STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CHARM VILLAGE	7212 US HWY 31 S INDIANAPOLIS, IN 46227

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 15, 16, and 19, 2016. Facility number: 003283 Provider number: 003283 AIM number: N/A Census bed type: Residential: 54 Total: 54 Sample: 9 These State findings are cited in accordance with 410 IAC 16.2-5. Q.R. completed by 14466 on September 21, 2016.	R 0000	This plan of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on September 27, 2016 does not constitute an admission of fault of liability to the government entity or any third party, or on the part of Country Charm Village, as to the accuracy of the surveyors' findings of the conclusions drawn therefrom. Submission of this plan of correction also does not constitute a non-compliance or deficiency or that the scope and severity regarding the deficiencies cited are correctly applied. Any changes of the communities policies and procedures should be considered to be a subsequent remedial measures as that concept is employed in Rule 47 of the Federal Rules of Evidence and any corresponding state rule of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the right to object to admission of this statement of deficiency or the plan of correction under any other theory of Law. The community submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
R 0055 Bldg. 00	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(3) Physical examinations and treatments. (4) Visitations. Based on observation, record review, and interview, the facility failed to ensure residents' privacy was respected, in that a resident with known intrusive behaviors (Resident #22) was not prevented from opening doors, turning door handles and entering other residents rooms without permission. (Resident #34 and #23) Findings include: The clinical record of Resident #22 was reviewed on 9/15/16 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, bipolar disorder, depression, anxiety, and impulse control disorder. Nurses' notes indicated: 5/23/16 at 10:00 a.m., "Res [resident] observed going in/out of other res rooms. res redirected." 5/23/16 at 5:00 p.m., "Res was seen by another res going through res mailboxes..." 6/11/16 at 12:30 p.m., "Writer informed by dietary staff that res was going into other res room without them giving him permission. Res informed not to go into	R 0055	1. Resident 22 has been given a 30 day notice to transfer/Discharge from this community. Resident 22 sister, who is his POA, his CICOA case manager, and the local Ombudsman have all been notified and are in agreement with this transfer/discharge . 2. The community will review all resident records and determine if other residents may be affected by the alleged deficient practice. Any residents identified will be evaluated for intrusive behaviors. Results will be reviewed by the Interim Director of Nursing. Appropriate interventions will be initiated up to and including discharge from the community if necessary. If a resident is determined able to remain within the Assisted Living Community with appropriate interventions, the resident will be re-evaluated within 90 days from the initial evaluation. 3. Measures put in place will be as follows: An initial assessment will be completed to determine the possible causes of the intrusive behavior. Appropriate interventions will be initiated if determined the resident is able to safely remain in the community. If a resident is determined able to remain in the Assisted Living Community with appropriate interventions, the resident will be re-evaluated within 90 days from the initial evaluation. A second assessment will be completed within 90 days of knowledge of the intrusive behavior for all residents privacy. 4. The Interim Director of Nursing will be responsible completion of assessments and the Executive Director will monitor compliance for the assessments. 5. The systemic changes will be completed by October 19, 2016.	10/19/2016

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	other res rooms. ED [Executive Director] informed writer that she observed res opening other res mailboxes..." 6/12/16 at 5:30 p.m., "...reported to writer...found res in a female res room taking her belts while she was in the bathroom..." Resident #22 was readmitted to the facility on 6/29/16, after being treated at a neuropsychiatric hospital. The neuropsychiatric hospital admission evaluation, dated 6/12/16, indicated Resident #22 was admitted for intrusive behaviors, touching other residents' food, eating non-food items, and going through other residents' mailboxes. A Behavior Management Plan, dated 6/29/16, the day Resident #22 returned to the facility from the neuropsychiatric hospital, indicated behavioral concerns of socially inappropriate behavior, opening several resident doors on dining area hallway on way to dining room, and intrusive behavior. A nurse's note dated 6/30/16 at 7:00 p.m., indicated Resident #22 was, "Attempting to turn handles to doors. Redirected..."			

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	A Behavior Management Plan dated 8/30/16 indicated, "Resident was seen walking into another resident's room. Dietary Manager instructed [resident] to not go into rooms. He asked why and manager just said because we are not supposed to. [Resident] then gave manager the middle finger and stuck his tongue out at her twice." On 9/15/16 at 10:05 a.m., son of Resident #34 indicated his mother had woken early in morning and found Resident #22 standing over her. Resident #34 called her son to report this. On 9/15/16 at 10:10 a.m., Resident #34 indicated she was watching TV the night before and Resident #22 opened her door and stood there staring at her. On 9/15/16 at 3:00 p.m., Resident #24 indicated she had seen Resident #22 rattle door knobs and enter other resident rooms. On 9/15/16 at 3:15 p.m., Resident #23 indicated Resident #22 came into his room a few days ago and just stood there. Resident #23 indicated, "If you say anything to him [Resident #22) he just says, 'I don't care.'" Observation on 9/16/15, of a facility			

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	video of Resident #22's hallway, with Executive Director and Maintenance Director, indicated on 9/14/16 at 6:44 p.m., Resident #22 tried Resident #34's door handle, and on the same day at 7:10 p.m., he tried the door again and opened Resident #34's door. On 9/16/16 at 2:20 p.m., the Executive Director indicated the facility was trying to come up with solutions to Resident #22's "intrusive behaviors". On 9/19/16 at 11:00 a.m., #1, requesting anonymity, indicated Resident #22 had been seen multiple times attempting to enter other residents room. On 9/19/16 at 11:05 a.m., #3, requesting anonymity, indicated Resident #22 had been seen multiple times attempting to enter other residents rooms.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure an odor in a resident's room and hallway outside the resident's room was maintained at a comfortable level for 1 of 7 resident	R 0144	1. The corrective action that has been accomplished was the carpet in resident 22's room has been removed, flooring under the carpet has been cleaned and new flooring has been laid. 2. The Housekeeping Supervisor and Executive Director will audit all apartments to ensure there are not any other residents apartments or areas out-side of residents apartment has an odor. The community will continue to remove heavily	10/19/2016

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	rooms reviewed. (Resident #22) Findings include: On 9/16/16 at 10:15 a.m., with Staff #4, a urine-like odor was smelled outside Resident #22's door. Upon entering Resident #22's room, an extremely strong urine-like smell was noted, both in the resident's bathroom and in the room itself. The urine odor caused the surveyor's eyes to water. The bathroom appeared clean. On 9/16/15 at 11:00 a.m., the Executive Director (ED) indicated Resident #22 uses the urinal and then dumps the urine on the carpet. On 9/16/16 at 3:20 p.m., Housekeeper #2 indicated Resident #22 urinates on the carpet. "We're supposed to thoroughly clean rooms 1 time per week, but we've been told to clean [Resident #22's] room more often." On 9/19/16 at 11:55 a.m., the ED indicated she had placed a work order to remove the carpet from Resident #22's room.		soiled carpet, clean and lay new flooring as needed. 3. The measures that will be put in place and systemic changes the community will make to ensure the alleged deficient practice does not recur shall include the following: Housekeepers shall check resident apartments for urine-like odors and other foul odors, document on the housekeeping cleaning logs the apartment number and report to the housekeeping supervisor. Housekeeping supervisor shall check the house-keeping cleaning logs daily and report the need to replace flooring to the Executive Director. 4. The corrective action will be the responsibility of the housekeeping supervisor and the Executive director will monitor monthly. 5. The systemic changes will be completed by October 19, 2016.	
R 0186	410 IAC 16.2-5-1.6(j)(1-2)(A-E)(3)(A-E) Physical Plant Standards - Noncompliance			

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Bldg. 00	(j) The following standards apply to toilet, lavatory, and tub or showers: (1) For facilities initially licensed after (effective date), each unit shall have a private toilet, lavatory, and tub or shower. (2) For facilities for which plans were approved prior to April 1, 1997, the following criteria is [sic., are] applicable: (A) Bathing facilities for residents not served by bathing facilities in their rooms shall be provided as follows: Residents — Bathtubs or Showers 3 to 22 — 1 23 to 37 — 2 38 to 52 — 3 53 to 67 — 4 68 to 82 — 5 83 to 97 — 6 (B) A central bathing tub shall be available. (C) Central bathing and toilet facilities shall be partitioned or curtained for privacy. (D) Toilets, bath, and shower compartments shall be separated from rooms by solid walls or partitions that extend from the floor to the ceiling. (E) Toilet facilities shall be provided as follows: Residents of the Same Sex — Toilets — Open-Front Lavatories 3 to 18 — 1 — 1 19 to 30 — 2 — 2 31 to 42 — 3 — 3 43 to 54 — 4 — 4 55 to 66 — 5 — 5 67 to 78 — 6 — 6 (3) For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, at least one (1) toilet and lavatory shall be provided for each eight (8) residents as follows:			

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	A) Toilet rooms adjacent to resident bedrooms shall serve no more than two (2) resident rooms or more than eight (8) beds. (B) The toilet room shall contain a toilet, lavatory, liquid soap, and disposable towel dispenser. (C) Each resident shall have access to a toilet and lavatory without entering a common corridor area. (D) For facility with common toilet facilities, at least one (1) toilet and one (1) lavatory for each gender on each floor utilized by residents. (E) All bathing and shower rooms shall have mechanical ventilation. Based on observation, interview, and record review, the facility failed to provide a soap dispenser in a public/residents' toilet room as indicated by current facility policy and procedure in 1 of 2 toilet rooms observed. Findings include: On 9/12/2016 at 2:30 p.m., 9/13/2016 at 2:00 p.m., and on 9/19/2016 at 11:00 a.m., toilet room in main hallway was observed to have no soap dispenser. Entrance door to the toilet room indicated it was for men/women. A Resident was observed exiting the toilet room. Chipped paint and drywall observed on the wall next to the sink. During an interview on 9/19/16 at 11:10 a.m., the Maintenance Director indicated, "Someone must have taken it off."	R 0186	1. The corrective action that has been accomplished was the soap dispenser in the main hallway toilet room for men/women has been placed back on the wall; in its original place and has been filled with soap. 2. The Housekeeping Supervisor will audit all public restrooms to ensure that a soap dispenser is present and has soap available. 3. The measures that will be put in place and systemic changes the community will make to ensure the alleged non compliance does not recur shall include the following: Housekeepers shall check all public/resident toilet rooms for secured soap dispensers on the walls above the lavatories are in good repair and are filled with soap. Housekeepers shall complete work orders for maintenance should repairs be needed; turn the work orders into the housekeeping supervisor who will give them to maintenance personnel. 4. The corrective action will be the responsibility of the housekeeping supervisor and maintenance personnel. The Executive Director will monitor compliance 3 times weekly until next survey 5. The systemic changes was completed on September 19, 2016 at 11:50 AM.	10/19/2016

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	During an interview on 9/19/16 at 11:15 a.m., the Administrator indicated, "I was not aware the soap dispenser was missing." During an interview on 9/19/16 at 11:40 a.m., the Administrator indicated, "The housekeepers are supposed to check off work tasks in a binder when checking the dispensers and if they can not fill or fix the dispenser they are to fill out a work order for maintenance." On 9/19/16 at 11:45 a.m., The Administrator provided policy/procedure titled "Country Charm Housekeeping Cleaning Schedule/Checklist and indicated the policy/procedure was the one currently being used by the facility. Policy/procedure, indicated "DAILY: Ensure all dispensers clean/sanitized and stocked with sanitizer...."			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.			

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	Based on observation, record review, and interview, the facility failed to ensure a service plan was initiated which reflected a resident's current status and needs, for 1 of 7 residents reviewed. (Resident #22) Findings include: The clinical record of Resident #22 was reviewed on 9/15/16 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, bipolar disorder, depression, anxiety, and impulse control disorder. Resident #22 was readmitted to the facility on 6/29/16, after being treated at a neuropsychiatric hospital. A hospital admission evaluation, dated 6/12/16, indicated he was admitted for intrusive behaviors, touching other residents' food, eating non-food items, and going through other residents' mailboxes. A Behavior Management Plan, dated 6/29/16, indicated behavioral concerns of socially inappropriate behavior, opening several resident doors on dining area hallway on way to dining room, and intrusive behavior. Nurses' notes indicated: 6/29/16 at 6:00 p.m., Resident #22 was	R 0214	1. The corrective action that will be accomplished for resident 22 is resident has been given a 30 day Transfer/Discharge Notice. 2. All service plans were reviewed to ensure all service plans reflect residents current status and needs. Any resident service plans identified as not reflecting the residents current status will be updated to reflect such. 3. Measures to be put in place are as follows: A re-assessment will be completed prior to resident returning to the community from a rehab stay. A second assessment will be completed within 30 days of returning to the community to ensure the resident service plan is current with appropriate interventions if needed and 90 days thereafter. 4. According to CSL policy the Interim Director of Nursing will be responsible for completion of assessments. The Executive Director will monitor compliance weekly until next survey. 5. The systemic changes will be completed by October 19, 2016.	10/19/2016

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	escorted back to his room after calling another resident, "a b...." 6/30/16 at 5:00 p.m., Resident #22 was using the call light repeatedly, "with no known wants/needs." 6/30/16 at 7:00 p.m., Resident #22 was, "Attempting to turn handles to doors. Redirected..." 7/2/16 at 5:30 p.m., "Assisted resident to bathroom & provided incontinent care..." 7/4/16 at 3:00 p.m. "res [resident] repeatedly pressing call button when staff answers light res responds [with] 'I pressed it cause I wanted to.'" 7/6/16 at 2:00 p.m. "Res repeatedly pressing call light this shift when asked what does he need res denies pressing light or says I don't want anything. Res had a bm [bowel movement] on bathroom floor x 2 this shift..." An outpatient clinical history from a local mental health center, dated 7/7/16, indicated reasons for visit were increased agitation, depression, inappropriate behaviors, defecating all over room/self, cursing at others and pulling fire alarm. Nurses's notes continued:			

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	7/8/16 at 12:00 p.m. "Res to start getting incont[inent] supplies shipped to facility..." 7/14/16 at 7:00 p.m. Res incontinent] of bowel. Defecated on [bathroom] floor then rubbed feces on his sink, wall & floor..." A Resident Assessment and Service Plan, dated 7/19/16, indicated Resident #22 was oriented to time and place, did not wander, and behaved appropriately to the situation, was independent with toileting and did not need assistance for bowel or bladder incontinence. The service plan indicated services would not need to be provided for these areas. On 9/16/16 at 2:20 p.m., the Executive Director indicated the Service Plan dated 7/19/16, was the most current plan for Resident #22.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and			

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	control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to complete infection control report as indicated by current facility policy/procedure in 3 out of 6 months reviewed. Findings include: A review of Infection Control Monitoring was completed on 9/19/16 at 10:30 a.m. The monitoring lacked documentation and evaluation for June, July, and August, 2016. During an interview on 9/19/16 at 9:45 a.m., The Administrator indicated, "We have not been tracking infections for the last few months, but we usually do." During an interview on 9/19/16 at 10:25 a.m., Qualified Medicine Aide #1 indicated, "I'm going through records to track infections for the last three months." During an interview on 9/19/16 at 10:30 a.m., The Administrator indicated "End of month infection report tallies have not been done for three months due to not	R 0407	1. The corrective action that has been accomplished is the Infection Control Monitoring has been updated with current individual Resident Infection Reports, physician orders, C &S, Chest x-rays, and the Infection Control Report Totals . 2. The community will audit all orders daily and complete a resident infection report for any resident receiving an antibiotic and place the information on the Infection Control Log. At the end of the month the community will tally all infections on the Infection Control Report. 3. Measures to be put in place follows: When a resident is determined to have an infection orders for treatment of the infection will be received from the attending physician. The licensed nurse on duty will complete the Resident Infection Report , place a copy of the physician orders with the Resident Infection Control Report, and log the information on the Infection Control log. At the end of the month the Interim Director of Nursing will compete the Infection Control Report with totals for the month. 4. The LPN on duty will be responsible for completion of the individual resident reports with physician orders and the Interim Director of Nursing will monitor daily completions of these reports. The Executive Director will monitor compliance weekly until next survey. 5. The systemic changes will be completed by October 19, 2016.	10/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/19/2016

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	having a Director of Nursing." On 9/19/16 at 10:30 a.m., the Administrator provided an undated policy and procedure titled "Infection Control Binder--Monthly Dividers" and indicated it was the current policy used by the facility. The policy indicated, "1. Audit all orders daily. All orders written are placed in my mailbox. 2. Any residents placed on antibiotics, complete the resident infection report. 3. Any resident placed on antibiotic, place on infection control log. 4. At the end of the month complete infection control report, tally all infections/antibiotics. 5. Infection control rounds sheet are placed in this binder. 6. All cultures and chest x-rays placed in this binder with the infection report."			
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to ensure a chest x-ray was completed prior to admission as indicated by facility policy for 1 of 3 residents reviewed for chest x-rays. (Resident #69)	R 0408	1. The corrective action was a chest x-ray has been completed for resident 69 on 9/19/2016. 2. The community will review all resident records and determine all residents who could be affected by the alleged non compliance and will complete a chest x-ray on those residents found to not have a chest x-ray at admission. 3. Measures to be put in place follows: The Sales Director shall give a checklist to the prospective Resident and /or the POA a checklist of items needed prior to admission. On the checklist is the item a "Copy of the Chest X-Ray". An assessment will be completed by the Interim Director of Nursing or the Executive Director; who	10/19/2016

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	Findings include: The clinical record review for Resident #69 was completed on 9/15/16 at 12:21 p.m. Diagnosis included, but were not limited to, dementia. The record indicated Resident #69 admitted to the facility on 8/21/16. During review of Resident #69's clinical record, no chest x-ray was found. On 9/19/16 at 9:23 a.m., the Executive Director (ED) indicated there was no chest x-ray found for Resident #69, and indicated a chest x-ray was scheduled to be completed on this day, 9/19/16. On 9/19/16 at 9:45 a.m., the ED provided an undated policy and procedure with the subject, Prior to admitting the resident into their apartment, Country Charm Village needs the following items, and indicated it was the current procedure for the facility. The procedure indicated, "...6. Copy of Chest X-Ray results within the last 6 months...."		will request a copy of the results of the chest x-ray during the assessment and place those results in the medical record. 4. An admission checklist is in the medical record. The licensed nurse shall follow the checklist and ensure all admission paperwork is complete. The Medical Records Clerk will audit the new admission records to ensure the licensed nurse have completed all admission papers. The Executive Director will monitor compliance weekly until next survey. 5. The systemic changes will be completed by October 19, 2016.	