than outside. On 5/3/22 at 12:01 p.m., the WD provided a current copy of the document titled "Charting and Documentation" dated 2/2021. It included, but was not		incontinence, dressing, bathing and toileting. Floor staff in Community stated correctly that the Community staff does not generally provide this care for the resident. What they did not state (because they were not asked) is that a third party provider provides this care. As the Community regrets that the resident was upset that incontinence and ADL assistance was required of her and was accurately charted in the resident record by ADON, the responsibility of the licensed staff in the Community will remain that documentation remains accurate. The community is disputing the R029 tag regarding privacy and would like this tag removed. This is due to the Director of Nursing stating that there was no one outside when she spoke to Resident F on her private outdoor patio regarding a medical concern. The DON stated that a male resident (assumed to be either Resident K or Resident L) walked out onto his private patio as she was exiting Resident F’s private patio. The DON has provided a written	

	limited to, "Policy...Chart all pertinent changes in the resident's condition...Be concise, accurate, and complete...Document only the facts...." On 5/3/22 at 12:01 p.m., the WE provided a current, undated copy of the document titled "Acknowledgment of Resident's Rights". It included, but was not limited to, "Resident rights...have the right to a dignified existence...You have the right to be treated with respect and dignity....Privacy...You have the right to personal privacy...." This State tag relates to Complaints IN00370738, IN00371778, and IN00378118 Based on interview and record review, the facility failed to ensure education was provided to a Resident (Resident F) in private for 2 of 3 residents reviewed for resident rights. Findings include The clinical record for Resident F was reviewed on 5/2/22 at 10:20 a.m. Diagnoses included, but were not limited to, chronic pain, anxiety, and diabetes. The nurse's note, dated 3/22/22 at 3:56 p.m., indicated the Wellness Director spoke with the resident on her porch about appearing to be under the		statement that is being attached as Exhibit A. 1. 1. Resident currently out at rehab at skilled nursing center, no further action possible with resident. 2. All residents are potentially at risk of same alleged deficient practice. 3. Interviews of residents and clinical staff will be completed by 5/26/22 by executive director to identify any additional issues with privacy in communication. 4. Nursing leadership and clinical staff will be in-serviced on resident rights, including privacy, by the executive director by 5/25/2022. 5. 2/week for one month 1/week for 1 month, then one monthly for 4 monthsThis will be completed in	

	influence of alcohol and how important it was to make sure she was safe. During an interview of 5/2/22 at 11:17 a.m., Resident K indicated he had been out on his patio when he heard the Wellness Director (WD) approach Resident F and told her loudly, that she had been drinking. Resident F told her she would take a breathalyzer test. It was shameful the way she talked to her and should have taken her inside to talk in private instead of outside where everybody could hear. During an interview on 5/2/22 at 1:35 p.m., Resident L indicated he had been sitting on his patio when he heard the WD approach Resident F. It was so disrespectful the way Resident F was spoken to. The WD told Resident F she had been drinking too much. Resident F told the WD she would take a breathalyzer test and the WD told her they don't do those but knew she had been drinking. It was just disrespectful for the WD to talk with her around other residents. During an interview on 5/3/22 at 11:33 a.m., the WD indicated the resident had been drinking alcohol, alcohol was found in her room, and her eyes were glassy. She spoke with the resident on her porch with		the following manner: DON/ designee (other than ADON) will review service plan, nurses' notes and visually observe resident to ensure documentation in nurses notes and service plan accurately reflect care provided and needed. ED /designee will audit privacy in communication as follows:2/week for one month 1/week for 1 month, then monthly for 4 months. This will be completed in the following manner: ED/Designee will walk the community and attempt to overhear conversations with staff in which privacy could be breached. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. The threshold that will be used to determine if the audits need to continue is the	

	regards to her drinking. She had spoken in a low voice or thought she did. There was no reason why she did not speak with the resident in her apartment rather than outside. On 5/3/22 at 12:01 p.m., the WD provided a current copy of the document titled "Charting and Documentation" dated 2/2021. It included, but was not limited to, "Policy...Chart all pertinent changes in the resident's condition...Be concise, accurate, and complete...Document only the facts...." On 5/3/22 at 12:01 p.m., the WE provided a current, undated copy of the document titled "Acknowledgment of Resident's Rights". It included, but was not limited to, "Resident rights...have the right to a dignified existence...You have the right to be treated with respect and dignity....Privacy...You have the right to personal privacy...." This State tag relates to Complaints IN00370738, IN00371778, and IN00378118		following: if there are any conversations that are overheard in which privacy is breached. Investigation completed regarding stated “inaccurate documentation.” The investigation of the Community revealed that: . Resident B requires assistance with ADLs, but this assistance is not usually provided by Community staff. Since this resident is a Medicaid waiver resident, she has a Purpose Home Health Aid that provides ADL care to resident. The Purpose Home Health Plan of Care for Resident B is attached as Exhibit D, which states that ADL care is provided for incontinence, dressing, bathing and toileting. Floor staff in Community stated correctly that the Community staff does not generally provide this care for the resident. What they did not state (because they were not	

			asked) is that a third party provider provides this care. As the Community regrets that the resident was upset that incontinence and ADL assistance was required of her and was accurately charted in the resident record by ADON, the responsibility of the licensed staff in the Community will remain that documentation remains accurate.	
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure a resident's (Resident F)	R 0036	To Whom it May Concern: Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. IDR has been requested for	06/08/2022

	family was notified of a fall and the consumption of alcohol while taking narcotics for 1 of 3 residents reviewed for family notification. Findings include: The clinical record for Resident F was reviewed on 5/2/22 at 10:20 a.m. Diagnoses included, but were not limited to, chronic pain, anxiety, and diabetes. The nurse's note, dated 3/22/22 and untimed, indicated pain management and the nurse practitioner were notified that Resident F seemed to be under the influence of unknown, possibly alcohol. Since alcohol and pain medication were respiratory depressants and not knowing how much alcohol the resident had consumed, the resident's pain medication would be held. The nurse's note, dated 3/22/22 at 3:56 p.m., indicated the Wellness Director spoke with the resident on her porch about appearing to be under the influence of alcohol and how important it was to make sure she was safe. The nurse's note, dated 3/27/22 at 3:20 a.m., indicated the resident pulled her call light due to a fall. The resident could not tell the nurse how she fell, just that she fell at the door. When the nurse and aide arrived, the		this tag. **<u>Request for paper review IDR with removal of deficiency for R036:</u>** The community is disputing the R036 tag regarding Notification of Family. Resident F has a Power of Attorney in place if a physician deems her incapable of making her own decisions. A physician has not deemed her incapable of making decisions to date. The POA paperwork for Resident F is attached as Exhibit B. She is her own responsible party and signs her own paperwork. Her Assisted Living Establishment Contract which she alone signed is attached as Exhibit C. 1. Resident currently out at rehab at skilled nursing center, no further action possible with resident. 2. All residents are potentially at risk of same alleged deficient practice.	

	resident was in living room. She had a small cut on her left hand and right leg. EMS (emergency medical services) was called due to resident was on blood thinners. The resident refused to go to the hospital. The clinical record lacked documentation of family notification related to the alcohol consumption with pain medication or of the fall on 3/27/22 at 3:20 a.m. During an interview between 5/1/22 at 6:10 p.m. and 5/3/22 at 1:30 p.m., Staff Member 9 indicated the family should be notified of any change in a resident's condition or status. On 5/3/22 at 12:01 p.m., the Wellness Director provided a current copy of the document titled "Significant Condition Change & Notification" dated 2/2021. It included, but was not limited to, "Purpose...to ensure that the resident's family...are notified or resident changes such as...An accident...with or without injury...A significant change in the resident's physical, mental...status...Other abnormal assessment findings...." This State tag relates to Complaint IN00378118 Based on interview and record review, the facility failed to ensure a resident's (Resident F)		3. All residents with POA will be audited by 6/3/22 to Identify if POA has been activated or if resident chooses communication to be completed via POA. Results of audit will be added to each individual service plan. 4. Nursing leadership and clinical staff will be in-serviced on proper POA notification on 5/25/2022 5. ED /designee will audit service plans for POA designation for 1/week for 2 months, then monthly for 4 months ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. The threshold for these audits is the following: if resident does not have in their service plan whether POA is active or not, the audits will continue.	

family was notified of a fall and the consumption of alcohol while taking narcotics for 1 of 3 residents reviewed for family notification.

Findings include:

The clinical record for Resident F was reviewed on 5/2/22 at 10:20 a.m. Diagnoses included, but were not limited to, chronic pain, anxiety, and diabetes.

The nurse's note, dated 3/22/22 and untimed, indicated pain management and the nurse practitioner were notified that Resident F seemed to be under the influence of unknown, possibly alcohol. Since alcohol and pain medication were respiratory depressants and not knowing how much alcohol the resident had consumed, the resident's pain medication would be held.

The nurse's note, dated 3/22/22 at 3:56 p.m., indicated the Wellness Director spoke with the resident on her porch about appearing to be under the influence of alcohol and how important it was to make sure she was safe.

The nurse's note, dated 3/27/22 at 3:20 a.m., indicated the resident pulled her call light due to a fall. The resident could not tell the nurse how she fell, just that she fell at the door. When the nurse and aide arrived, the

	resident was in living room. She had a small cut on her left hand and right leg. EMS (emergency medical services) was called due to resident was on blood thinners. The resident refused to go to the hospital. The clinical record lacked documentation of family notification related to the alcohol consumption with pain medication or of the fall on 3/27/22 at 3:20 a.m. During an interview between 5/1/22 at 6:10 p.m. and 5/3/22 at 1:30 p.m., Staff Member 9 indicated the family should be notified of any change in a resident's condition or status. On 5/3/22 at 12:01 p.m., the Wellness Director provided a current copy of the document titled "Significant Condition Change & Notification" dated 2/2021. It included, but was not limited to, "Purpose...to ensure that the resident's family...are notified or resident changes such as...An accident...with or without injury...A significant change in the resident's physical, mental...status...Other abnormal assessment findings...." This State tag relates to Complaint IN00378118			

R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was in good repair related to the drywall, vents, sprinkle head, ceiling and exit door for 2 of 2 kitchen observations. On 5/2/22, between 11:45 a.m. and 12:20 p.m., the following were observed in the kitchen: -There was a piece of dry wall tape, 18 inches in length, hanging from the ceiling to the right of the food preparation table which revealed a crack, approximately 2 feet in length and .7 inches in width, with water was dripping down from it. -There were multiple dry water stains next to the crack in the ceiling. -The vents at each exit door were covered with a thick gray dust. -The AC vents, above the serving area, were discolored.	R 0154	To Whom it May Concern: Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Kitchen vents have been cleaned, areas of discolored ceiling have been treated and painted, HVAC is being repaired and or replaced, ceiling damage from HVAC repair will be repaired. Dishwasher exhaust fan has been repaired. 2. All residents are potentially at risk of same alleged deficient practice. 3. Executive Director and Dietary Manager will complete sanitary Inspection by 5/24/22 to ensure that all areas of kitchen are properly maintained. 4. Dietary manager and dietary	06/08/2022

	There were yellow stains on and around both of the vents. -The wall above the clock had a yellowish color with dust particles to the left of the clock. -The serving window door was covered with a clear splatter. -The sprinkle head above the food prep area had had pulled away from the ceiling leaving a 1/4 inch gap. -The AC vent above the dishwashing area was discolored with black streaks. -The ceiling at the back wall of the dishwashing area had multiple black, spotted areas. On 5/2/22 at 11:55 a.m., the executive director was unsure of when the vents at the exit doors were last cleaned and there was currently a technician working on the leak . On 5/2/22 at 12:05 p.m., the Dietary Manager indicated the areas on the ceiling at the back wall of the dishwashing area looked like mildew or mold. The exhaust fan was not working so moisture was unable to be pulled out of the kitchen. On 5/2/22 at 12:06 p.m., the Executive Director retrieved a ladder. He dampened a paper towel, wiped the vent with the wet paper towel, and the black		Staff to be in-serviced on cleaning procedures and reporting of malfunctioning equipment by 5/25/2022. Cleaning schedules to posted and monitored by Dietary Manager. 5. Kitchen Sanitation will be audited for cleanliness 3/week for 4 weeks, 2/week for 4 weeks, 1/week for 2 months, then monthly ongoing by Dietary Director. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Kitchen sanitation audit must score 85% or better to reduce to monthly.	

substance came off. He then dampened another paper towel and wiped the ceiling. The stains would lighten but not come off. He indicated the area was either food splatter or a growth of some sort. He also just learned the exhaust fan was not working.

On 5/3/22 at 9:53 a.m., the following issues continued in the kitchen:

-There was a piece of dry wall tape, 18 inches in length, hanging from the ceiling to the right of the food preparation table which revealed a crack, approximately 2 ft in length, 2 centimeters in width, with water was dripping down from it.

-There were multiple dry water stains next to the crack in the ceiling.

-The vents at each exit door were covered with a thick gray dust.

-The AC vents, above the serving area, were discolored. There were yellow stains on and around both of the vents.

-The wall above the clock had a yellowish color with dust particles to the left of the clock.

-The serving window door was covered with a clear splatter.

-The sprinkle head above the

food prep area had had pulled away from the ceiling leaving a 1/4 inch gap.

-The ceiling at the back wall of the dishwashing area had multiple black, spotted areas .

5/3/22 at 12:59 p.m., the Executive Director indicated they did not have a policy on maintaining equipment. If there was an issue with something, staff would report it.

This State tag relates to Complaint IN00371778.

Based on observation and interview, the facility failed to ensure the kitchen was in good repair related to the drywall, vents, sprinkle head, ceiling and exit door for 2 of 2 kitchen observations.

On 5/2/22, between 11:45 a.m. and 12:20 p.m., the following were observed in the kitchen:

-There was a piece of dry wall tape, 18 inches in length, hanging from the ceiling to the right of the food preparation table which revealed a crack, approximately 2 feet in length and .7 inches in width, with water was dripping down from it.

-There were multiple dry water stains next to the crack in the ceiling.

-The vents at each exit door

were covered with a thick gray dust.

-The AC vents, above the serving area, were discolored. There were yellow stains on and around both of the vents.

-The wall above the clock had a yellowish color with dust particles to the left of the clock.

-The serving window door was covered with a clear splatter.

-The sprinkle head above the food prep area had had pulled away from the ceiling leaving a 1/4 inch gap.

-The AC vent above the dishwashing area was discolored with black streaks.

-The ceiling at the back wall of the dishwashing area had multiple black, spotted areas.

On 5/2/22 at 11:55 a.m., the executive director was unsure of when the vents at the exit doors were last cleaned and there was currently a technician working on the leak .

On 5/2/22 at 12:05 p.m., the Dietary Manager indicated the areas on the ceiling at the back wall of the dishwashing area looked like mildew or mold. The exhaust fan was not working so moisture was unable to be pulled out of the kitchen.

On 5/2/22 at 12:06 p.m., the Executive Director retrieved a ladder. He dampened a paper towel, wiped the vent with the wet paper towel, and the black substance came off. He then dampened another paper towel and wiped the ceiling. The stains would lighten but not come off. He indicated the area was either food splatter or a growth of some sort. He also just learned the exhaust fan was not working.

On 5/3/22 at 9:53 a.m., the following issues continued in the kitchen:

-There was a piece of dry wall tape, 18 inches in length, hanging from the ceiling to the right of the food preparation table which revealed a crack, approximately 2 ft in length, 2 centimeters in width, with water was dripping down from it.

-There were multiple dry water stains next to the crack in the ceiling.

-The vents at each exit door were covered with a thick gray dust.

-The AC vents, above the serving area, were discolored. There were yellow stains on and around both of the vents.

	-The wall above the clock had a yellowish color with dust particles to the left of the clock. -The serving window door was covered with a clear splatter. -The sprinkle head above the food prep area had had pulled away from the ceiling leaving a 1/4 inch gap. -The ceiling at the back wall of the dishwashing area had multiple black, spotted areas . 5/3/22 at 12:59 p.m., the Executive Director indicated they did not have a policy on maintaining equipment. If there was an issue with something, staff would report it. This State tag relates to Complaint IN00371778.			

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