STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT HUNTER STATION	400 HUNTER STATION ROAD, SELLERSBURG, , 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: November 20 and 21, 2023 Facility number: 013841 Residential Census: 96 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 27, 2023.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	
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	R 0042	**Corrective Action(s) for Residents Affected by the Deficient Practice** No residents were affected by the Deficient practice. The binder was reviewed and updated by the Executive Director after her	12/16/2023

	interview, the facility failed to ensure the survey report was available and signage to indicate the location of the survey report was posted. This deficient practice had the potential to affect all 96 residents currently residing at the facility. Findings include: During an observation on 11/20/23 at 11:02 a.m., the survey reports could not be located. There was no signage to indicate a location of the survey reports. During an interview on 11/20/23 at 11:04 a.m., the receptionist at the front desk indicated she had the survey reports and she obtained the reports on a lower shelf located behind her desk. She did not know of any signs to indicate their location. During an interview on 11/20/23 at 11:06 a.m., the Executive Director indicated she was going to work on the survey report binder, but did not know where it was. During an interview on 11/20/23 at 11:07 a.m., the Regional Clinical Specialist indicated the binder had been on the taller bookshelf behind the receptionist's desk and there used to be a sign there. She did not know how long it had been since a sign or the report had		start. A survey results binder was placed on the chest in living room and a notice of its location was posted in the lobby on 11/20/2023. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice; however, none were affected. A Survey results binder was placed on the chest in the living room and a notice of its location was posted in the lobby on 11/20/2023. **Measures to Ensure the Deficient Practice Does Not Recur** Staff will be educated on Resident rights the Executive Director, the Wellness Director and/or the designee by 12/15/2023 to include the location of the survey binder and the resident’s right to examine the most recent annual	

	been there. During an interview on 11/20/23 at 12:40 p.m., the Executive Director indicated there was no policy for posting the survey report binder or signage and they just followed the State guidelines. Based on observation and interview, the facility failed to ensure the survey report was available and signage to indicate the location of the survey report was posted. This deficient practice had the potential to affect all 96 residents currently residing at the facility. Findings include: During an observation on 11/20/23 at 11:02 a.m., the survey reports could not be located. There was no signage to indicate a location of the survey reports. During an interview on 11/20/23 at 11:04 a.m., the receptionist at the front desk indicated she had the survey reports and she obtained the reports on a lower shelf located behind her desk. She did not know of any signs to indicate their location. During an interview on 11/20/23 at 11:06 a.m., the Executive Director indicated she was going to work on the survey report binder, but did not know		survey, the plan of correction and any subsequent surveys. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Executive Director and/or the designee will observe the survey binder in the posted location as well as the posting of the location 5 times per week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks to ensure the residents have the ability to examine the survey results.The Executive Director will review results with the Quality Assurance committee monthly. If 100% compliance is not achieved, the Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe	R 0148	**Corrective Action(s) for Residents Affected by the Deficient Practice** Apartments 104, 127 and 224 water temps were checked on 11/21/2023 and remain between 105 degrees Fahrenheit (F) and 120 degrees F. **Corrective Action(s) for Other Residents Potentially Affected** All	12/16/2023

functioning and compliance with state electrical codes.

(3) All plumbing shall function properly and comply with state plumbing codes.

(4) At least yearly, heating and ventilating systems shall be inspected.

Based on observation and interview, the facility failed to ensure water temperatures were maintained between a safe range of 105 degrees Fahrenheit (F) and 120 degrees F for 3 of 4 room water temperatures observed (Rooms 224, 104, and 127). This deficient practice had the potential to affect all 96 residents currently residing at the facility.

Findings include:

During an observation on 11/20/23 at 10:27 a.m., the Assistant Maintenance Director checked the water temperature in Room 224. The bathroom sink water temperature was 129 degrees F.

During an observation on 11/20/23 at 10:32 a.m., the Assistant Maintenance Director checked the water temperature in Room 104. The bathroom sink water temperature was 132.7 degrees F.

During an observation on

residents have the potential to be affected by this deficient practice. The Maintenance Director lowered the temperature at the water heater on 11/20/2023. Louisville Mechanical replaced parts on the mixing valve on 12/1/2023. Water temperatures remain between 105 degrees F and 120 degrees F.

Measures to Ensure the Deficient Practice Does Not Recur

Staff will be educated on Sanitation and Safety Standards as it relates to water temperatures in residential area including lower and upper limits. Education will be given by Executive Director and/or designee and Maintenance Director by 12/15/2023.

The Monitoring Process to Ensure the Deficient Practice Does Not Recur

The Maintenance Director and/or Maintenance Assistant will test the water

	11/20/23 at 10:35 a.m., the Assistant Maintenance Director checked the water temperature in Room 127. The bathroom sink water temperature was 129.3 degrees F. During a tour on 11/20/23 at 10:53 a.m., the Assistant Maintenance Director indicated the water heaters were located on the Dementia Unit for the first floor. The two tank temperature gauges indicated 150 degrees F on each. The Assistant Maintenance Director indicated the high water temperatures in resident rooms were dependant on the usage by the residents on each floor. The temperatures were checked daily. During an interview on 11/20/23 at 11:12 a.m., Resident 9 indicated the water temperature would be too hot if he didn't regulate it. During an interview on 11/20/23 at 11:16 a.m., Resident 10 indicated the water temperature was fine to her. During an interview on 11/20/23 at 11:19 a.m., Resident 11 indicated she had to add cold water to the hot water to cool it down. She could avoid a burn by adding the cold water. During an interview on 11/20/23 at 11:22 a.m., Resident 12 indicated the water was okay. She had to watch because it got		temperatures in various apartments at varying times including 5 apartments per week for 4 weeks then 3 times weekly for 4 weeks then weekly ongoing. The plumber will inspect the water heaters routinely to ensure mixing valve is in good repair. The Executive Director will review results with the Quality Assurance committee monthly. If 100% compliance is not achieved, the Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

hot real fast. She turned on the cold water real quick.

During an interview on 11/20/23 at 11:26 a.m., Resident 13 indicated when he turned on the hot water only, it was hot.

During an observation on 11/20/23 at 1:05 p.m., with the Maintenance Director in Room 224 the water temperature was checked. The kitchen sink's water temperature read 127 degrees F after the Assistant Maintenance Director lowered the valve pressure on the ceiling pipe outside of the room.

During an interview on 11/20/23 at 1:08 p.m., the Administrator was aware of the elevated water temperatures. She indicated she would ensure the residents' water temperatures returned to the safe level.

During an observation on 11/20/23 at 1:10 p.m., the water heaters on the second floor were checked by the Maintenance Director and Assistance Maintenance Director. They were both set to 150 degrees F on the gauge. The Maintenance Director lowered the gauges to 140 degrees F. He indicated he would start there and adjust them the following day if needed.

The Water Temperatures policy, included, but was not limited to,

"... The Community will maintain the resident water temperature within a range of 105 degrees and 120 degrees Fahrenheit... Indiana water temperature must be between 100 degrees - 120 degrees."

Based on observation and interview, the facility failed to ensure water temperatures were maintained between a safe range of 105 degrees Fahrenheit (F) and 120 degrees F for 3 of 4 room water temperatures observed (Rooms 224, 104, and 127). This deficient practice had the potential to affect all 96 residents currently residing at the facility.

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During an interview on 11/20/23 at 11:19 a.m., Resident 11 indicated she had to add cold water to the hot water to cool it down. She could avoid a burn by adding the cold water.

During an interview on 11/20/23 at 11:22 a.m., Resident 12 indicated the water was okay. She had to watch because it got hot real fast. She turned on the cold water real quick.

During an interview on 11/20/23 at 11:26 a.m., Resident 13 indicated when he turned on the hot water only, it was hot.

During an observation on 11/20/23 at 1:05 p.m., with the Maintenance Director in Room 224 the water temperature was checked. The kitchen sink's water temperature read 127 degrees F after the Assistant Maintenance Director lowered the valve pressure on the ceiling pipe outside of the room.

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	within a range of 105 degrees and 120 degrees Fahrenheit... Indiana water temperature must be between 100 degrees - 120 degrees."			

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

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