

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2023
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 CROWNPOINTE CIRCLE, ANDERSON, , 46012			
(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. This visit included the Investigation of Complaint IN00397891. Complaint IN00397891 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 3, 4, and 5, 2023 Facility number: 012129 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 11, 2023.	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission by CrownPointe of Anderson, that the allegations contained in this survey report are accurate or reflect accurately the provision of service to residents of CrownPointe of Anderson. A corrective action is in place. In-services will be held starting immediately to train all staff members on the updated policies. All staff have been educated via in-service regarding updated policies or any changes. Staff received direction and instruction on completing in-service . All identified concerns will be logs, tracked, and monitored by facility representative with tracking forms .		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in	R 0117	Education provided to staff in the form of in-service. During said in service the staff was educated on	01/23/2023	

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number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of one staff member with CPR and first aid certification for 9 of 33 shifts reviewed. Findings include: Review of work schedules for 12/25/22 to 1/4/22 (11 days 33 shifts) found 9 of 33 shifts	the process of getting CPR Certification completed on time. Administrator and Director of health services took questions provided education. Class Certification has been scheduled and complete . We will be monitoring and follow-up with our audit tool monthly . The director of health services or designee will check Monthly and ongoing there after. Nurse Consultant will audit once monthly for 6 months or until 100% compliance is achieved. Audit will be done to ensure individualized service plan is complete. Affected residents remain in facility and did not experience any adverse effects related to alleged deficient practice.	
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lacked a scheduled employee with CPR and first aid certification as follows:

12/25/22 -2nd shift (2:00 p.m. to 10:00 p.m.),

12/28/22-2nd shift,

12/29/22-2nd shift,

12.29.22-3rd shift (10:00 p.m. to 6:00 a.m.),

12/31/22- 2nd shift,

1/1/23 - 2nd shift,

1/1/23 - 3rd shift,

1/2/23 - 2nd shift,

1/4/23 - 2nd shift.

During an interview, on 1/5/23 at 2:40 p.m., the Administrator indicated the facility did not have record of an employee working who had CPR or first aid training during the above nine (9) shifts.

Based on interview and record review, the facility failed to ensure a minimum of one staff member with CPR and first aid certification for 9 of 33 shifts reviewed.

Findings include:

Review of work schedules for 12/25/22 to 1/4/22 (11 days 33 shifts) found 9 of 33 shifts

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	lacked a scheduled employee with CPR and first aid certification as follows: 12/25/22 -2nd shift (2:00 p.m. to 10:00 p.m.), 12/28/22-2nd shift, 12/29/22-2nd shift, 12.29.22-3rd shift (10:00 p.m. to 6:00 a.m.), 12/31/22- 2nd shift, 1/1/23 - 2nd shift, 1/1/23 - 3rd shift, 1/2/23 - 2nd shift, 1/4/23 - 2nd shift. During an interview, on 1/5/23 at 2:40 p.m., the Administrator indicated the facility did not have record of an employee working who had CPR or first aid training during the above nine (9) shifts.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.	R 0144	Affected residents remain in facility and did not experience any adverse effects related to alleged deficient practice. Education provided to staff in the form of in-service. During said in service the Maintenance and Housekeeping staff was educated	01/23/2023

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Based on observation and interview, the facility failed to maintain the facility in a clean, hygienic, and homelike manner.

Findings include:

During a random observation, on 1/3/23 at 10:25 a.m., the exit door next to room 110 was noted to be missing part of the seal, making daylight visible and air to be felt from the outside.

During environmental observations on 1/4/23 from 9:36 a.m. to 9:45 a.m., the following environmental concerns were noted:

The first floor women's guest and resident bathroom had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover. The door knob and mount had been changed, leaving a large discolored circle and a small hole by the knob.

The first floor men's guest and resident bathroom had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover.

on daily cleaning, preventive maintenance and repairs. Administrator and Director of Maintenance will provide training services and questions provided for education. We will be monitoring and follow-up with our audit tool weekly, monthly and up to 6 months or until 100% compliance .The Maintenance Director or designee will monitor weekly and ongoing there after.

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The door in the main dining room did not have a secured seal, resulting in daily light and air being seen and felt from the outside.

The door surrounding the elevator by room 105 had chipped off pain and multiple scuffs.

Rooms 109, 110, 108, 111, 112, and 113 had scuff marks on the lower portion of the doors to the resident rooms.

During environmental observations on 1/5/23 from 11:06 to 11:33 a.m. the following concerns were noted:

Rooms 128, 127, 127-S, 126, 121, 122, 123 had scuff marks on the lower portions of the doors to the resident rooms.

The exit door by room 123 lacked any form of seal, allowing daylight to be seen and air to be felt from the outside.

Rooms 202, 203, 206, 208, 211, 212, 213, 214, 215, 221, 222, 223, 223-S, 224, and 218 had scuff marks on the lower portions of the door to the resident rooms.

The upstairs women's resident and guest bathroom by the catwalk had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up

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on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover.

The upstairs men's resident and guest bathroom by the catwalk had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover.

The upstairs fire place lounge located off the catwalk had heavy dust build up on picture frames, the fireplace mantel, the bookcase. The dust was thick and could be removed when running a finger across surfaces. The dust caused a dull gray appearance on the items.

The second floor lounge, which housed the piano, had a heavy dust build up on the picture frames.

During an interview, on 1/5/23 at 11:36 a.m., the Administrator indicated walker, scooters, and wheelchairs hit door frames and doors leaving scuffs. He had not been aware the issue was pervasive throughout the facility. The facility had been working on repairing seals on exit doors. He would attempt to find verification of the work the facility had completed

No additional information was

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provided of repairs or replacements to exterior door seals prior to exit from the facility.

Based on observation and interview, the facility failed to maintain the facility in a clean, hygienic, and homelike manner.

Findings include:

During a random observation, on 1/3/23 at 10:25 a.m., the exit door next to room 110 was noted to be missing part of the seal, making daylight visible and air to be felt from the outside.

During environmental observations on 1/4/23 from 9:36 a.m. to 9:45 a.m., the following environmental concerns were noted:

The first floor women's guest and resident bathroom had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover. The door knob and mount had been changed, leaving a large discolored circle and a small hole by the knob.

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The door in the main dining room did not have a secured seal, resulting in daily light and air being seen and felt from the outside.

The door surrounding the elevator by room 105 had chipped off pain and multiple scuffs.

Rooms 109, 110, 108, 111, 112, and 113 had scuff marks on the lower portion of the doors to the resident rooms.

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The exit door by room 123 lacked any form of seal, allowing daylight to be seen and air to be felt from the outside.

Rooms 202, 203, 206, 208, 211, 212, 213, 214, 215, 221, 222, 223, 223-S, 224, and 218 had scuff marks on the lower portions of the door to the resident rooms.

The upstairs women's resident

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and guest bathroom by the catwalk had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover.

The upstairs men's resident and guest bathroom by the catwalk had dark discoloration on the grout throughout the floor tile on the entire bathroom. There was a heavy dust build up on picture frames, vents, and light fixtures. The over head light had a bare bulb without a shield or cover.

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The second floor lounge, which housed the piano, had a heavy dust build up on the picture frames.

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	repairing seals on exit doors. He would attempt to find verification of the work the facility had completed No additional information was provided of repairs or replacements to exterior door seals prior to exit from the facility.			
R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietitian. Based on interview and record review, the facility failed ensure all menus and substitutions were approved by a registered dietitian. This deficient practice had the potential to impact 57 of 57 residents who received meals from the kitchen. Findings include: Review of facility menus for 1/3/23, 1/4/23, and 1/5/23, provided by the Administrator on 1/3/23 at 11:00 a.m., indicated they were not signed as approved by a registered dietitian. During an interview, on 1/3/23 at 3:15 p.m., the Administrator indicated the facility purchased recipes and menu guidance	R 0269	Affected residents remain in facility and did not experience any adverse effects related to alleged deficient practice. . The plan of correction will include education and in service training on completing All menus have been updated and signed off by Registered RD on 1/3/23. All dietary staff have a be educated on RD Menu Substitutions and log .All residents are provided menus to complete on a weekly basis. Noted on all menus may change dependent on availability of items and seasonality. All Education provided to staff in the form of in-service and menu training is in place. During said in service the staff was educated on substitution logs, food prep, food safety and menus. We will be monitoring and follow-up with our audit tool monthly . The Administrator or designee will check Daily Weekly Monthly and ongoing for 6 months or until 100%	01/23/2023

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from a food services company, then the facility developed it's own menus. The current menus were not approved by the registered dietitian. The breakfasts were not on a menu, but were a list of items from which the residents made choices. He did not know why there were neither eggs, nor oatmeal available for breakfast in the morning. Breakfast choices were subject to availability.

During an interview, on 1/3/23 at 11:45 a.m., Resident 42 indicated there were not always alternatives offered if you did not like the food.

During an interview, on 1/3/23 at 11:47 a.m., Resident 30 indicated the meat was often dry and overcooked. The facility no longer served sauces, which helped with the dry meat. She lifted a bottle of honey mustard and said she carried her own sauce now.

During an interview, on 1/3/23 at 11:50 a.m., Resident 40 indicated she did not believe the meal the night before was adequate. She had been served a taco and some beans. The taco did not have the usual taco toppings.

During an interview, on 1/3/23 at 11:51 a.m., Resident 44 indicated she had not been

compliance is achieved.

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happy with the meals they had served of late. They frequently did not have common items such as iced tea or lemonade.

During an interview, on 1/3/23 at 11:52 a.m., Resident 45 indicated the salad bar had not been up to standard of late. There were seldom enough topping to make a satisfying salad.

During an interview, on 1/3/23 at 12:23 p.m., Resident 33 indicated the food started going down hill about 5 months ago. Sandwiches were often cold and dry. One could not get toppings like lettuce and tomatoes. Pasta in the pasta salad was not cooked completely, resulting in hard bits of pasta in the salad.

During an interview, on 1/3/23 at 12:10 p.m., Resident 39 indicated the food was of poor quality. French fries were served cold. The menus didn't make sense, they were served potato salad and potato chips in the same meal.

The most current registered dietitian report, provided by the Administrator on 1/5/23 at 10:00 a.m., was dated 2/17/22.

Based on interview and record review, the facility failed ensure all menus and substitutions were approved by a registered dietician. This deficient practice had the potential to impact 57 of

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57 residents who received meals from the kitchen.

Findings include:

Review of facility menus for 1/3/23, 1/4/23, and 1/5/23, provided by the Administrator on 1/3/23 at 11:00 a.m., indicated they were not signed as approved by a registered dietitian.

During an interview, on 1/3/23 at 3:15 p.m., the Administrator indicated the facility purchased recipes and menu guidance from a food services company, then the facility developed it's own menus. The current menus were not approved by the registered dietitian. The breakfasts were not on a menu, but were a list of items from which the residents made choices. He did not know why there were neither eggs, nor oatmeal available for breakfast in the morning. Breakfast choices were subject to availability.

During an interview, on 1/3/23 at 11:45 a.m., Resident 42 indicated there were not always alternatives offered if you did not like the food.

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During an interview, on 1/3/23 at 11:51 a.m., Resident 44 indicated she had not been happy with the meals they had served of late. They frequently did not have common items such as iced tea or lemonade.

During an interview, on 1/3/23 at 11:52 a.m., Resident 45 indicated the salad bar had not been up to standard of late. There were seldom enough topping to make a satisfying salad.

During an interview, on 1/3/23 at 12:23 p.m., Resident 33 indicated the food started going down hill about 5 months ago. Sandwiches were often cold and dry. One could not get toppings like lettuce and tomatoes. Pasta in the pasta salad was not cooked completely, resulting in hard bits of pasta in the salad.

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	served cold. The menus didn't make sense, they were served potato salad and potato chips in the same meal. The most current registered dietitian report, provided by the Administrator on 1/5/23 at 10:00 a.m., was dated 2/17/22.			
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 the dietary department maintained kitchen equipment in a clean, sanitary manner. This deficient practice had the potential to impact 57 of 57 residents who received meals from the facility kitchen. Findings include: During the kitchen sanitation tour, on 1/3/23 at 10:30 a.m., the following concerns regarding clean kitchen equipment were observed: The vent hood above the stove had a heavy build-up of dark	R 0273	Affected residents remain in facility and did not experience any adverse effects related to alleged deficient practice. . The plan of correction will include education and in service training. Education and training have been provided to all dietary staff. Training covered Sanitation, cleaning schedules Temperature logs, equipment cleaning (a new stove has been purchased and installed) substitution logs, food preparation and food safety. During said in service all Dietary staff has been training. We will be monitoring and follow-up with our audit tools. The Administrator or designee will check Weekly Monthly and ongoing for 6 months or until 100% compliance is achieved.	01/23/2023

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	brownish black oily debris. The back-splash behind the griddle/grill portion of the stove was covered with a heavy dark black burnt on substance covering approximately 3/4 of the backslash surface. The drip pan/drawer located on the right side of the griddle had food debris around the mouth of the tray. The handle of the tray was covered with a greasy residue. The tray/pan was firmly stick inside the stove and could not be removed for cleaning. The griddle/grill flat surface had food residue over the heating surface of the grill. The residue was brown, tan, and black with dusty particles throughout. The front ledge of the stove in front of the burners had a large strip of thick sticky black residue running the entire length of the ledge. The residue was approximately one inch wide. The burners of the stove were heavily dusted with a brown, black, and white powdery substance and multiple food particles.			
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The drip pan located under the burners of the stove was heavily covered with burn on liquids and food particles. The residue covered approximately 95% of the aluminum which lined the pan.

The convection oven had a sticky residue on both handles. The inside of the convection oven had dark brown sticky greasy food residue on the inside doors, racks, and bottom of the oven.

During an interview, on 1/3/23 at 10:30 a.m., the Dietary Manager indicated she had no idea when the hood over the stove was last cleaned and didn't know why the back-splash was covered with a dark residue. The staff were unable to remove the drip pan/drawer beside the grill, but it didn't matter because the grill didn't work. She didn't know what the residue was on top of the griddle or when the stove/griddle combination unit was last cleaned. She didn't know there was a removable drip pan under the burners and had never seen it removed or cleaned. She had not had any formal training since she began her position in September of 2022 and had not met with the Registered Dietitian since she began her employment. She did not have any certification as a Dietary Manager. She had not taken a class nor was she

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currently enrolled in a program.

A facility job description, dated 10/2010, titled "Job Description: Food Services Supervisor", provided by the Administrator on 1/5/2023 at 2:30 p.m., indicated the following: "...Prior experience providing or managing a dietary department for the elderly is preferred...Ensure that daily schedule cleaning is conducted within the dietary department to maintain a sanitary environment...Ensure that the dietary department complies with the established sanitary [sentence ended abruptly]...."

Based on observation, interview, and record review, the facility failed to ensure the dietary department maintained kitchen equipment in a clean, sanitary manner. This deficient practice had the potential to impact 57 of 57 residents who received meals from the facility kitchen.

Findings include:

During the kitchen sanitation tour, on 1/3/23 at 10:30 a.m., the following concerns regarding clean kitchen equipment were observed:

The vent hood above the stove had a heavy build-up of dark brownish black oily debris.

The back-splash behind the

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griddle/grill portion of the stove was covered with a heavy dark black burnt on substance covering approximately 3/4 of the backslash surface.

The drip pan/drawer located on the right side of the griddle had food debris around the mouth of the tray. The handle of the tray was covered with a greasy residue. The tray/pan was firmly stick inside the stove and could not be removed for cleaning.

The griddle/grill flat surface had food residue over the heating surface of the grill. The residue was brown, tan, and black with dusty particles throughout.

The front ledge of the stove in front of the burners had a large strip of thick sticky black residue running the entire length of the ledge. The residue was approximately one inch wide.

The burners of the stove were heavily dusted with a brown, black, and white powdery substance and multiple food particles.

The drip pan located under the burners of the stove was heavily covered with burn on liquids and food particles. The residue covered approximately 95% of the aluminum which lined the pan.

The convection oven had a sticky residue on both handles.

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The inside of the convection oven had dark brown sticky greasy food residue on the inside doors, racks, and bottom of the oven.

During an interview, on 1/3/23 at 10:30 a.m., the Dietary Manager indicated she had no idea when the hood over the stove was last cleaned and didn't know why the back-splash was covered with a dark residue. The staff were unable to remove the drip pan/drawer beside the grill, but it didn't matter because the grill didn't work. She didn't know what the residue was on top of the griddle or when the stove/griddle combination unit was last cleaned. She didn't know there was a removable drip pan under the burners and had never seen it removed or cleaned. She had not had any formal training since she began her position in September of 2022 and had not met with the Registered Dietitian since she began her employment. She did not have any certification as a Dietary Manager. She had not taken a class nor was she currently enrolled in a program.

A facility job description, dated 10/2010, titled "Job Description: Food Services Supervisor", provided by the Administrator on 1/5/2023 at 2:30 p.m., indicated the following: "...Prior experience providing or managing a dietary department

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	for the elderly is preferred...Ensure that daily schedule cleaning is conducted within the dietary department to maintain a sanitary environment...Ensure that the dietary department complies with the established sanitary [sentence ended abruptly]...."			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited	R 0274	Affected residents remain in facility and did not experience any adverse effects related to alleged deficient practice. . The plan of correction will include education and in service training on completing Education and training have been setup for Dietary Manager. The manager has been setup for training for serv safe and provided education on menus, food preparation on Jan 11 2023 food service and sanitation standards from GFS Registered Dietitian. Additional training was provided by corporate dietitian on January 5th covering sanitation and menus. During said in service the Dietary manager was educated Sanitation Food Preparation, food handling services took questions provided education. We will be monitoring and follow-up with our audit tool weekly .The Administrator or designee will check Weekly Monthly and ongoing for 6 months or until 100% compliance is achieved.	01/23/2023

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college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management.

(E) An individual with training and experience in food service supervision and management.

(2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis.

(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.

Based on observation, interview, and record review, the facility failed to ensure the dietary department was directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. This deficient practice had the potential to impact 57 of 57 residents who received their meals from the kitchen.

Findings include:

During a kitchen sanitation tour, on 1/3/22 at 10:30 a.m., the dietary manager indicated she had begun her position as

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Dietary Manager in September 2022. She had no certification or formalized training in dietary management and was not currently enrolled in a dietary management or SafeServ program. She had never managed a dietary department prior to being hired in the position and had not received any services, training, education or guidance from a registered dietitian. She had worked in this facility as a cook or dietary aide prior to being hired as a dietary manager and the registered dietitian had not been in the facility since she began her current role.

During an interview, on 1/4/23 at 9:59 a.m., the Administration indicated the current Dietary Manager was not trained in ServSafe, nor did she have a dietary manager certification. In addition, she was not enrolled in any program as of 1/3/23. The facility had difficulty finding a qualified candidate for Dietary Manager and had chosen to hire an individual who had worked in their dietary department as a cook/aide. The registered dietitian had not been in the facility as frequently as they would like.

Review of a facility document, dated 11/14/12 and titled "Agreement for [company name] to Provide Nutrition Management Services",

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provided by the Administrator on 1/5/23 at 2:46 p.m., indicated the following: "...Option One-Consultant Dietitian Services- [company name] and profession support includes the provision of clinical nutrition, food services monitoring and educational programs...."

Review of a facility job description, dated 10/2010 and titled "Job Description: Food Services Supervisor", provided by the Administrator on 1/5/2023 at 2:30 p.m., indicated the following: "...Prior experience providing or managing a dietary department for the elderly is preferred....Ensure that daily schedule cleaning is conducted within the dietary department to maintain a sanitary environment...Ensure that the dietary department complies with the established sanitary [sentence ended abruptly]...."

Based on observation, interview, and record review, the facility failed to ensure the dietary department was directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. This deficient practice had the potential to impact 57 of 57 residents who received their meals from the kitchen.

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Findings include:

During a kitchen sanitation tour, on 1/3/22 at 10:30 a.m., the dietary manager indicated she had begun her position as Dietary Manager in September 2022. She had no certification or formalized training in dietary management and was not currently enrolled in a dietary management or SafeServ program. She had never managed a dietary department prior to being hired in the position and had not received any services, training, education or guidance from a registered dietitian. She had worked in this facility as a cook or dietary aide prior to being hired as a dietary manager and the registered dietitian had not been in the facility since she began her current role.

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During an interview, on 1/4/23 at 9:59 a.m., the Administration indicated the current Dietary Manager was not trained in ServSafe, nor did she have a dietary manager certification. In addition, she was not enrolled in any program as of 1/3/23. The facility had difficulty finding a qualified candidate for Dietary Manager and had chosen to hire an individual who had worked in their dietary department as a cook/aide. The registered dietitian had not been in the facility as frequently as they would like.

Review of a facility document, dated 11/14/12 and titled "Agreement for [company name] to Provide Nutrition Management Services", provided by the Administrator on 1/5/23 at 2:46 p.m., indicated the following: "...Option One-Consultant Dietitian Services- [company name] and profession support includes the provision of clinical nutrition, food services monitoring and educational programs...."

Review of a facility job description, dated 10/2010 and titled "Job Description: Food Services Supervisor", provided by the Administrator on 1/5/2023 at 2:30 p.m., indicated the following: "...Prior experience providing or managing a dietary department for the elderly is

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	preferred....Ensure that daily schedule cleaning is conducted within the dietary department to maintain a sanitary environment...Ensure that the dietary department complies with the established sanitary [sentence ended abruptly]...."			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on interview and record review, the facility failed to develop the comprehensive care plan for 2 of 2 residents	R 0383	Director of Health Services immediately educated by Nurse Consultant regarding alleged deficiencies in individualized service plans for residents with major mental health diagnoses. All service plans will be reviewed and corrected per regulations. Nurse Consultant will audit service plans of all residents with a major mental health diagnosis once monthly for 6 months or until 100% compliance is achieved. Audit will be done to ensure individualized service plan is complete. Affected residents remain in facility and did not experience any adverse effects related to alleged deficient practice.	01/23/2023

reviewed for care plan development with mental health professionals. (Residents 48 & 13)

Findings include:

1. Resident 48's clinical record was reviewed on 1/5/23 at 10:26 a.m. Diagnoses included, but were not limited to, bipolar disorder (a major mental illness), anxiety, depression, and diabetes. The resident's payor status was Medicaid through the waiver program.

The resident's current medications included Zyprexa (an antipsychotic medication) and bupropion (an anti-depressant medication).

The resident's most current 11/28/22, "Psychiatry Progress Note", indicated the appointment purpose was "Psych follow-up and medication management."

The resident's recent service plan was dated 8/8/22. The record lacked a care plan developed with the mental health provider to address psychosocial rehabilitation provided within the community, nor a comprehensive range of activities to meet multiple levels of need.

2. Resident 13's clinical record was reviewed on 1/5/23 at 10:46 a.m. Diagnoses include,

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but were not limited to, bipolar disorder (a major mental illness), anxiety, and depression. The resident's payor status was Medicaid through the waiver program.

The resident's current medications included bupropion (an anti-depressant medication) and diazepam (an anti-anxiety medication).

The resident's most current 11/16/22, "Psychiatry Progress Note", indicated the appointment purpose was "Psych follow-up and medication management."

The resident's most recent service plan was dated 10/1/22. The record lacked a care plan developed with the mental health provider to address psychosocial rehabilitation services provided within the community, nor a comprehensive range of activities to meet multiple levels of need.

During an interview, on 1/5/23 at 11:57 a.m., the DON indicated the facility did not coordinate a care plan for major mental illness with the psychiatric services provider.

Based on interview and record review, the facility failed to develop the comprehensive care plan for 2 of 2 residents reviewed for care plan

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development with mental health professionals. (Residents 48 & 13)

Findings include:

1. Resident 48's clinical record was reviewed on 1/5/23 at 10:26 a.m. Diagnoses included, but were not limited to, bipolar disorder (a major mental illness), anxiety, depression, and diabetes. The resident's payor status was Medicaid through the waiver program.

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2. Resident 13's clinical record was reviewed on 1/5/23 at 10:46 a.m. Diagnoses include, but were not limited to, bipolar

disorder (a major mental illness), anxiety, and depression. The resident's payor status was Medicaid through the waiver program.

The resident's current medications included bupropion (an anti-depressant medication) and diazepam (an anti-anxiety medication).

The resident's most current 11/16/22, "Psychiatry Progress Note", indicated the appointment purpose was "Psych follow-up and medication management."

The resident's most recent service plan was dated 10/1/22. The record lacked a care plan developed with the mental health provider to address psychosocial rehabilitation services provided within the community, nor a comprehensive range of activities to meet multiple levels of need.

During an interview, on 1/5/23 at 11:57 a.m., the DON indicated the facility did not coordinate a care plan for major mental illness with the psychiatric services provider.

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

TITLE

(X6) DATE

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FORM APPROVED

OMB NO. 0938-0391

SIGNATURE		
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