

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/06/2022	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 13390 N ILLINOIS STREET, CARMEL, , 46032					
(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 Complaints IN00381347, IN00376114 and IN00374357. Complaint IN00381347 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376114 - Substantiated. State deficiencies related to the allegations are cited at R216 and R217. Complaint IN00374357 - Substantiated. State deficiencies related to the allegations are cited at R216. Survey dates: October 4, 5 and 6, 2022 Facility number: 013297 Residential Census: 46 These State Residential	R 0000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.				

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	Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed October 18, 2022.			
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure the State Survey Results were easily found or a notice of where the survey binder was located was posted. This deficient practice has the potential to effect 46 of 46 residents residing in the facility and visitors. Finding includes: During an observation of the facility, on 10/04/22 beginning at 8:45 a.m., the State Survey Results binder was not found. Receptionist 1 indicated it was in the Executive Director's office. On 10/04/22 at 9:20 a.m., the survey results binder was not located in the lobby or another	R 0042	1. As explained to the surveyor, the Survey Results Binder was put on a shelf while the newly hired receptionist cleaned and organized the front desk counter. Once the surveyor requested it, the Executive Director went to where it was normally placed and found it on a different shelf. She immediately placed the binder in its normal location, while being interviewed by the state surveyor. As stated to the surveyor, the Executive Director is aware of the regulation regarding the placement of the Survey Results Binder and quoted that to the surveyor. The binder is located in the foyer at the main entrance, on a shelf that is visible and within reach for residents, staff and visitors to access. The Executive Director also keeps a duplicate binder up to date in her office in case the one out front is in use or misplaced. We will follow the surveyor's	11/01/2022

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area on the first floor. There were no signs posted to indicate where the binder could be found.

On 10/04/22 at 10:37 a.m., an inquiry was made regarding where the survey result book could be found. At that time, the Executive Director removed the binder from a low shelf behind the reception station. She indicated Receptionist 1 was new and moved it when she was cleaning and organizing her area; the binder was usually kept behind the reception station or at the far right of the reception desk.

During an interview, on 10/04/22 at 1:55 p.m., Resident E indicated she did not know there was a binder.

During an interview, on 10/04/22 at 2:14 p.m., Resident B indicated he did not know where the book could be found.

During an interview, on 10/04/22 at 2:25 p.m., Resident F indicated she did not know where the binder was located.

During an interview, on 10/06/2022, Executive Director 2 indicated the facility did not have a policy regarding the survey results book. It was addressed in the regulations. He did know it needed to be "up front and center" or there needed to be a sign posted

advice of placing a sign identifying the binder location in a frame at the front desk.

2.
New signage identifying the location of the binder will be placed in a visible location for all residents to notice.

3.
The Executive Director will inform the leadership team and staff of the location of the binder noting the new signage (identifying the location of the binder) so that all are aware and can direct residents, staff and visitors to the Survey Results Binder as requested.

4.
Each day when rounding the community, the Executive Director will check to verify the binder and the new signage are in a visible location.

5.
The binder was immediately returned to its location after the surveyor asked where it was kept. The signage will be in

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relating to where the book could be located.

Based on observation and interview, the facility failed to ensure the State Survey Results were easily found or a notice of where the survey binder was located was posted. This deficient practice has the potential to effect 46 of 46 residents residing in the facility and visitors.

Finding includes:

During an observation of the facility, on 10/04/22 beginning at 8:45 a.m., the State Survey Results binder was not found. Receptionist 1 indicated it was in the Executive Director's office.

On 10/04/22 at 9:20 a.m., the survey results binder was not located in the lobby or another area on the first floor. There were no signs posted to indicated where the binder could be found.

On 10/04/22 at 10:37 a.m., an inquiry was made regarding where the survey result book could be found. At that time, the Executive Director removed the binder from a low shelf behind the reception station. She indicated Receptionist 1 was new and moved it when she was cleaning and organizing her area; the binder was usually

place by 11/1/22.

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	kept behind the reception station or at the far right of the reception desk. During an interview, on 10/04/22 at 1:55 p.m., Resident E indicated she did not know there was a binder. During an interview, on 10/04/22 at 2:14 p.m., Resident B indicated he did not know where the book could be found. During an interview, on 10/04/22 at 2:25 p.m., Resident F indicated she did not know where the binder was located. During an interview, on 10/06/2022, Executive Director 2 indicated the facility did not have a policy regarding the survey results book. It was addressed in the regulations. He did know it needed to be "up front and center" or there needed to be a sign posted relating to where the book could be located.			
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	R 0092	1. Fire drills will be completed per the state regulation – at least 12 drills will be conducted each year; conducted quarterly on each shift. At least every 6 months, the facility shall attempt to hold the fire and disaster drill in conjunction	12/31/2022

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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 conduct fire drills for 6 of 12 months and the facility was unable to provide documentation to show the fire department had been invited or involved in fire drills every six months. This deficient practice has the potential to effect 46 of 46 residents residing in the facility.

Finding includes:

During an interview, on 10/05/22 at 11:03 a.m., the Executive Director indicated fire drills were

with the local fire department. All drill trainings shall be documented with the names and signature of personnel present. Documentation from the local fire department will be provided as proof that they were invited and whether or not they could attend at least once every 6 months.

2. Fire drills will continue to be logged per state regulation going forward. The facility will attempt to invite the fire department to a drill training at least once every 6 months.

3. At the start of each month, the Executive Director will meet with the Maintenance Supervisor to schedule each drill. The Executive Director will ensure the drill is completed and logged by signing off on each log sheet and will keep an electronic copy on file as well.

4. The Maintenance Supervisor will upload the

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to be put into the system and the last maintenance employee did not put them into the system (document record of occurrence) and the facility was unable to provide 12 fire drills. The fire department was invited in May but declined. She was unable to show documentation of the invitation or declination.

The fire drill documents were provided, by the Executive Director, on 10/05/2022 at 1:00 p.m. There was no documentation to show fire drills were conducted in October 2021, November 2021, December 2021, January 2022, February 2022 and March 2022. The facility was unable to provide documentation to show the fire department had been invited to or had attended the fire drills which had been conducted.

A facility policy, titled "FIRE DRILL PROCEDURE," dated 09/22/2017 and provided by the Executive Director on 10/05/2022 at 1:00 p.m., indicated "...the facility operates 24 hours, a total of 12 drills a year with four on each shift are require...."

Based on interview and record review, the facility failed to conduct fire drills for 6 of 12 months and the facility was unable to provide documentation to show the fire

completed logs into the corporate system where his regional is able to track and audit all drill trainings. The Maintenance Supervisor will keep a binder with the drill logs and documentation from the fire department in an easily assessable location. The Executive Director will audit the Fire Drills each quarter to ensure all shifts are being trained and the fire department is invited at least once every 6 months.

5.
Complete by the end of the 4th quarter, 12/31/22 and continuing thereafter.

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department had been invited or involved in fire drills every six months. This deficient practice has the potential to effect 46 of 46 residents residing in the facility.

Finding includes:

During an interview, on 10/05/22 at 11:03 a.m., the Executive Director indicated fire drills were to be put into the system and the last maintenance employee did not put them into the system (document record of occurrence) and the facility was unable to provide 12 fire drills. The fire department was invited in May but declined. She was unable to show documentation of the invitation or declination.

The fire drill documents were provided, by the Executive Director, on 10/05/2022 at 1:00 p.m. There was no documentation to show fire drills were conducted in October 2021, November 2021, December 2021, January 2022, February 2022 and March 2022. The facility was unable to provide documentation to show the fire department had been invited to or had attended the fire drills which had been conducted.

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	10/05/2022 at 1:00 p.m., indicated "...the facility operates 24 hours, a total of 12 drills a year with four on each shift are require...."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in 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.	R 0117	1. A CPR & First Aid Training Course will be provided to selected employees in each department. Wellness will ensure that there is at least 1 awake wellness staff person per 50 residents with current CPR & First Aid Certificate on shift at all times. 2. Current CPR & First Aid Certificates will be on file for all trained employees. 3. Employee schedules will be audited weekly to ensure certified staff coverage meets the state regulations. 4. Each department lead will sign off on employee schedules which will also highlight the certified staff coverage in their department per shift. The weekly	12/31/2022

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Based on interview and record review, the facility failed to ensure one awake person certified for Cardiopulmonary Resuscitation (CPR) and/or First Aid was on duty for 3 of 14 twelve hours shifts reviewed for CPR.

Finding includes:

A review of the daily staffing sheet indicated the facility did not have a staff member, certified in CPR and First Aid, on duty from 7:00 p.m., to 7:00 a.m., on 09/30/22 and 10/03/22. The facility did not have a staff member, certified in First-Aid on duty from 7:00 a.m., to 7:00 p.m., on 10/04/22.

During an interview, on 10/05/22 at 10:41 a.m., the Executive Director indicated the facility was to be staffed every shift with a CPR and First Aid Certified Staff.

An undated facility policy, titled "Indiana RCF Staffing Requirement," provided by the Clinical Specialist on 10/06/22 at 11:37 a.m., indicated "...A minimum of one awake staff person who has current CPR and first aid certificated shall be onsite at all times...."

Based on interview and record review, the facility failed to ensure one awake person certified for Cardiopulmonary Resuscitation (CPR) and/or First

schedules will be audited and signed off by the Executive Director to ensure the state regulation is met.

5.
Training course completion and department schedule audits will be complete by 12/31/22.

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	Aid was on duty for 3 of 14 twelve hours shifts reviewed for CPR. Finding includes: A review of the daily staffing sheet indicated the facility did not have a staff member, certified in CPR and First Aid, on duty from 7:00 p.m., to 7:00 a.m., on 09/30/22 and 10/03/22. The facility did not have a staff member, certified in First-Aid on duty from 7:00 a.m., to 7:00 p.m., on 10/04/22. During an interview, on 10/05/22 at 10:41 a.m., the Executive Director indicated the facility was to be staffed every shift with a CPR and First Aid Certified Staff. An undated facility policy, titled "Indiana RCF Staffing Requirement," provided by the Clinical Specialist on 10/06/22 at 11:37 a.m., indicated "...A minimum of one awake staff person who has current CPR and first aid certificated shall be onsite at all times...."			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee)	R 0119	1. All employees will participate in a general and job specific orientation by the department designee in which the employee will work.	12/31/2022

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of the department in which the employee will work. Orientation of all employees shall include the following:

(1) Instructions on the needs of the specialized populations:

(A) aged;

(B) developmentally disabled;

(C) mentally ill;

(D) dementia; or

(E) children;

served in the facility.

(2) A review of the facility's policy manual and applicable procedures, including:

(A) organization chart;

(B) personnel policies;

(C) appearance and grooming policies for employees; and

(D) residents' rights.

(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.

(4) Review of ethical considerations and confidentiality in resident care and records.

(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.

2.

Prior to working independently, the employee's orientation will include instructions on the needs of specialized populations for the aged, developmentally disabled, mentally ill, dementia or children served in the facility. Employees will receive a job description overview, facility tour, review the facility's policy manual and applicable procedures to include organizational chart, personnel policies, appearance and grooming policies, residents' rights, instruction in first aid, emergency procedures, fire & disaster preparedness and evacuation procedures. Review of ethical considerations and confidentiality in resident care and records. For direct care staff, a personal introduction in the particular needs of each resident to whom the employee will be providing care. Documentation of the orientation requirements will be in each of the employee's personnel record.

3.

Employee orientation will be provided for all

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(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.

Based on interview and record review, the facility failed to provide documentation for general orientation and job specific orientation for 4 of 5 new employees reviewed for orientation. (Dementia Care Director, Dietary Server 3, CNA 4 and the Life Enrichment Director)

Findings include:

A review of the employee records began on 10/04/22. The facility was unable to provide a general orientation or job specific orientation for the following employees:

1. The Dementia Care Director, start date 07/17/22, did not have a general orientation or job specific orientation on file.
2. Dietary Server 3, start date 07/06/22, did not have a general orientation or a job specific orientation on file.
3. Certified Nursing Assistant (CNA) 4, start date 09/12/22, did not have a general orientation or a job specific orientation on file.
4. The Life Enrichment Director, start date 07/18/22, did not have a general orientation or a job

current and future employees. Documentation of completion via a typed checklist will be signed off by the employee and department designee and placed in each employee file prior to working independently.

4. A random group of employee files will be audited by the Executive Director for the completed orientation checklists to ensure staff are ready to work independently.

5. Orientation training and checklist completion will be signed off on and filed by 12/31/22 and continuing with future employees.

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specific orientation on file.

During an interview, on 10/05/22 at 2:00 p.m., the Executive Director indicated general orientation consisted of a slide show and there was no way to track who had completed it. The facility did not have a check off document for general orientation or a job specific skill check off.

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A facility document, titled "Community Orientation Checklist-Licensed IN," provided by the Clinical Specialist on 10/06/22 at 11:37 a.m., indicated on day 1 the new employee was to have a community tour, learn about technology, such as the Nurse Call System and fire safety. On day 2 orientation included, but was not limited to, infection control, emergency procedures and incident reports. The back side of the form was titled "On the Job Training and Skills Checklist" and indicated "...Orienteer will progress through observing...then completing the skill with the assistance of the trainer...then completing the skill with trainer supervision...Trainer will determine how much exposure is needed before checking orientee off and should use judgement based on orientee's experience level and current abilities during observation...." The check off included resident care activities.

An undated facility document, titled "PROGRAM STATEMENT RESIDENTIAL CARE FACILITY (INDIANA)," provided by Executive Director 2 on 10/06/22 at 9:47 a.m., indicated "...In order to meet the various needs of the community members, community staff must be trained and competent in many different areas...Training

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will be provided in Reporting Requirements, First-Aid, CPR, Personal Care, Supervision and Protection, Resident Rights, Safety and Fire Prevention, Nutrition, and Prevention and Containment of Communicable Diseases, as well as other area specific to the residents we serve or as needed...Staff are trained using a combination of approved curriculum, Dementia Training, and organizational specific policies and procedures...Continuing education will be presented through staff meetings and in-house services/training...."

Based on interview and record review, the facility failed to provide documentation for general orientation and job specific orientation for 4 of 5 new employees reviewed for orientation. (Dementia Care Director, Dietary Server 3, CNA 4 and the Life Enrichment Director)

Findings include:

A review of the employee records began on 10/04/22. The facility was unable to provide a general orientation or job specific orientation for the following employees:

1. The Dementia Care Director, start date 07/17/22, did not have a general orientation or job specific orientation on file.

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2. Dietary Server 3, start date 07/06/22, did not have a general orientation or a job specific orientation on file.

3. Certified Nursing Assistant (CNA) 4, start date 09/12/22, did not have a general orientation or a job specific orientation on file.

4. The Life Enrichment Director, start date 07/18/22, did not have a general orientation or a job specific orientation on file.

During an interview, on 10/05/22 at 2:00 p.m., the Executive Director indicated general orientation consisted of a slide show and there was no way to track who had completed it. The facility did not have a check off document for general orientation or a job specific skill check off.

A facility document, titled "Community Orientation Checklist-Licensed IN," provided by the Clinical Specialist on 10/06/22 at 11:37 a.m., indicated on day 1 the new employee was to have a community tour, learn about technology, such as the Nurse Call System and fire safety. On day 2 orientation included, but was not limited to, infection control, emergency procedures and incident reports. The back side of the form was titled "On the Job Training and Skills Checklist" and indicated

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"...Orienteer will progress through observing...then completing the skill with the assistance of the trainer...then completing the skill with trainer supervision...Trainer will determine how much exposure is needed before checking orientee off and should use judgement based on orientee's experience level and current abilities during observation...."
The check off included resident care activities.

An undated facility document, titled "PROGRAM STATEMENT RESIDENTIAL CARE FACILITY (INDIANA)," provided by Executive Director 2 on 10/06/22 at 9:47 a.m., indicated "...In order to meet the various needs of the community members, community staff must be trained and competent in many different areas...Training will be provided in Reporting Requirements, First-Aid, CPR, Personal Care, Supervision and Protection, Resident Rights, Safety and Fire Prevention, Nutrition, and Prevention and Containment of Communicable Diseases, as well as other area specific to the residents we serve or as needed...Staff are trained using a combination of approved curriculum, Dementia Training, and organizational specific policies and procedures...Continuing education will be presented through staff meetings and

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	in-house services/training...."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be	R 0120	1. The facility will ensure that all employees are current on dementia trainings. 2. An audit of employee Relias trainings will be completed to identify staff who are not current on dementia training. Employees will have the option of completing an in-person training to be checked off on Relias by the director or may complete the dementia training hours online through Relias. 3. Each department lead will audit their employee's Relias record as a tracking tool to ensure their staff is current with dementia training. 4. Monthly, the Executive Director will audit the Relias reports to ensure all training is complete. 5. Completed by 12/31/22	12/31/2022

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maintained and shall indicate the following:

- (A) The time, date, and location.
- (B) The name of the instructor.
- (C) The title of the instructor.
- (D) The names of the participants.
- (E) The program content of inservice.

The employee will acknowledge attendance by written signature.

Based on interview and record review, the facility failed to ensure 4 of 10 employees were current on Dementia in-services. (Receptionist 5, LPN 6, Resident Assistant 7 and Sous Chef 8)

Finding includes:

A review of the employee records began on 10/04/22. The facility was unable to provide Dementia training for the following employees: Receptionist 5 (6 hours), LPN 6 (3 hours), Resident Assistant (RA) 7 (3 hours) and Sous Chef 8 (3 hours).

During an interview, on 10/06/22 at 9:47 a.m., Executive Director 2 indicated existing staff needed three (3) hours of dementia training and six (6) hours for new employees. He did not have a specific policy and provided a document which

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addressed the training.

An undated facility document, titled "PROGRAM STATEMENT RESIDENTIAL CARE FACILITY (INDIANA)," provided by Executive Director 2 on 10/06/22 at 9:47 a.m., indicated "...In order to meet the various needs of the community members, community staff must be trained and competent in many different areas...Training will be provided in Reporting Requirements, First-Aid, CPR, Personal Care, Supervision and Protection, Resident Rights, Safety and Fire Prevention, Nutrition, and Prevention and Containment of Communicable Diseases, as well as other area specific to the residents we serve or as needed...Staff are trained using a combination of approved curriculum, Dementia Training, and organizational specific policies and procedures...Continuing education will be presented through staff meetings and in-house services/training...."

Based on interview and record review, the facility failed to ensure 4 of 10 employees were current on Dementia in-services. (Receptionist 5, LPN 6, Resident Assistant 7 and Sous Chef 8)

Finding includes:

A review of the employee

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records began on 10/04/22. The facility was unable to provide Dementia training for the following employees: Receptionist 5 (6 hours), LPN 6 (3 hours), Resident Assistant (RA) 7 (3 hours) and Sous Chef 8 (3 hours).

During an interview, on 10/06/22 at 9:47 a.m., Executive Director 2 indicated existing staff needed three (3) hours of dementia training and six (6) hours for new employees. He did not have a specific policy and provided a document which addressed the training.

An undated facility document, titled "PROGRAM STATEMENT RESIDENTIAL CARE FACILITY (INDIANA)," provided by Executive Director 2 on 10/06/22 at 9:47 a.m., indicated "...In order to meet the various needs of the community members, community staff must be trained and competent in many different areas...Training will be provided in Reporting Requirements, First-Aid, CPR, Personal Care, Supervision and Protection, Resident Rights, Safety and Fire Prevention, Nutrition, and Prevention and Containment of Communicable Diseases, as well as other area specific to the residents we serve or as needed...Staff are trained using a combination of approved curriculum, Dementia Training, and organizational

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	specific policies and procedures...Continuing education will be presented through staff meetings and in-house services/training...."			
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.	R 0121	1. Employees who have not completed a 2 step TB Test will participate in a Mantoux TB Test Clinic for both steps and if not able to perform the annual Mantoux test, will participate in a chest x-ray every 5 years. 2. Employee files will be audited to determine TB Test completion per regulation. If not, complete will do so immediately via a clinic to ensure all employees are up to date. 3. As part of the employee orientation, the testing result paperwork will be filed and checked off of the employee checklist in each employee file. Existing employees in need of the annual test may provide the annual Risk Assessment or participate in a clinic. Current	12/31/2022

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(2) All employees who have a positive reaction to the skin test 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 perform a two-step Mantoux test (a tuberculosis skin test) for 2 of 5 new employees (Dietary Server 4 and Resident Assistant 7), failed to perform the second step Mantoux test for 2 of 5 new employees (CNA 10 and the Life Enrichment (LE) Director) and failed to perform annual Mantoux test on 1 of 5 established employee (Housekeeper 9) reviewed for Mantoux skin testing.

Findings include:

A review of the employee records began on 10/04/22.

The facility was unable to provide a two step tuberculosis test for Dietary Server 4 and

test result paperwork or risk assessment will be kept in the employee files.

4. Monthly audits of employee files will be completed on a random group of files to ensure testing is current and complete. Clinics will be regularly provided as testing is needed to keep employees up to date.

5. Completed by 12/31/22 then random monthly audits going forward.

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Resident Assistant (RA) 7.

The Facility was unable to provide the second test of a two step Mantoux series for CNA 10 and the Life Enrichment Director.

The facility was unable to provide an annual tuberculosis skin test or tuberculosis assessment/education for Housekeeper 9.

During an interview, on 10/05/22 at 4:20 p.m., the Executive Director indicated the facility did not have the information.

A facility policy, titled "TB Infection Control Plan-Indiana," dated 06/21/21 and provided by the Executive Director 2 on 10/06/22 at 10:11 a.m., indicated "...At the time of employment, or within (1) month prior to employment and at least annually thereafter, employees...of facilities shall be screened for tuberculosis...The first tuberculosis must be read prior to the employee starting work...For healthcare workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the base line 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

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step...."

Based on interview and record review, the facility failed to perform a two-step Mantoux test (a tuberculosis skin test) for 2 of 5 new employees (Dietary Server 4 and Resident Assistant 7), failed to perform the second step Mantoux test for 2 of 5 new employees (CNA 10 and the Life Enrichment (LE) Director) and failed to perform annual Mantoux test on 1 of 5 established employee (Housekeeper 9) reviewed for Mantoux skin testing.

Findings include:

A review of the employee records began on 10/04/22.

The facility was unable to provide a two step tuberculosis test for Dietary Server 4 and Resident Assistant (RA) 7.

The Facility was unable to provide the second test of a two step Mantoux series for CNA 10 and the Life Enrichment Director.

The facility was unable to provide an annual tuberculosis skin test or tuberculosis assessment/education for Housekeeper 9.

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	During an interview, on 10/05/22 at 4:20 p.m., the Executive Director indicated the facility did not have the information. A facility policy, titled "TB Infection Control Plan-Indiana," dated 06/21/21 and provided by the Executive Director 2 on 10/06/22 at 10:11 a.m., indicated "...At the time of employment, or within (1) month prior to employment and at least annually thereafter, employees...of facilities shall be screened for tuberculosis...The first tuberculosis must be read prior to the employee starting work...For healthcare workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the base line 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...."			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical,	R 0216	1. Evaluations will be completed every 6 months or if a change of condition for each resident not in compliance. Self-Medication Evaluations will be completed every 6 months or if a change of condition for residents who are or who desire to self-medicate. Staff will	12/31/2022

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cognitive, and mental status.

(2) The resident ' s independence in the activities of daily living.

(3) The resident ' s weight taken on admission and semiannually thereafter.

(4) If applicable, the resident ' s ability to self-administer medications.

(d) The evaluation shall be documented in writing and kept in the facility.

Based on record review and interview, the facility failed to perform a semi-annual evaluation for 3 of 7 residents (Residents D, E and H) and failed to have an assessment for self administration of medications for 1 of 2 residents (Resident F) reviewed for assessments/evaluations.

Findings include:

1. The record for Resident D was reviewed on 10/04/22. Diagnoses included, but were not limited to, protein calorie malnutrition, right femur fracture and type 2 diabetes.

The record did not contain a current semi-annual evaluation of the resident's needs.

2. The record for Resident E was reviewed on 10/04/22. Diagnoses included, but were not limited to, hypertensive

ensure residents, for whom we provide medication management, take medication by observation before leaving the resident. Changes to evaluations will be care planned immediately and signed off on by the resident and Wellness Director or Executive Director and a copy provided to the resident at request.

2. All residents' medical files, who are allowed to self-medicate, will be checked by wellness staff to ensure evaluations are current. All residents' medical files will be checked for a wellness evaluation completed within the last 6 months.

3. If evaluations are found to be expired, evaluations will be completed right away and provided a care conference if there are changes to the care plan. An in-service will be provided by the Wellness Director for all wellness staff able to pass medications on the

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heart failure, motor neuron disease and fracture of t11-t12 vertebra.

The record did not contain a current semi-annual evaluation of the resident's needs.

3. The record for Resident H was reviewed on 10/04/22. Diagnoses included, but were not limited to, hypertension, atrial fibrillation and hyperlipidemia.

The record did not contain a current semi-annual evaluation of the resident's needs.

4. During an observation of medication administration, on 10/4/2022 at 12:09 p.m., LPN 15 prepared Carvedliol (a blood pressure medication) 12.5 milligrams (mg) and olanzapine (an antipsychotic) 10 mg for Resident F. The nurse took the medications to the resident's room, knocked on the door and handed the medications to the resident, who took the cup of medications and shut the door. The nurse did not observe the medication administration. The nurse indicated she did not know if the resident could self administer medications.

The record for Resident F was reviewed on 10/4/22. Diagnoses included, but were not limited to, bipolar disorder, edema and hypertension.

process of medication management and an in-service training log of staff who were trained completed and filed.

4. The evaluation expirations dates will be logged into Point Click Care (PCC) and with a calendar notification as a reminder. The Wellness Director will track all evaluation completions and care plan conferences completed in PCC. The Wellness Director will audit all staff who are able to pass medications monthly by observing a medication pass.

5. Completed by 12/31/22

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The resident did not have an assessment to self administer medications.

During an interview, on 10/06/22 at 11:33 a.m., the Clinical Specialist indicated the facility did not have the information.

A facility policy, titled "Evaluation & Care Conference," dated 01/15/20 and provided by the Executive Director on 10/04/22 at 12:33 p.m., indicated "...Evaluation...Ongoing every 3 months while on services...."

A facility policy, titled "Medication Resident Self Administration," dated 08/01/17 and provided by the Clinical Specialist on 10/04/22 at 2:24 p.m., indicated "...Any resident who wishes to self-administer medications must...pass the Self-Administration Evaluation...."

This State Residential Finding relates to Complaint IN00374357 and Complaint IN00376114.

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Based on record review and interview, the facility failed to perform a semi-annual evaluation for 3 of 7 residents (Residents D, E and H) and failed to have an assessment for self administration of medications for 1 of 2 residents (Resident F) reviewed for assessments/evaluations.

Findings include:

1. The record for Resident D was reviewed on 10/04/22. Diagnoses included, but were not limited to, protein calorie malnutrition, right femur fracture and type 2 diabetes.

The record did not contain a current semi-annual evaluation of the resident's needs.

2. The record for Resident E was reviewed on 10/04/22. Diagnoses included, but were not limited to, hypertensive heart failure, motor neuron disease and fracture of t11-t12 vertebra.

The record did not contain a current semi-annual evaluation of the resident's needs.

3. The record for Resident H was reviewed on 10/04/22. Diagnoses included, but were not limited to, hypertension, atrial fibrillation and hyperlipidemia.

The record did not contain a

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current semi-annual evaluation of the resident's needs.

4. During an observation of medication administration, on 10/4/2022 at 12:09 p.m., LPN 15 prepared Carvedliol (a blood pressure medication) 12.5 milligrams (mg) and olanzapine (an antipsychotic) 10 mg for Resident F. The nurse took the medications to the resident's room, knocked on the door and handed the medications to the resident, who took the cup of medications and shut the door. The nurse did not observe the medication administration. The nurse indicated she did not know if the resident could self administer medications.

The record for Resident F was reviewed on 10/4/22. Diagnoses included, but were not limited to, bipolar disorder, edema and hypertension.

The resident did not have an assessment to self administer medications.

During an interview, on 10/06/22 at 11:33 a.m., the Clinical Specialist indicated the facility did not have the information.

A facility policy, titled "Evaluation & Care Conference," dated 01/15/20 and provided by the Executive Director on 10/04/22 at 12:33 p.m., indicated "...Evaluation...Ongoing every 3

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	months while on services...." A facility policy, titled "Medication Resident Self Administration," dated 08/01/17 and provided by the Clinical Specialist on 10/04/22 at 2:24 p.m., indicated "...Any resident who wishes to self-administer medications must...pass the Self-Administration Evaluation...." This State Residential Finding relates to Complaint IN00374357 and Complaint IN00376114.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as	R 0217	1. All evaluations will be reviewed and made current in PCC. The current care plan will be agreed upon with the resident and signed by the resident and Wellness Director or Executive Director. A copy will be provided immediately if requested.	12/31/2022

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	appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to have a signed service plan for 7 of 7 residents reviewed for service plans. (Residents B, C, D, E, F, G and H) Findings include: 1. The record for Resident B was reviewed on 10/04/22. Diagnoses included, but were not limited to, chronic heart failure, major depressive disorder and type 2 diabetes.		2. Following an evaluation, the agreed upon care plan will be signed by the resident and Wellness Director or Executive Director. A copy of the care plan will be given to the resident immediately if request. 3. All care plans will be signed by the resident and Wellness Director or Executive Director and filed in the medical chart. An electronic care plan will be current at all times on PCC. The care plan expiration date for each resident will be noted in PCC and will be tracked on a calendar with notification. 4. The Wellness Director will audit the medical records at random monthly to ensure that all files have signed care plans in place. 5. Completed by 12/31/22	
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The record did not contain a current signed Service Plan.

2. The record for Resident C was reviewed on 10/04/22. Diagnoses included, but were not limited to, a right femur fracture and Alzheimer's disease.

The record did not contain a current signed Service Plan.

3. The record for Resident D was reviewed on 10/04/22. Diagnoses included, but were not limited to, type 2 diabetes, protein calorie malnutrition and hypertension.

The record did not contain a current signed Service Plan.

4. The record for Resident E was reviewed on 10/04/22. Diagnoses included, but were not limited to, hypertensive heart failure, motor neuron disease and fracture of t11-t12 vertebra.

The record did not contain a current signed Service Plan.

5. The record for Resident F was reviewed on 10/04/22. Diagnoses included, but were not limited to, bipolar disorder, edema and hypertension.

The record did not contain a current signed Service Plan.

6. The record for Resident G

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was reviewed on 10/04/22.
Diagnoses included, but were not limited to, glaucoma, essential tremor and dementia.

The record did not contain a current signed Service Plan.

7. The record for Resident H was reviewed on 10/04/22.
Diagnoses included, but were not limited to hypertension, atrial fibrillation and hyperlipidemia.

The record did not contain a current signed Service Plan.

During an interview, on 10/06/22 at 11:33 a.m., the Clinical Specialist indicated the facility did not have the information to provide.

A facility policy, titled ""Evaluation & Care Conference," dated 01/15/20 and provided by the Executive Director on 10/04/22 at 12:33 p.m., indicated "...The Director or Designee will schedule a meeting with the resident/client, family or responsible party to review care recommendations, changes in care, and address any concern that may arise using the Care Conference form...."

This State Residential Finding relates to Complaint IN00376114.

Based on record review and interview, the facility failed to

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have a signed service plan for 7 of 7 residents reviewed for service plans. (Residents B, C, D, E, F, G and H)

Findings include:

1. The record for Resident B was reviewed on 10/04/22. Diagnoses included, but were not limited to, chronic heart failure, major depressive disorder and type 2 diabetes.

The record did not contain a current signed Service Plan.

2. The record for Resident C was reviewed on 10/04/22. Diagnoses included, but were not limited to, a right femur fracture and Alzheimer's disease.

The record did not contain a current signed Service Plan.

3. The record for Resident D was reviewed on 10/04/22. Diagnoses included, but were not limited to, type 2 diabetes, protein calorie malnutrition and hypertension.

The record did not contain a current signed Service Plan.

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4. The record for Resident E was reviewed on 10/04/22. Diagnoses included, but were not limited to, hypertensive heart failure, motor neuron disease and fracture of t11-t12 vertebra.

The record did not contain a current signed Service Plan.

5. The record for Resident F was reviewed on 10/04/22. Diagnoses included, but were not limited to, bipolar disorder, edema and hypertension.

The record did not contain a current signed Service Plan.

6. The record for Resident G was reviewed on 10/04/22. Diagnoses included, but were not limited to, glaucoma, essential tremor and dementia.

The record did not contain a current signed Service Plan.

7. The record for Resident H was reviewed on 10/04/22. Diagnoses included, but were not limited to hypertension, atrial fibrillation and hyperlipidemia.

The record did not contain a current signed Service Plan.

During an interview, on 10/06/22 at 11:33 a.m., the Clinical Specialist indicated the facility did not have the information to provide.

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	A facility policy, titled ""Evaluation & Care Conference," dated 01/15/20 and provided by the Executive Director on 10/04/22 at 12:33 p.m., indicated "...The Director or Designee will schedule a meeting with the resident/client, family or responsible party to review care recommendations, changes in care, and address any concern that may arise using the Care Conference form...." This State Residential Finding relates to Complaint IN00376114.			
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 open dates were placed on food items in the pantry, freezer and cooler, failed to have a thermometer in the ice cream cooler, failed to ensure foods were properly sealed in the ice cream cooler and freezer and failed to ensure food items in the pantry and freezer were	R 0273	1. All food preparation and serving areas in culinary will be maintained in accordance with state and local sanitation and safe food handling standards. 2. The facility will ensure that labels with open dates and expiration dates are placed on food items in the pantry, freezer and cooler. The ice cream cooler will have a thermometer in it and ice cream containers and coolers will be properly sealed. All items in the freezer and	12/31/2022

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stored off the floor. This deficient practice had the potential to effect 46 of 46 residents who receive food from the facility kitchen.

Findings include:

During a walk through of the kitchen with the Chef, on 10/04/22 beginning at 10:42 a.m., the following items were found:

- A box of individually wrapped oyster crackers was found laying on its side on the floor of the dry goods storage room.
- Two bags of corn flakes cereal were found open without an open date.
- One 16 ounce (oz) container of concentrated sweet tea was found without an open date on the container. There was 12 oz left in the container.
- A one gallon container of bar-b-que sauce, 1/8 full, was found without an open date on the container. At the time the Chef indicated it should have been refrigerated.
- The ice cream freezer chest did not have a thermometer.
- A full 3 gallon container of chocolate ice cream was found with the lid partially on leaving the ice cream exposed to air.

pantry will be stored off of the floor at least 6 inches from the ground and food will be properly sealed as to not be exposed to the air. The staff will have selected employees Serve Safe certified to assist with managing and maintaining sanitation and safe food handling.

3.
Temp logs and sanitation will be completed daily and monitored by the Executive Chef, Sous Chef or Dining Room Manager. Daily observation of food storage areas will be done by the Executive Chef, Sous Chef or Dining Room Manager to ensure proper storage, labeling and FIFO method utilized.

4.
The Executive Director will randomly observe the food storage areas, temp check logs and sanitation each week.

5.
Completed by 12/31/22

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|--|--|--|--|
| <ul style="list-style-type: none">- A full 3 gallon container of strawberry ice cream was found with the lid partially on leaving the ice cream exposed to air.- An almost empty 3 gallon container of cherry ice cream was found without a lid, leaving the remaining ice cream exposed to air.- In the freezer a box of frozen French fries, a box of frozen lemon juice and a box of frozen peas were found stored on the floor.- A box of turkey patties was found open to air and without an open date. There were six (6) patties left.- A rectangular metal pan containing frozen fish fillets was found open to air and without a date. There were 12 fillets in the container.- A gallon sized plastic container containing pepperoni slices, colored brown and red, was found with a date of 08/27. There was no discard date found on the container.- A container of 12 breaded chicken fingers were found in an open box and exposed to air. There was no open date. | | | |
|--|--|--|--|

- A 2.5 pound (lb) container of mozzarella cheese was found wrapped in plastic without an open date. - A 2.5 lb container of feta cheese was found wrapped in plastic without an open date. - A 2 lb block of Swiss cheese was found wrapped in plastic without an open date. A facility policy, titled "Proper Food Storage," dated as reviewed on 06/06/22 and provided by the Executive Director on 10/04/22 at 3:14 p.m., indicated "...All foods must be stored on shelves a minimum of 6 inches from the ground...Label all open containers with open date and expiration date...Keep foods properly wrapped or covered and dated with date opened and date expires...All cooked or prepped foods need to be in containers that are covered, labeled and dated with date made and date expires...Have thermometers in all refrigerators and freezers and check them daily to ensure proper temperatures are being kept...When to date mark foods:...Anytime the original packaging is opened...." Based on observation, interview and record review, the facility failed to ensure open dates were placed on food items in the			
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pantry, freezer and cooler, failed to have a thermometer in the ice cream cooler, failed to ensure foods were properly sealed in the ice cream cooler and freezer and failed to ensure food items in the pantry and freezer were stored off the floor. This deficient practice had the potential to effect 46 of 46 residents who receive food from the facility kitchen.

Findings include:

During a walk through of the kitchen with the Chef, on 10/04/22 beginning at 10:42 a.m., the following items were found:

- A box of individually wrapped oyster crackers was found laying on its side on the floor of the dry goods storage room.
- Two bags of corn flakes cereal were found open without an open date.
- One 16 ounce (oz) container of concentrated sweet tea was found without an open date on the container. There was 12 oz left in the container.
- A one gallon container of bar-b-que sauce, 1/8 full, was found without an open date on the container. At the time the Chef indicated it should have been refrigerated.
- The ice cream freezer chest

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did not have a thermometer.

- A full 3 gallon container of chocolate ice cream was found with the lid partially on leaving the ice cream exposed to air.

- A full 3 gallon container of strawberry ice cream was found with the lid partially on leaving the ice cream exposed to air.

- An almost empty 3 gallon container of cherry ice cream was found without a lid, leaving the remaining ice cream exposed to air.

- In the freezer a box of frozen French fries, a box of frozen lemon juice and a box of frozen peas were found stored on the floor.

- A box of turkey patties was found open to air and without an open date. There were six (6) patties left.

- A rectangular metal pan containing frozen fish fillets was found open to air and without a date. There were 12 fillets in the container.

- A gallon sized plastic container containing pepperoni slices, colored brown and red, was found with a date of 08/27. There was no discard date found on the container.

- A container of 12 breaded chicken fingers were found in an

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open box and exposed to air.
There was no open date.

- A 2.5 pound (lb) container of mozzarella cheese was found wrapped in plastic without an open date.
- A 2.5 lb container of feta cheese was found wrapped in plastic without an open date.
- A 2 lb block of Swiss cheese was found wrapped in plastic without an open date.

A facility policy, titled "Proper Food Storage," dated as reviewed on 06/06/22 and provided by the Executive Director on 10/04/22 at 3:14 p.m., indicated "...All foods must be stored on shelves a minimum of 6 inches from the ground...Label all open containers with open date and expiration date...Keep foods properly wrapped or covered and dated with date opened and date expires...All cooked or prepped foods need to be in containers that are covered, labeled and dated with date made and date expires...Have thermometers in all refrigerators and freezers and check them daily to ensure proper temperatures are being kept...When to date mark foods:...Anytime the original packaging is opened...."

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R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infections including the Covid-19 virus, when the facility failed to ensure staff were wearing their face masks correctly while interacting with a resident (Speech Therapist 14) and while working in the kitchen. (Cook 11, Kitchen Staff 12 and 13 and Sous Chef 8) Findings include: 1. During a random observation, on 10/05/22 at 9:05 a.m., the	R 0407	1. The facility will ensure that proper infection control policies and procedures are followed when it comes to proper PPE usage in an effort to prevent the spread of germs, infections and viruses. 2. The facility will provide in-service training to all staff on proper infection control procedures. These trainings will be logged and signed by staff who attend. The facility will ensure staff are following infection control policies and procedures (and proper PPE usage) through observation and notification. 3. The staff will hold each other accountable for proper infection control by notifying each other or their leader immediately when improper infection control procedures are identified. The leader will provide continuing education and resources through in-service training as well as ensure staff completion of Relias ICP training.	12/31/2022
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Speech Therapist was observed sitting less than six (6) feet from an unmasked resident. Her mask was worn under her chin.

During an interview, on 10/05/22 at 9:28 a.m., the Executive Director indicated everyone was to wear a mask in the facility.

During an interview, on 10/05/22 at 10:49 a.m., Speech Therapist 14 indicated she has just taken down her mask to scratch her nose and wipe away sweat.

2. During an observation of the kitchen, beginning on 10/05/22 at 9:43 a.m., Cook 11 was observed with his mask below his nose. Kitchen Staff 12 and 13 were observed with their mask below their nose.

During an interview, on 10/05/22 at 9:47 a.m., Cook 11 indicated the mask was to be worn over the nose when around residents.

During an observation, on 10/05/22 at 10:26 a.m., Sous Chef 8 was observed in the kitchen with a mask worn below the nose. At that time, he indicated the mask was to be worn over the mouth and nose.

A facility policy, titled "PPE-Face Masks," dated 08/01/2017 and provided by the Corporate Support Nurse on 10/04/2022 at 2:45 p.m., indicated "...Employees shall

4.
Leadership will ensure proper infection prevention and control through audits of training logs and Relias completion logs.

5.
Completed by 12/31/22

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wear face masks...when required per infection control precautions...be sure that face mask covers the nose and mouth...."

Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infections including the Covid-19 virus, when the facility failed to ensure staff were wearing their face masks correctly while interacting with a resident (Speech Therapist 14) and while working in the kitchen. (Cook 11, Kitchen Staff 12 and 13 and Sous Chef 8)

Findings include:

1. During a random observation, on 10/05/22 at 9:05 a.m., the Speech Therapist was observed sitting less than six (6) feet from an unmasked resident. Her mask was worn under her chin.

During an interview, on 10/05/22 at 9:28 a.m., the Executive Director indicated everyone was to wear a mask in the facility.

During an interview, on 10/05/22 at 10:49 a.m., Speech Therapist 14 indicated she has just taken down her mask to scratch her nose and wipe away sweat.

2. During an observation of the kitchen, beginning on 10/05/22

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	at 9:43 a.m., Cook 11 was observed with his mask below his nose. Kitchen Staff 12 and 13 were observed with their mask below their nose. During an interview, on 10/05/22 at 9:47 a.m., Cook 11 indicated the mask was to be worn over the nose when around residents. During an observation, on 10/05/22 at 10:26 a.m., Sous Chef 8 was observed in the kitchen with a mask worn below the nose. At that time, he indicated the mask was to be worn over the mouth and nose. A facility policy, titled "PPE-Face Masks," dated 08/01/2017 and provided by the Corporate Support Nurse on 10/04/2022 at 2:45 p.m., indicated "...Employees shall wear face masks...when required per infection control precautions...be sure that face mask covers the nose and mouth...."			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the	R 0410	1. The facility will ensure that residents have completed a 2 step Mantoux TB test upon admission (or within 3 months prior to admission) or a chest x-ray to provide a negative TB test result.	12/31/2022

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FORM APPROVED

OMB NO. 0938-0391

date given, date read, and by whom administered and read.

(f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on record review and interview, the facility failed to ensure a 2 step tuberculosis test was completed for 1 of 7 residents reviewed for 2 step tuberculosis. (Resident C)

Finding includes:

The record for Resident C was reviewed on 10/05/22. Diagnoses included, but were not limited to, Alzheimer's dementia and a right femur fracture.

Resident C admitted to the facility on 05/05/22.

2.

The Wellness Director will audit the medical files of all residents to confirm completion of both steps of the 2 step Mantoux TB Test or a chest x-ray with negative TB test results. Any residents who are found not compliant, the 1st step of the TB Test will be administered followed by a 2nd step within 1-3 weeks.

3.

As part of an admission checklist, the Wellness Director will ensure both steps of the 2 step Mantoux are complete, or a chest x-ray is received and filed in the resident's medical record.

4.

The Wellness Director will audit the medical records at random monthly.

5.

Completed by 12/31/22.

The resident did not have a first or second step tuberculosis test in the record.

During an interview, on 10/06/22 at 11:33 a.m., the Clinical Specialist indicated the facility did not have the information to provide.

A facility policy, titled "TB Infection Control Plan-Indiana," dated 06/21 and provided by the Executive Director 2 on 10/06/22 at 10:11 a.m., indicated "...a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission...For residents 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 within one (1) to three (3) weeks after the first test...."

Based on record review and interview, the facility failed to ensure a 2 step tuberculosis test was completed for 1 of 7 residents reviewed for 2 step tuberculosis. (Resident C)

Finding includes:

The record for Resident C was reviewed on 10/05/22.

Diagnoses included, but were

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not limited to, Alzheimer's dementia and a right femur fracture.

Resident C admitted to the facility on 05/05/22.

The resident did not have a first or second step tuberculosis test in the record.

During an interview, on 10/06/22 at 11:33 a.m., the Clinical Specialist indicated the facility did not have the information to provide.

A facility policy, titled "TB Infection Control Plan-Indiana," dated 06/21 and provided by the Executive Director 2 on 10/06/22 at 10:11 a.m., indicated "...a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission...For residents 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 within one (1) to three (3) weeks after the first test...."

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

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
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