

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 05/02/2024
NAME OF PROVIDER OR SUPPLIER TOWNE PARK ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 503 S MURPHY AVE, BRAZIL, , 47834			
(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 IN00428338. Complaint IN00428338- No deficiencies related to the allegations are cited. Survey dates: May 1 and 2, 2024 Facility number: 014623 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 13, 2024.	R 0000	This facility is asking for Paper Compliance for State Residential Licensure with Complaint (IN00428338). Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet State and Federal requirements.		
R 0157	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(n) n) The facility shall develop, adopt, and implement written policies and	R 0157	• No residents were negatively affected by the alleged deficient practice. • All residents residing in the facility can be affected by the alleged deficient practice.	05/25/2024	

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procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area. Based on observation, record review, and interview, the facility failed to ensure sanitization solution chemical levels were monitored and documented with potential to affect 34 of 34 residents. Findings include: During the initial kitchen tour, on 5/1/24 at 9:50 a.m., a red quaternary sanitizer solution (Quat [ammonia solution used to sanitize food contact surfaces]) bucket was observed to be full sitting in the hand washing sink next to the dishwashing station. A temperature log for the dishwashing machine was located, but no log for chemical testing of the sanitizing sink or Quat bucket was located. During an interview on 5/1/24 at 10:00 a.m., Dietary Aide (DA) 6 indicated he did not test chemical levels for anything. He only wrote down temperatures on the log located at the dishwashing station. During an interview on 5/1/24 at 10:01 a.m., the Dietary Manager (DM) indicated the solution was used to wipe down and sanitize surfaces in the kitchen and	The sanitizing sink and Quat bucket will be tested once a shift using appropriate testing strips. • Re-education was completed for all dietary staff by Administrator/Designee on 5/21/24 with emphasis on using the appropriate testing strips and proper documentation to be completed with return demonstration. • Dietary manager/Designee will complete an audit on process of testing the sanitizing sink and Quat bucket five times a week x 4 weeks, then three times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. Results will be forwarded to the Interdisciplinary Team for Review and further recommendations.	
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residential dining room. When asked to test the chemical level, the DM dumped and refilled the bucket with sanitizing solution from the triple sink, retrieved a container of test strips labeled Ecolab chlorine test strips, dipped it into the solution, then indicated the test strips were not working right because they were not the right ones. The DM asked DA 6 if he knew where the correct test strips were, and he indicated he did not know. The DM indicated she had not seen them since she started working at the facility back in February. She indicated they did not have a test log for the testing but knew what strips she needed, then pointed to the poster above the sanitizing tub in the triple sink with a picture of chemical testing strips, and indicated they were the ones she was looking for. The DM indicated she would need to order the correct test strips and get the form she used to use at another facility.

On 4/1/24 3:28 p.m., the ADM provided a document, dated 8/14/19, titled, "General Sanitation of Kitchen," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive, cleaning schedule. Procedure:

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A. Cleaning and sanitation tasks for the kitchen will be recorded. B. Tasks will be assigned to be the responsibility of specific positions. C. Tasks will be addressed as to frequency of cleaning. D. The method and agents to be used for cleaning will be written for each task. E. A cleaning schedule will be posted and employees will initial and date tasks when completed...."

Based on observation, record review, and interview, the facility failed to ensure sanitization solution chemical levels were monitored and documented with potential to affect 34 of 34 residents.

Findings include:

During the initial kitchen tour, on 5/1/24 at 9:50 a.m., a red quaternary sanitizer solution (Quat [ammonia solution used to sanitize food contact surfaces]) bucket was observed to be full sitting in the hand washing sink next to the dishwashing station. A temperature log for the dishwashing machine was located, but no log for chemical testing of the sanitizing sink or Quat bucket was located.

During an interview on 5/1/24 at 10:00 a.m., Dietary Aide (DA) 6 indicated he did not test chemical levels for anything. He

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only wrote down temperatures on the log located at the dishwashing station.

During an interview on 5/1/24 at 10:01 a.m., the Dietary Manager (DM) indicated the solution was used to wipe down and sanitize surfaces in the kitchen and residential dining room. When asked to test the chemical level, the DM dumped and refilled the bucket with sanitizing solution from the triple sink, retrieved a container of test strips labeled Ecolab chlorine test strips, dipped it into the solution, then indicated the test strips were not working right because they were not the right ones. The DM asked DA 6 if he knew where the correct test strips were, and he indicated he did not know. The DM indicated she had not seen them since she started working at the facility back in February. She indicated they did not have a test log for the testing but knew what strips she needed, then pointed to the poster above the sanitizing tub in the triple sink with a picture of chemical testing strips, and indicated they were the ones she was looking for. The DM indicated she would need to order the correct test strips and get the form she used to use at another facility.

On 4/1/24 3:28 p.m., the ADM provided a document, dated 8/14/19, titled, "General

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	Sanitation of Kitchen," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive, cleaning schedule. Procedure: A. Cleaning and sanitation tasks for the kitchen will be recorded. B. Tasks will be assigned to be the responsibility of specific positions. C. Tasks will be addressed as to frequency of cleaning. D. The method and agents to be used for cleaning will be written for each task. E. A cleaning schedule will be posted and employees will initial and date tasks when completed...."			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to ensure an expired medication was disposed of properly and failed	R 0300	• No residents were affected by the alleged deficient practice. • Any new admission(s) who require a TST can be affected by the alleged deficient practice. None noted. The opened TST solution was immediately removed and discarded. • All licensed staff were re-educated by DON on 5/21/24 with emphasis on the expiration dates of opened TST solution of 30 days. • An audit of TST solution will be completed three times a week x 4 weeks, then weekly x 4 weeks, then monthly to ensure date opened is documented	05/25/2024

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to ensure a medication was labeled properly for 1 of 1 medication storage room reviewed for medication storage.

Finding includes:

1. On 5/2/24 at 12:15 p.m., the medication storage room refrigerator contained an opened multi-use vial of Aplisol (a clear, colorless, solution for injection as an aid in the diagnosis of tuberculosis) solution had an open date of 5/2/23.

2. On 5/2/24 at 12:16 p.m., the medication storage room refrigerator contained an opened and undated multi-use vial of Aplisol solution. The vial was in a box that indicated it was delivered to the facility on 12/20/23.

During an interview, on 5/2/24 at 12:16 p.m., Qualified Medication Aide (QMA) 4 indicated she was unaware of how long Aplisol solution was good for once it was opened.

During an interview, on 5/2/24 at 12:27 p.m., the Administrator indicated Aplisol was good for 30 days once opened and the vials should be labeled with an open date. He indicated the vials should have been discarded.

During an interview, on 5/2/24 at

and not expired. Results will be forwarded to the Interdisciplinary Team for review and further recommendations.

12:28 p.m., the Director of Nursing (DON) indicated she was unaware of how long the Aplisol solution was good for once opened and she would have to check the policy.

On 5/2/24 at 12:38 p.m., the Administrator provided and identified an undated document as a current facility policy, titled, "Determining Expiration Dates." The policy indicated, "...Aplisol 30 days once opened (Refrigerated)...."

Based on observation, interview, and record review, the facility failed to ensure an expired medication was disposed of properly and failed to ensure a medication was labeled properly for 1 of 1 medication storage room reviewed for medication storage.

Finding includes:

1. On 5/2/24 at 12:15 p.m., the medication storage room refrigerator contained an opened multi-use vial of Aplisol (a clear, colorless, solution for injection as an aid in the diagnosis of tuberculosis) solution had an open date of 5/2/23.

2. On 5/2/24 at 12:16 p.m., the medication storage room refrigerator contained an opened and undated multi-use vial of Aplisol solution. The vial

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	was in a box that indicated it was delivered to the facility on 12/20/23. During an interview, on 5/2/24 at 12:16 p.m., Qualified Medication Aide (QMA) 4 indicated she was unaware of how long Aplisol solution was good for once it was opened. During an interview, on 5/2/24 at 12:27 p.m., the Administrator indicated Aplisol was good for 30 days once opened and the vials should be labeled with an open date. He indicated the vials should have been discarded. During an interview, on 5/2/24 at 12:28 p.m., the Director of Nursing (DON) indicated she was unaware of how long the Aplisol solution was good for once opened and she would have to check the policy. On 5/2/24 at 12:38 p.m., the Administrator provided and identified an undated document as a current facility policy, titled, "Determining Expiration Dates." The policy indicated, "...Aplisol 30 days once opened (Refrigerated)...."			
R 0378	Mental Health Screening-Deficiency 410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3)	R 0378	• Resident #41 no longer resides in the facility. Residents #16, 28, 13 have had a Mental Health Screening completed on 5/21/24.	05/25/2024

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(b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following:

(1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders:

(A) Schizophrenia.

(B) Schizoaffective disorder.

(C) Mood (bipolar and major depressive type) disorder.

(D) Paranoid or delusional disorder.

(E) Panic or other severe anxiety disorder.

(F) Somatoform or paranoid disorder.

(G) Personality disorder.

(H) Atypical psychosis or other psychotic disorder (not otherwise specified).

(2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years.

(3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the staff, or the individual.

Based on record review and

• Any resident who receives the Medicaid Waiver services can be affected by the alleged deficient practice. All residents who receive the Medicaid Waiver services have had a Mental Health Screening completed on 5/21/24.

• An in-service was completed by the Regional Nurse Support to the DON with emphasis on completing a Mental Health Screen for all Medicaid Waiver recipients on 5/20/21.

• An audit will be completed on all new admissions by the Administrator/Designee x 6 months to ensure substantial compliance. Results will be forwarded to the Interdisciplinary Team for review and further recommendations

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FORM APPROVED

OMB NO. 0938-0391

interview, the facility failed to complete mental health screenings on admission for 4 of 7 clinical records reviewed (Resident 16, 28, 13, and 41).

Findings include:

1. On 5/2/24, at 9:55 a.m., Resident 16's records were reviewed. Her diagnoses included, but were not limited to, history of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and history of generalized anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed). The record indicated Medicaid waiver was the primary payer source, and lacked documentation of mental health (psychological or emotional health) screening being completed.

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2. 5/2/24 at 11:08 a.m., Resident 28's clinical records were reviewed. Her diagnoses included, but were not limited to, chronic pain (long standing pain that persists beyond the usual recovery period or occurs along with a long-standing health condition). The record indicated Medicaid waiver was the primary payer source and lacked documentation of mental health screening being completed.

3. On 5/2/24 at 1:00 p.m., Resident 13's clinical record was reviewed. Her diagnoses included, but were not limited to, depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities), and malignant neoplasm of the vulva (cancer that occurs on the outer surface area of the female genitalia). The record indicated Medicaid waiver was the primary payer source, and lacked documentation of mental health screening being completed.

4. On 5/2/24, at 1:06 p.m., Resident 41's clinical record was reviewed. Her diagnoses included, but were not limited to, insomnia (a sleep disorder in which you have trouble falling and/or staying asleep) The record indicated Medicaid waiver was the primary payer source, and lacked documentation of mental health

screening being completed.

During an interview on 5/2/24 at 10:32 a.m., the Director of Nursing (DON) indicated the mental health screenings performed were the Brief Interview for Mental Status (BIMS) assessments (used to screen and identify the cognitive [mental process involved in knowing, learning, and understanding things] condition of residents upon admission) located in the chart, completed initially, upon admission, quarterly, and as needed.

During an interview on 5/2/24 at 11:38 a.m., the Administrator (ADM) and DON indicated the BIMS and level of service were the only assessments completed.

During an interview on 5/2/24 at 1:57 p.m., the ADM indicated no policy was available related to mental health screenings for Medicaid patients. He indicated if it was a state regulation, and they should have been doing them.

Based on record review and interview, the facility failed to complete mental health screenings on admission for 4 of 7 clinical records reviewed (Resident 16, 28, 13, and 41).

Findings include:

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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