

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 12/21/2021	
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 IN00367671. Complaint IN00367671 - Substantiated. State deficiencies related to the allegations are cited at R0040, R0041, and R0273. Survey dates: December 17, 20, and 21, 2021 Facility number: 014623 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 29, 2021.	R 0000	F 0000 This facility is asking for Paper Compliance for State Residential Licensure with a substantiated complaint (IN00367671) Survey conducted on December 17, 20, and 21, 2021. 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 0040	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(o)(1-3)	R 0040	Residents B, M, L, K, J and F are unknown without a Resident Identifier list; however, Resident Council meeting has been	01/21/2022			

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(o) Residents have the right to form and participate in a resident council, and families of residents have the right to form a family council, to discuss alleged grievances, facility operation, residents ' rights, or other problems and to participate in the resolution of these matters as follows: (1) Participation is voluntary. (2) During resident or family council meetings, privacy shall be afforded to the extent practicable unless a member of the staff is invited by the resident council to be present. (3) The licensee shall provide space within the facility for meetings and assistance to residents or families who desire to attend meetings. Based on interview and record review, the facility failed to assist the residents to ensure Resident Council meetings were held to provide the residents an opportunity to discuss and express concerns and grievances for 6 of 7 residents interviewed (Residents B, M, L, K, J, and F). Findings include: During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated there had not been any Resident Council meeting held for several months. She had attended the meetings regularly when they were held.		scheduled for Wednesday, January 26, 2022 An audit of residents was completed with no additional concerns identified. Administrator and Activity Director have been re-educated related to assisting residents to ensure Resident Council meetings are held The Administrator or designee will conduct an audit monthly for 6 months to ensure assistance is provided to the residents to ensure Resident Council meetings are held. Results will be forwarded to the Interdisciplinary Team for review and further recommendations	
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The residents had been told that the facility would no longer be holding the meetings because they were "nothing more than gripe sessions." The Resident Council meetings were the best place for the residents to air their grievances and concerns. Now all they had were comment cards, that when they were filled out, "just seem to disappear," into the Administrator's office, and most of the time they never heard anything more about their concerns. The residents did talk about concerns amongst themselves, but without any administrative representation the concerns did not go away.

During an interview, on 12/17/21 at 2:49 p.m., the Activity Director indicated the facility had held Resident Council meetings monthly in the past but had not held any meetings for a while. The Administrator had told her that Assisted Living facilities were not required to hold Resident Council meetings. The meetings had just become "gripe sessions anyway." They had set up comment cards and a suggestion box for the residents to write down and communicate their concerns and grievances.

During a telephone interview, on 12/17/21 at 3:04 p.m., the Ombudsman indicated he had been made aware that the facility had stopped holding

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Resident Council meetings. He had been told the meetings were no longer being held because the Executive Director believed the meetings had become "gripe sessions" and she no longer wanted to hear so many complaints.

During an interview, on 12/20/21 at 9:28 a.m., Resident M indicated she had attended the Resident Council meetings in the past but had not attended any type of resident meeting for quite a while. No one had told her about any meetings even being planned. She could not say if the facility had a suggestion box and wasn't sure how to voice a concern or grievance.

During an interview, on 12/20/21 at 9:43 a.m., Resident L indicated she had attended Resident Council meetings in the past, but it had been some time since they had one. She was not sure why. There were cards where you could write down your opinion, but she had not used it.

During an interview, on 12/20/21 at 9:56 a.m., Resident K indicated she had attended the Resident Council meetings in the past and would attend again if they had them.

During an interview, on 12/20/21 at 11:17 a.m., Resident J

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indicated he had attended the Resident Council meetings in the past, but as far as he knew, they had stopped having the meetings. He felt it was just as well because nothing ever came from voicing any concerns or grievances anyway. When they held the meetings, the residents would voice their grievances and concerns, but nothing was ever done. If anything had been done, no one ever told him about it, and he never saw any results. He also felt that if he complained too much, there would be repercussions towards him. He felt that he did not have any voice at the facility, so he had just stopped expressing his concerns and grievances and learned to live with things.

During an interview, on 12/20/21 at 12:00 p.m., the Executive Director indicated the residents were able to organize and hold their own meetings, just as the regulations indicated. The facility did not have any Resident Council policy since Resident Council meetings were not required in residential facilities.

During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated the activity department would put out a monthly calendar and the calendar would be distributed to all the residents. If there was a special event the staff would let the

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residents know. She had attended Resident Council meetings when they were held in the past. The residents had been told that staff were tired of the way the council meetings had been going due to all of the complaints about different issues. She would attend Resident Council meetings if they had the meetings again.

On 12/17/21 at 2:49 p.m., review of the Resident Council meeting minutes indicated the last Resident Council meeting had been held in June 2021.

On 12/20/21 at 9:10 a.m., the Administrator provided an undated document, titled, "Resident Bill of Rights," and indicated it was policy currently being used by the facility. The policy indicated, "...Quality of Life in the Facility, You have the right to: ...Voice complaints or grievances...Organize and participate in resident groups...."

On 12/20/21 at 12:05 p.m., the Executive Director provided an undated document, titled, "The Right to Voice Complaints, Grievances and Suggestions About Community Operations," and indicated it was the policy currently being used by the facility. The policy indicated, "Towne Park encourage all residents...to express complaints about the community...Procedure: Towne

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Park team members are expected to listen courteously and respectfully to complaints...Another way to air grievances is through the monthly Resident Meetings...."

This State Residential Finding relates to Complaint IN00367671.

Based on interview and record review, the facility failed to assist the residents to ensure Resident Council meetings were held to provide the residents an opportunity to discuss and express concerns and grievances for 6 of 7 residents interviewed (Residents B, M, L, K, J, and F).

Findings include:

During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated there had not been any Resident Council meeting held for several months. She had attended the meetings regularly when they were held. The residents had been told that the facility would no longer be holding the meetings because they were "nothing more than gripe sessions." The Resident Council meetings were the best place for the residents to air their grievances and concerns. Now all they had were comment cards, that when they were filled out, "just seem to disappear," into the Administrator's office,

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and most of the time they never heard anything more about their concerns. The residents did talk about concerns amongst themselves, but without any administrative representation the concerns did not go away.

During an interview, on 12/17/21 at 2:49 p.m., the Activity Director indicated the facility had held Resident Council meetings monthly in the past but had not held any meetings for a while. The Administrator had told her that Assisted Living facilities were not required to hold Resident Council meetings. The meetings had just become "gripe sessions anyway." They had set up comment cards and a suggestion box for the residents to write down and communicate their concerns and grievances.

During a telephone interview, on 12/17/21 at 3:04 p.m., the Ombudsman indicated he had been made aware that the facility had stopped holding Resident Council meetings. He had been told the meetings were no longer being held because the Executive Director believed the meetings had become "gripe sessions" and she no longer wanted to hear so many complaints.

During an interview, on 12/20/21 at 9:28 a.m., Resident M indicated she had attended the

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Resident Council meetings in the past but had not attended any type of resident meeting for quite a while. No one had told her about any meetings even being planned. She could not say if the facility had a suggestion box and wasn't sure how to voice a concern or grievance.

During an interview, on 12/20/21 at 9:43 a.m., Resident L indicated she had attended Resident Council meetings in the past, but it had been some time since they had one. She was not sure why. There were cards where you could write down your opinion, but she had not used it.

During an interview, on 12/20/21 at 9:56 a.m., Resident K indicated she had attended the Resident Council meetings in the past and would attend again if they had them.

During an interview, on 12/20/21 at 11:17 a.m., Resident J indicated he had attended the Resident Council meetings in the past, but as far as he knew, they had stopped having the meetings. He felt it was just as well because nothing ever came from voicing any concerns or grievances anyway. When they held the meetings, the residents would voice their grievances and concerns, but nothing was ever done. If anything had been

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done, no one ever told him about it, and he never saw any results. He also felt that if he complained too much, there would be repercussions towards him. He felt that he did not have any voice at the facility, so he had just stopped expressing his concerns and grievances and learned to live with things.

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During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated the activity department would put out a monthly calendar and the calendar would be distributed to all the residents. If there was a special event the staff would let the residents know. She had attended Resident Council meetings when they were held in the past. The residents had been told that staff were tired of the way the council meetings had been going due to all of the complaints about different issues. She would attend Resident Council meetings if they had the meetings again.

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On 12/20/21 at 9:10 a.m., the Administrator provided an undated document, titled, "Resident Bill of Rights," and indicated it was policy currently being used by the facility. The policy indicated, "...Quality of Life in the Facility, You have the right to: ...Voice complaints or grievances...Organize and participate in resident groups...."

On 12/20/21 at 12:05 p.m., the Executive Director provided an undated document, titled, "The Right to Voice Complaints, Grievances and Suggestions About Community Operations," and indicated it was the policy currently being used by the facility. The policy indicated, "Towne Park encourage all residents...to express complaints about the community...Procedure: Towne Park team members are expected to listen courteously and respectfully to complaints...Another way to air grievances is through the monthly Resident Meetings...."

This State Residential Finding relates to Complaint IN00367671.

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R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to ensure the process of grievance investigations and the resolutions to investigated grievances were communicated to the residents for 3 of 7 residents interviewed (Residents B, M, and J). Findings include: During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated that Resident Council meetings were the best way for the residents to air grievances. The Resident Council meetings were no longer being held, due to the administrative staff feeling the meetings had become "nothing more than gripe sessions". Now all they had were comment cards, that when	R 0041	Residents B, M and J are unknown without a Resident Identifier list; however, Residents were interviewed with no additional concerns identified An audit of residents was completed with no additional concerns identified Staff has been re-educated on the process of grievance investigations and the resolutions to investigated grievances being communicated to the resident. The Administrator or designee will follow up on grievances within 72 hours. Administrator or designee will also conduct an audit of completed grievances twice a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results will be forwarded to the Interdisciplinary Team for review and further recommendations	01/21/2022
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filled out, "just seem to disappear," into the Administrator's office, and most of the time they never heard anything more about their grievance.

During an interview, on 12/20/21 at 9:28 a.m., Resident M indicated she wasn't sure how to voice a grievance. She had attended the Resident Council meetings in the past but had not attended any type of resident meeting for quite a while.

During an interview, on 12/20/21 at 11:17 a.m., Resident J indicated he had participated in the Resident Council meetings, in the past, but now he understood they had stopped having the meetings. When he attended a meeting and voiced a grievance, nothing would ever be resolved, so he had just given up expressing his grievances. If there had been anything done about his grievances, no one had communicated it to him, nor had he ever noticed any resolution. He was aware that there were now comment cards. If he had a grievance now, he would just deal with it. He had become resolved to just tolerate the issue, rather than push it. He felt he had no voice at the facility.

During an interview, on 12/21/21 at 9:30 a.m., the Administrator's indicated the facility did not

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have a grievance policy. The document titled, "The Right to Voice Complaints, Grievances and Suggestions About Community Operations," would serve as the policy. The current grievance procedure involved comment cards which were available for the resident to complete. When completed they could be given to any of the administrative staff and the cards would be brought to her. If the issue was something she could take care of then she would resolve it. If the issue involved a different staff member, she would work with that individual to resolve the issue. There was not a grievance log maintained, but she kept many of the comment cards, in her office. There was no other documentation maintained related to grievances. The individual who reported the grievance would know when the issue had been resolved when they saw the change that they requested.

On 12/20/21 at 9:10 a.m., the Administrator provided an undated document, titled, "Resident Bill of Rights," and indicated it was policy currently being used by the facility. The policy indicated, "...Quality of Life in the Facility, You have the right to: ...Voice complaints or grievances without fear of retaliation...."

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On 12/20/21 at 12:05 p.m., the Executive Director provided an undated document, titled, "The Right to Voice Complaints, Grievances and Suggestions About Community Operations," and indicated it was the policy currently being used by the facility. The policy indicated, "Towne Park encourage all residents...to express complaints about the community...Procedure: Towne Park team members are expected to listen courteously and respectfully to complaints...Another way to air grievances is through the monthly Resident Meetings...At no time will any team member of the community take any improper action against a resident for making a complaint...."

This State Residential Finding relates to Complaint IN00367671.

Based on interview and record review, the facility failed to ensure the process of grievance investigations and the resolutions to investigated grievances were communicated to the residents for 3 of 7 residents interviewed (Residents B, M, and J).

Findings include:

During an interview, on 12/17/21 at 1:07 p.m., Resident B

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indicated that Resident Council meetings were the best way for the residents to air grievances. The Resident Council meetings were no longer being held, due to the administrative staff feeling the meetings had become "nothing more than gripe sessions". Now all they had were comment cards, that when filled out, "just seem to disappear," into the Administrator's office, and most of the time they never heard anything more about their grievance.

During an interview, on 12/20/21 at 9:28 a.m., Resident M indicated she wasn't sure how to voice a grievance. She had attended the Resident Council meetings in the past but had not attended any type of resident meeting for quite a while.

During an interview, on 12/20/21 at 11:17 a.m., Resident J indicated he had participated in the Resident Council meetings, in the past, but now he understood they had stopped having the meetings. When he attended a meeting and voiced a grievance, nothing would ever be resolved, so he had just given up expressing his grievances. If there had been anything done about his grievances, no one had communicated it to him, nor had he ever noticed any resolution. He was aware that there were

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now comment cards. If he had a grievance now, he would just deal with it. He had become resolved to just tolerate the issue, rather than push it. He felt he had no voice at the facility.

During an interview, on 12/21/21 at 9:30 a.m., the Administrator's indicated the facility did not have a grievance policy. The document titled, "The Right to Voice Complaints, Grievances and Suggestions About Community Operations," would serve as the policy. The current grievance procedure involved comment cards which were available for the resident to complete. When completed they could be given to any of the administrative staff and the cards would be brought to her. If the issue was something she could take care of then she would resolve it. If the issue involved a different staff member, she would work with that individual to resolve the issue. There was not a grievance log maintained, but she kept many of the comment cards, in her office. There was no other documentation maintained related to grievances. The individual who reported the grievance would know when the issue had been resolved when they saw the change that they requested.

On 12/20/21 at 9:10 a.m., the Administrator provided an

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	undated document, titled, "Resident Bill of Rights," and indicated it was policy currently being used by the facility. The policy indicated, "...Quality of Life in the Facility, You have the right to: ...Voice complaints or grievances without fear of retaliation...." On 12/20/21 at 12:05 p.m., the Executive Director provided an undated document, titled, "The Right to Voice Complaints, Grievances and Suggestions About Community Operations," and indicated it was the policy currently being used by the facility. The policy indicated, "Towne Park encourage all residents...to express complaints about the community...Procedure: Towne Park team members are expected to listen courteously and respectfully to complaints...Another way to air grievances is through the monthly Resident Meetings...At no time will any team member of the community take any improper action against a resident for making a complaint...." This State Residential Finding relates to Complaint IN00367671.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	Service plans for Residents B, F, and N have been reviewed and signed by the resident.	01/21/2022

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(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 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

An audit of service plans was completed and signatures were obtained from resident and/or Resident Representative as needed.

Clinical staff has been re-educated on Service plans including obtaining Resident and/or Resident Representative signatures

The Director of Nursing or designee will conduct an audit of 5 random Service Plans to ensure signatures were obtained twice a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results will be forwarded to the Interdisciplinary Team for review and further recommendations

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documentation of the services to be provided.

Based on record review and interview, the facility failed to ensure service plans were signed by the resident for 3 of 7 residents reviewed for service plans (Residents N, F, and B).

Findings include:

1. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

A service plan, dated 4/22/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone. The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail. The plan indicated the resident was unable to sign related to confusion.

During an interview, on 12/21/21 at 9:33 a.m., the Director of Nursing (DON) indicated she had not attempted to obtain signatures on the service plans reviewed by phone. Sometimes it was hard for the residents to sign the plans because the system utilized an electronic signature.

2. During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated she could not recall ever attending a service plan

meeting or that she had received a copy of any service plan.

Resident F's record was reviewed on 12/20/21 at 11:40 a.m. The resident was admitted to the facility on 12/7/19.

An AL (Assisted Living) Service Plan for Resident Care, dated 7/9/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone with the Director of Nursing (DON). The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail and was electronically signed by the DON.

On 12/20/21 at 11:58 a.m., DON indicated the service plans were signed electronically by herself when she had spoken to the resident's POA on the telephone.

On 12/20/21 at 12:05 p.m., the Executive Director (ED) indicated Resident F's service plan was reviewed with the resident's POA over the telephone and the DON electronically signed the service plan on 7/9/21.

3. During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service

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plan.

Resident B's record was reviewed on 12/18/21 at 10:15 a.m. The face sheet indicated the resident had admitted to the facility on 3/11/21.

An Assisted Living Service Plan for Residential Care, dated 3/17/21, indicated the resident's Power of Attorney (POA) and the resident reviewed the service plan upon admission. The plan lacked documentation the facility attempted to obtain the resident or POA's signature.

An Assisted Living Level of Service Determination, dated 11/19/21, indicated the resident's power of attorney (POA), counselor, Executive Director, and Administrator's reviewed the service plan by phone. The plan lacked documentation of the plan being reviewed with the resident and that the facility attempted to obtain the resident or POA's signature.

During an interview, on 12/20/21, the Administrator indicated the facility did not have a policy on service plans. The state regulation would serve as the policy.

Based on record review and interview, the facility failed to ensure service plans were signed by the resident for 3 of 7 residents reviewed for service

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plans (Residents N, F, and B).

Findings include:

1. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

A service plan, dated 4/22/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone. The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail. The plan indicated the resident was unable to sign related to confusion.

During an interview, on 12/21/21 at 9:33 a.m., the Director of Nursing (DON) indicated she had not attempted to obtain signatures on the service plans reviewed by phone. Sometimes it was hard for the residents to sign the plans because the system utilized an electronic signature.

2. During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident F's record was reviewed on 12/20/21 at 11:40 a.m. The resident was admitted to the facility on 12/7/19.

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An AL (Assisted Living) Service Plan for Resident Care, dated 7/9/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone with the Director of Nursing (DON). The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail and was electronically signed by the DON.

On 12/20/21 at 11:58 a.m., DON indicated the service plans were signed electronically by herself when she had spoken to the resident's POA on the telephone.

On 12/20/21 at 12:05 p.m., the Executive Director (ED) indicated Resident F's service plan was reviewed with the resident's POA over the telephone and the DON electronically signed the service plan on 7/9/21.

3. During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident B's record was reviewed on 12/18/21 at 10:15 a.m. The face sheet indicated the resident had admitted to the facility on 3/11/21.

An Assisted Living Service Plan

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An Assisted Living Level of Service Determination, dated 11/19/21, indicated the resident's power of attorney (POA), counselor, Executive Director, and Administrator's reviewed the service plan by phone. The plan lacked documentation of the plan being reviewed with the resident and that the facility attempted to obtain the resident or POA's signature.

During an interview, on 12/20/21, the Administrator indicated the facility did not have a policy on service plans. The state regulation would serve as the policy.

Based on record review and interview, the facility failed to ensure service plans were signed by the resident for 3 of 7 residents reviewed for service plans (Residents N, F, and B).

Findings include:

1. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

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A service plan, dated 4/22/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone. The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail. The plan indicated the resident was unable to sign related to confusion.

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An AL (Assisted Living) Service Plan for Resident Care, dated 7/9/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone with the Director of Nursing (DON). The plan lacked documentation the facility

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Based on record review and interview, the facility failed to ensure service plans were signed by the resident for 3 of 7 residents reviewed for service plans (Residents N, F, and B).

Findings include:

1. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

A service plan, dated 4/22/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone. The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail. The plan indicated the resident was unable to sign related to confusion.

During an interview, on 12/21/21 at 9:33 a.m., the Director of Nursing (DON) indicated she had not attempted to obtain signatures on the service plans reviewed by phone. Sometimes it was hard for the residents to sign the plans because the system utilized an electronic signature.

2. During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident F's record was reviewed on 12/20/21 at 11:40 a.m. The resident was admitted to the facility on 12/7/19.

An AL (Assisted Living) Service Plan for Resident Care, dated 7/9/21, indicated the resident's Power of Attorney (POA)

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reviewed the service plan by phone with the Director of Nursing (DON). The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail and was electronically signed by the DON.

On 12/20/21 at 11:58 a.m., DON indicated the service plans were signed electronically by herself when she had spoken to the resident's POA on the telephone.

On 12/20/21 at 12:05 p.m., the Executive Director (ED) indicated Resident F's service plan was reviewed with the resident's POA over the telephone and the DON electronically signed the service plan on 7/9/21.

3. During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident B's record was reviewed on 12/18/21 at 10:15 a.m. The face sheet indicated the resident had admitted to the facility on 3/11/21.

An Assisted Living Service Plan for Residential Care, dated 3/17/21, indicated the resident's Power of Attorney (POA) and the resident reviewed the

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service plan upon admission. The plan lacked documentation the facility attempted to obtain the resident or POA's signature.

An Assisted Living Level of Service Determination, dated 11/19/21, indicated the resident's power of attorney (POA), counselor, Executive Director, and Administrator's reviewed the service plan by phone. The plan lacked documentation of the plan being reviewed with the resident and that the facility attempted to obtain the resident or POA's signature.

During an interview, on 12/20/21, the Administrator indicated the facility did not have a policy on service plans. The state regulation would serve as the policy.

Based on record review and interview, the facility failed to ensure service plans were signed by the resident for 3 of 7 residents reviewed for service plans (Residents N, F, and B).

Findings include:

1. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

A service plan, dated 4/22/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone. The plan

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lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail. The plan indicated the resident was unable to sign related to confusion.

During an interview, on 12/21/21 at 9:33 a.m., the Director of Nursing (DON) indicated she had not attempted to obtain signatures on the service plans reviewed by phone. Sometimes it was hard for the residents to sign the plans because the system utilized an electronic signature.

2. During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident F's record was reviewed on 12/20/21 at 11:40 a.m. The resident was admitted to the facility on 12/7/19.

An AL (Assisted Living) Service Plan for Resident Care, dated 7/9/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone with the Director of Nursing (DON). The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail and was electronically signed by the DON.

On 12/20/21 at 11:58 a.m., DON indicated the service plans were signed electronically by herself when she had spoken to the resident's POA on the telephone.

On 12/20/21 at 12:05 p.m., the Executive Director (ED) indicated Resident F's service plan was reviewed with the resident's POA over the telephone and the DON electronically signed the service plan on 7/9/21.

3. During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident B's record was reviewed on 12/18/21 at 10:15 a.m. The face sheet indicated the resident had admitted to the facility on 3/11/21.

An Assisted Living Service Plan for Residential Care, dated 3/17/21, indicated the resident's Power of Attorney (POA) and the resident reviewed the service plan upon admission. The plan lacked documentation the facility attempted to obtain the resident or POA's signature.

An Assisted Living Level of Service Determination, dated 11/19/21, indicated the resident's power of attorney

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(POA), counselor, Executive Director, and Administrator's reviewed the service plan by phone. The plan lacked documentation of the plan being reviewed with the resident and that the facility attempted to obtain the resident or POA's signature.

During an interview, on 12/20/21, the Administrator indicated the facility did not have a policy on service plans. The state regulation would serve as the policy.

Based on record review and interview, the facility failed to ensure service plans were signed by the resident for 3 of 7 residents reviewed for service plans (Residents N, F, and B).

Findings include:

1. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

A service plan, dated 4/22/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone. The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail. The plan indicated the resident was unable to sign related to confusion.

During an interview, on 12/21/21 at 9:33 a.m., the Director of

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Nursing (DON) indicated she had not attempted to obtain signatures on the service plans reviewed by phone. Sometimes it was hard for the residents to sign the plans because the system utilized an electronic signature.

2. During an interview, on 12/20/21 at 2:20 p.m., Resident F indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident F's record was reviewed on 12/20/21 at 11:40 a.m. The resident was admitted to the facility on 12/7/19.

An AL (Assisted Living) Service Plan for Resident Care, dated 7/9/21, indicated the resident's Power of Attorney (POA) reviewed the service plan by phone with the Director of Nursing (DON). The plan lacked documentation the facility attempted to obtain the POA's signature at a later time or by mail and was electronically signed by the DON.

On 12/20/21 at 11:58 a.m., DON indicated the service plans were signed electronically by herself when she had spoken to the resident's POA on the telephone.

On 12/20/21 at 12:05 p.m., the Executive Director (ED)

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indicated Resident F's service plan was reviewed with the resident's POA over the telephone and the DON electronically signed the service plan on 7/9/21.

3. During an interview, on 12/17/21 at 1:07 p.m., Resident B indicated she could not recall ever attending a service plan meeting or that she had received a copy of any service plan.

Resident B's record was reviewed on 12/18/21 at 10:15 a.m. The face sheet indicated the resident had admitted to the facility on 3/11/21.

An Assisted Living Service Plan for Residential Care, dated 3/17/21, indicated the resident's Power of Attorney (POA) and the resident reviewed the service plan upon admission. The plan lacked documentation the facility attempted to obtain the resident or POA's signature.

An Assisted Living Level of Service Determination, dated 11/19/21, indicated the resident's power of attorney (POA), counselor, Executive Director, and Administrator's reviewed the service plan by phone. The plan lacked documentation of the plan being reviewed with the resident and that the facility attempted to obtain the resident or POA's

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	signature. During an interview, on 12/20/21, the Administrator indicated the facility did not have a policy on service plans. The state regulation would serve as the policy.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure a licensed nurse completed an administration of a nebulizer treatment (breathing treatment of an electric-powered device which converts liquid medication into a mist that can be inhaled) with documented lung assessments and the facility failed to ensure the nebulizer treatment was administered as ordered and per facility policy and procedures for 1 of 1 resident observed during medication administration of a	R 0241	Resident E has been assessed with no concerns identified An audit was completed to identify residents receiving nebulizer treatments with no additional concerns identified Clinical staff has been re-educated on administration of nebulizer treatments by a licensed nurse and completion of lung assessments The Director of Nursing or designee will conduct an audit to ensure nebulizer treatments are administered by a licensed nurse and lung assessments are completed twice a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results will be forwarded to the Interdisciplinary Team for review and further recommendations	01/21/2022

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	nebulizer treatment (Resident E).			
	Finding includes:			

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On 12/17/21 at 12:08 p.m., Qualified Medication Aide (QMA) 6 entered Resident E's room and indicated to the resident that she needed to administer a nebulizer (a machine that changes liquid medication into a mist to be inhaled) treatment to the resident. Resident E asked QMA 6 why she needed a nebulizer treatment and if she was contagious with an infection. QMA 6 indicated to Resident E that she had breathing problems, the nebulizer treatment would help the resident to breath better, and no, the resident was not contagious with an infection. QMA 6 set up the nebulizer device, placed the liquid medication into the nebulizer cup, attached the nebulizer cup to the mouthpiece, turned on the nebulizer compressor, handed Resident E the mouthpiece, instructed Resident E to take slow, deep breaths through the mouthpiece. QMA 6 indicated to Resident E to turn off the nebulizer device compressor after the medication in the nebulizer cup was empty. QMA 6 vacated Resident E's room, while Resident E was self-administering the nebulizer treatment.

Resident E's record was reviewed on 12/20/21 at 8:45 a.m., diagnoses included but not limited to chronic obstructive

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pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and Alzheimer's disease (a progressive neurologic disorder that causes a continuous decline in thinking, behavioral and social skills that affects a person's ability to function independently).

A progress noted, dated 11/23/21, written by the Director of Nursing (DON) indicated Resident E had confusion and was alert and oriented to self and place.

A quarterly self-administration of medication assessment, completed on 12/19/21 at 1:05 a.m., indicated Resident E would not self-administer medications.

A physician's order, dated 8/26/21 to 12/19/21, indicated to administer 1 vial via inhalation of ipratropium-albuterol (bronchodilator which relax and open air passages to the lungs to make breathing easier) solution nebulization 0.5 milligram (mg) - 3mg (2.5 mg base)/3 milliliters (mL) four times a day for the diagnosis of COPD.

A physician's order, dated 12/19/21, indicated to administer 1 vial via inhalation of ipratropium-albuterol solution

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nebulization 0.5 milligram (mg) - 3mg (2.5 mg base)/3 milliliters (mL) four times a day for the diagnosis of COPD with special instructions of "nurse comment on lung sounds."

The December 2021 medication administration record (MAR) for Resident E indicated QMA 6 had administered the nebulizer treatments to Resident E on December 2, 3, 9, 10, 11, 12, 16, and 17, 2021. The medical record lacked documentation of pre (before), or post (after) nebulizer treatment assessments completed on Resident E.

The Administrator on 12/17/21 at 3:30 p.m., indicated staff should remain with the resident during a nebulizer treatment. The Administrator provided and identified a document as a current facility policy, titled "Nebulizer Treatments," dated 8/14/19, which indicated, "...Policy: In the event a resident requires the use of a nebulizer for the administration of a breathing treatment, the community will offer assistance as ordered by the resident's physician...Remain with resident during treatment...Continue treatment until medicine is gone...Turn compressor off...Request resident to take several deep breaths and cough...After treatment, rinse nebulizer cup with warm soapy

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water and air dry...."

On 12/21/21 at 9:07 a.m., the Executive Director (ED) indicated the facility did not have a policy for QMA duties, the facility followed the Indiana Qualified Medication Aide Scope of Practice. QMA 6 should not have administered nebulizer treatments to Resident E because a licensed nurse needed to complete and document the resident's lung assessments.

The Indiana Qualified Medication Aide Scope of Practice indicated, "...The following tasks shall NOT be included in the QMA scope of practice: ...Administer medication used for intermittent positive pressure breathing (IPPD) treatments or any form of medication inhalation treatments, such as nebulizers...."

Based on observation, interview, and record review, the facility failed to ensure a licensed nurse completed an administration of a nebulizer treatment (breathing treatment of an electric-powered device which converts liquid medication into a mist that can be inhaled) with documented lung assessments and the facility failed to ensure the nebulizer treatment was administered as ordered and per facility policy

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and procedures for 1 of 1 resident observed during medication administration of a nebulizer treatment (Resident E).

Finding includes:

On 12/17/21 at 12:08 p.m., Qualified Medication Aide (QMA) 6 entered Resident E's room and indicated to the resident that she needed to administer a nebulizer (a machine that changes liquid medication into a mist to be inhaled) treatment to the resident. Resident E asked QMA 6 why she needed a nebulizer treatment and if she was contagious with an infection. QMA 6 indicated to Resident E that she had breathing problems, the nebulizer treatment would help the resident to breath better, and no, the resident was not contagious with an infection. QMA 6 set up the nebulizer device, placed the liquid medication into the nebulizer cup, attached the nebulizer cup to the mouthpiece, turned on the nebulizer compressor, handed Resident E the mouthpiece, instructed Resident E to take slow, deep breaths through the mouthpiece. QMA 6 indicated to Resident E to turn off the nebulizer device compressor after the medication in the nebulizer cup was empty. QMA 6 vacated Resident E's

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room, while Resident E was self-administering the nebulizer treatment.

Resident E's record was reviewed on 12/20/21 at 8:45 a.m., diagnoses included but not limited to chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and Alzheimer's disease (a progressive neurologic disorder that causes a continuous decline in thinking, behavioral and social skills that affects a person's ability to function independently).

A progress noted, dated 11/23/21, written by the Director of Nursing (DON) indicated Resident E had confusion and was alert and oriented to self and place.

A quarterly self-administration of medication assessment, completed on 12/19/21 at 1:05 a.m., indicated Resident E would not self-administer medications.

A physician's order, dated 8/26/21 to 12/19/21, indicated to administer 1 vial via inhalation of ipratropium-albuterol (bronchodilator which relax and open air passages to the lungs to make breathing easier) solution nebulization 0.5 milligram (mg) - 3mg (2.5 mg

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base)/3 milliliters (mL) four times a day for the diagnosis of COPD.

A physician's order, dated 12/19/21, indicated to administer 1 vial via inhalation of ipratropium-albuterol solution nebulization 0.5 milligram (mg) - 3mg (2.5 mg base)/3 milliliters (mL) four times a day for the diagnosis of COPD with special instructions of "nurse comment on lung sounds."

The December 2021 medication administration record (MAR) for Resident E indicated QMA 6 had administered the nebulizer treatments to Resident E on December 2, 3, 9, 10, 11, 12, 16, and 17, 2021. The medical record lacked documentation of pre (before), or post (after) nebulizer treatment assessments completed on Resident E.

The Administrator on 12/17/21 at 3:30 p.m., indicated staff should remain with the resident during a nebulizer treatment. The Administrator provided and identified a document as a current facility policy, titled "Nebulizer Treatments," dated 8/14/19, which indicated, "...Policy: In the event a resident requires the use of a nebulizer for the administration of a breathing treatment, the community will offer assistance as ordered by the resident's

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	physician...Remain with resident during treatment...Continue treatment until medicine is gone...Turn compressor off...Request resident to take several deep breaths and cough...After treatment, rinse nebulizer cup with warm soapy water and air dry...." On 12/21/21 at 9:07 a.m., the Executive Director (ED) indicated the facility did not have a policy for QMA duties, the facility followed the Indiana Qualified Medication Aide Scope of Practice. QMA 6 should not have administered nebulizer treatments to Resident E because a licensed nurse needed to complete and document the resident's lung assessments. The Indiana Qualified Medication Aide Scope of Practice indicated, "...The following tasks shall NOT be included in the QMA scope of practice: ...Administer medication used for intermittent positive pressure breathing (IPPD) treatments or any form of medication inhalation treatments, such as nebulizers...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving	R 0273	Hair restraints were applied, foods were dated and disposed of by the use by dates and dry foods have been stored off the floor.	01/21/2022

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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 hair restraints were worn in the kitchen, foods were dated and disposed of by the use by dates, and dry foods were stored off of the floor during 1 of 2 random kitchen observations.

Findings include:

During a random kitchen observation, on 12/17/21 at 9:54 a.m., the Dietary Manager provided a tour throughout the kitchen and food prep areas. She was not wearing a hair restraint during the tour. During the tour, the Activity Director entered the kitchen and requested food for a resident. The Activity Director was not wearing a hair restraint. Sugar was stored in a closed container with no opened or use by date. The Dietary Manager indicated she thought it had been dated, but the label got wet, and it was no longer visible. It needed to be re-dated. A walk in refrigerator contained green beans with a use by date of 12/16/21, a container of unidentified leftover meat undated and unlabeled, a bag of unidentified leftover meat

An audits was completed of all residents with no concerns identified.

Dietary staff has been re-educated on wearing hair restraints while in the Kitchen, proper labeling/storage of food and storing dry food off of the floor.

The Administrator or designee will conduct an audit to ensure proper wearing of hair restraints, labeling/storage of food and dry food is stored off the floor twice a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results will be forwarded to the Interdisciplinary Team for review and further recommendations.

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undated and unlabeled, two bags of opened uncooked baby carrots with use by dates of 12/11/21, a bag of pre-cooked turkey dated 11/15/21, a second bag of pre-cooked turkey dated 12/6/21 which leaked a yellowish clear liquid onto a box on the bottom shelf when the dietary manager moved the bag, a round object wrapped in foil labeled ham was undated, seven uncovered and undated fruit cups next to the leaking bag of pre-cooked turkey, and two undated bags of raw chicken sitting on a tray with a box of pre-cooked turkey. The Dietary Manager indicated she thought the use by date on the green beans was incorrect, the unidentified meat should have been labeled and dated, the baby carrots should have been removed, the pre-cooked turkey bags should have been removed and one was leaking, the foil object should have been removed, the fruit cups should have been covered and dated, the raw chicken should have been dated and not stored on the same tray as the pre-cooked turkey. Two containers of apple juice and a flat of 12 large cans of cream of chicken soup were stored directly on the floor in the dry storage area. The Dietary Manager indicated food items should not have been stored directly on the floor.

During a lunch observation, on

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12/17/21 at 11:14 a.m., the Dietary Manger was observed entering and exiting the kitchen without a hair restraint.

During an interview, on 12/17/21 at 11:17 a.m., the Dietary Manger indicated she had just put a hair restraint on. She put her ear warmer on earlier and had not realized she did not have a hair restraint in place. She should have had one.

On 12/17/21 at 12:22 p.m., the Administrator provided a document titled, "FOOD SAFETY AND SANITATION," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: Follow all local, state, federal standards and regulations in order to assure a safe and sanitary Food Service department. Procedure: ...B. Employees...3...Hair restraints are required and should cover all hair on the head...D. Food storage...1. Food that is stored is protected from contamination and growth of any pathogenic organisms. 2. Among the food protection measures that are performed by the food service department are: ...Foods stored in the storeroom are placed on clean racks at least 6 inches above floor...and 2 inches from the wall...All leftovers are labeled, covered, and dated when stored. They are used within 72 hours (or

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discarded)...."

This Residential tag relates to Complaint IN00367671.

Based on observation, interview, and record review, the facility failed to ensure hair restraints were worn in the kitchen, foods were dated and disposed of by the use by dates, and dry foods were stored off of the floor during 1 of 2 random kitchen observations.

Findings include:

During a random kitchen observation, on 12/17/21 at 9:54 a.m., the Dietary Manger provided a tour throughout the kitchen and food prep areas. She was not wearing a hair restraint during the tour. During the tour, the Activity Director entered the kitchen and requested food for a resident. The Activity Director was not wearing a hair restraint. Sugar was stored in a closed container with no opened or use by date. The Dietary Manager indicated she thought it had been dated, but the label got wet, and it was no longer visible. It needed to be re-dated. A walk in refrigerator contained green beans with a use by date of 12/16/21, a container of unidentified leftover meat undated and unlabeled, a bag of unidentified leftover meat undated and unlabeled, two

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bags of opened uncooked baby carrots with use by dates of 12/11/21, a bag of pre-cooked turkey dated 11/15/21, a second bag of pre-cooked turkey dated 12/6/21 which leaked a yellowish clear liquid onto a box on the bottom shelf when the dietary manager moved the bag, a round object wrapped in foil labeled ham was undated, seven uncovered and undated fruit cups next to the leaking bag of pre-cooked turkey, and two undated bags of raw chicken sitting on a tray with a box of pre-cooked turkey. The Dietary Manger indicated she thought the use by date on the green beans was incorrect, the unidentified meat should have been labeled and dated, the baby carrots should have been removed, the pre-cooked turkey bags should have been removed and one was leaking, the foil object should have been removed, the fruit cups should have been covered and dated, the raw chicken should have been dated and not stored on the same tray as the pre-cooked turkey. Two containers of apple juice and a flat of 12 large cans of cream of chicken soup were stored directly on the floor in the dry storage area. The Dietary Manger indicated food items should not have been stored directly on the floor.

During a lunch observation, on 12/17/21 at 11:14 a.m., the

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	Dietary Manger was observed entering and exiting the kitchen without a hair restraint. During an interview, on 12/17/21 at 11:17 a.m., the Dietary Manger indicated she had just put a hair restraint on. She put her ear warmer on earlier and had not realized she did not have a hair restraint in place. She should have had one.			
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On 12/17/21 at 12:22 p.m., the Administrator provided a document titled, "FOOD SAFETY AND SANITATION," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: Follow all local, state, federal standards and regulations in order to assure a safe and sanitary Food Service department. Procedure: ...B. Employees...3...Hair restraints are required and should cover all hair on the head...D. Food storage...1. Food that is stored is protected from contamination and growth of any pathogenic organisms. 2. Among the food protection measures that are performed by the food service department are: ...Foods stored in the storeroom are placed on clean racks at least 6 inches above floor...and 2 inches from the wall...All leftovers are labeled, covered, and dated when stored. They are used within 72 hours (or discarded)...."

This Residential tag relates to Complaint IN00367671.

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R 0275	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(h) (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure residents' diet orders were reviewed and revised by a physician for 4 of 7 residents (Residents P, C, D, and N). Findings include: 1. Resident P's record was reviewed on 12/21/21 at 9:25 a.m. The resident was admitted to the facility on 8/9/21. The resident's current physician's orders lacked a diet order. On 12/21/21 at 10:25 a.m., the Director of Nursing (DON) indicated she was unable to find a current diet order for Resident P. 2. Resident C's record was reviewed on 12/17/21 at 2:36 p.m. The resident was admitted to the facility on 4/22/17. The resident's current physician's orders lacked a diet order. During an interview, on 12/20/21 at 3:18 p.m., the Director of	R 0275	Residents C, D, N and P are unknown without a Resident Identifier list. An audit was completed of all resident diet orders with no concerns identified. Clinical staff has been re-educated on diet order review and revision by the physician as the Resident's condition requires. The Director of Nursing or designee will conduct 5 random audits to ensure diet orders are reviewed and revised by the physician as the Residents' condition requires twice a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results will be forwarded to the Interdisciplinary Team for review and further recommendations.	01/21/2022
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Nursing (DON) indicated she was unable to find a current diet order for Resident C.

3. Resident D's record was reviewed on 12/20/21 at 10:30 a.m. The resident was admitted to the facility on 3/4/21.

The resident's current physician's orders lacked a diet order.

During an interview on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated Resident D did not have a current diet order. He admitted to the facility from home, and a diet order was not put in place.

4. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

The resident's current physician's orders lacked a diet order.

During an interview, on 12/21/21 at 9:33 a.m., the DON indicated she was unable to find a diet order for Resident N.

During an interview, on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated if a resident received a regular diet there was not a physician's order in place.

During an interview, on 12/20/21

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at 12:55 p.m., the Executive Director (ED) indicated the residents were responsible to make their own dietary choices and diet orders were not necessary. If a resident had to have a modified texture diet, they would have to re-evaluate the resident to ensure they were able to provide care for them. There was no facility policy for diet orders.

On 12/21/21 at 2:13 p.m., the Administrator provided a document titled, "Resident Handbook," and indicated it was the policy currently being used by the facility. The policy indicated, "...Therapeutic Diets: Towne Park does not provide therapeutic diet requests. Our liberalized menu is designed to allow the resident to make good food choices regarding their particular diet needs...."

Based on record review and interview, the facility failed to ensure residents' diet orders were reviewed and revised by a physician for 4 of 7 residents (Residents P, C, D, and N).

Findings include:

1. Resident P's record was reviewed on 12/21/21 at 9:25 a.m. The resident was admitted to the facility on 8/9/21.

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The resident's current physician's orders lacked a diet order.

On 12/21/21 at 10:25 a.m., the Director of Nursing (DON) indicated she was unable to find a current diet order for Resident P.

2. Resident C's record was reviewed on 12/17/21 at 2:36 p.m. The resident was admitted to the facility on 4/22/17.

The resident's current physician's orders lacked a diet order.

During an interview, on 12/20/21 at 3:18 p.m., the Director of Nursing (DON) indicated she was unable to find a current diet order for Resident C.

3. Resident D's record was reviewed on 12/20/21 at 10:30 a.m. The resident was admitted to the facility on 3/4/21.

The resident's current physician's orders lacked a diet order.

During an interview on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated Resident D did not have a current diet order. He admitted to the facility from home, and a diet order was not put in place.

4. Resident N's record was reviewed on 12/20/21 at 3:00

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FORM APPROVED

OMB NO. 0938-0391

p.m. The resident was admitted to the facility on 4/22/21.

The resident's current physician's orders lacked a diet order.

During an interview, on 12/21/21 at 9:33 a.m., the DON indicated she was unable to find a diet order for Resident N.

During an interview, on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated if a resident received a regular diet there was not a physician's order in place.

During an interview, on 12/20/21 at 12:55 p.m., the Executive Director (ED) indicated the residents were responsible to make their own dietary choices and diet orders were not necessary. If a resident had to have a modified texture diet, they would have to re-evaluate the resident to ensure they were able to provide care for them. There was no facility policy for diet orders.

On 12/21/21 at 2:13 p.m., the Administrator provided a document titled, "Resident Handbook," and indicated it was the policy currently being used by the facility. The policy indicated, "...Therapeutic Diets: Towne Park does not provide therapeutic diet requests. Our liberalized menu is designed to

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allow the resident to make good food choices regarding their particular diet needs...."

Based on record review and interview, the facility failed to ensure residents' diet orders were reviewed and revised by a physician for 4 of 7 residents (Residents P, C, D, and N).

Findings include:

1. Resident P's record was reviewed on 12/21/21 at 9:25 a.m. The resident was admitted to the facility on 8/9/21.

The resident's current physician's orders lacked a diet order.

On 12/21/21 at 10:25 a.m., the Director of Nursing (DON) indicated she was unable to find a current diet order for Resident P.

2. Resident C's record was reviewed on 12/17/21 at 2:36 p.m. The resident was admitted to the facility on 4/22/17.

The resident's current physician's orders lacked a diet order.

During an interview, on 12/20/21 at 3:18 p.m., the Director of Nursing (DON) indicated she was unable to find a current diet order for Resident C.

3. Resident D's record was

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reviewed on 12/20/21 at 10:30 a.m. The resident was admitted to the facility on 3/4/21.

The resident's current physician's orders lacked a diet order.

During an interview on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated Resident D did not have a current diet order. He admitted to the facility from home, and a diet order was not put in place.

4. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

The resident's current physician's orders lacked a diet order.

During an interview, on 12/21/21 at 9:33 a.m., the DON indicated she was unable to find a diet order for Resident N.

During an interview, on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated if a resident received a regular diet there was not a physician's order in place.

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P.

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The resident's current physician's orders lacked a diet order.

During an interview on 12/20/21 at 12:11 p.m., the Director of Nursing (DON) indicated Resident D did not have a current diet order. He admitted to the facility from home, and a diet order was not put in place.

4. Resident N's record was reviewed on 12/20/21 at 3:00 p.m. The resident was admitted to the facility on 4/22/21.

The resident's current physician's orders lacked a diet order.

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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.)

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