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	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMONS ON MERIDIAN, THE	8549 N MERIDIAN STREET INDIANAPOLIS, IN 46260

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00433084, IN00432871 and IN00415348. Complaint IN00433084 - No deficiencies related to the allegations are cited. Complaint IN00432871 - No deficiencies related to the allegations are cited. Complaint IN00415348 - No deficiencies related to the allegations are cited. Survey dates: May 9, 10 and 13, 2024. Facility number: 013933 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 20, 2024.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to obtain a criminal background check on 1 of 5 employees reviewed for employee records. (Housekeeper 1)	R 0116	What corrective action(s) will be accomplished for those Residents found to be affected by the deficient practice:	06/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carrie Hamilton	Executive Director	06/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Finding includes: The employee records were reviewed on 5/9/24. Housekeeper 1 was hired on 1/16/24. A criminal background check was not found in Housekeeper 1's employee file. During an interview, on 5/9/24 at 2:58 p.m., the Corporate Direct Clinic Services for Senior Living staff indicated the facility was aware of the background check needed to be completed prior to hiring employees. A facility policy, titled "Pre-Hire Background & Licensure Screening Policy," dated as last revised 08/22 and received from the interim Executive Director on 5/9/24 at 3:06 p.m., indicated "...The Company will conduct the background screening...which must be completed and returned as clear prior to hiring and the start of work...."		No Residents were affected by the deficient practice. Criminal background check was submitted on 5/9/24 and Housekeeper 1 removed from schedule. Criminal background check was returned with no findings. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All Residents have the potential to be affected. No resident was affected. Audit was completed by 5/13/24 to ensure all employees of facility had completed criminal background check on file. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Business office manager will be re-educated by 6/6/24 on Pre-Hire Background and Licensure Screening Policy, including but not limited to ensuring criminal background checks are completed and part of employee files upon hire. How the corrective action(s) will be monitored to ensure the deficient practice does not recur i.e., what quality assurance program will be put into place: A new hire monitoring tool will be	

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			completed weekly x 4 weeks, then monthly x 3 months. If 100% threshold is not met, then disciplinary action and new action plan will be completed. Monitoring tool will be completed by Executive Director/designee.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure staff covered facial hair while working in the kitchen, to ensure dishes were clean and air dried prior to placing on a shelf, to ensure food items were labeled with open dates and to ensure food was not left open to air in the freezer, pantry, and cooler. This deficient practice had the potential to affect 53 of 53 residents who received meals from the kitchen. Findings include: During an observation of the kitchen, on 5/9/24 beginning at 2:00 p.m., with Dietary Staff 3 in attendance the following observations were noted: 1. On 5/9/24 at 2:10 p.m., Kitchen Staff 2 was observed to have facial hair which was not covered with a hair net.	R 0273	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice: Kitchen staff 2 on 5/9/24 was immediately re-educated and facial hair was covered with hair net. On 5/9/24, plastic containers with fluid or debris were re-washed, sanitized, and dried. On 5/9/24, foods in reach-in freezer, walk-in cooler, and pantry were reviewed and corrected so all items appropriately covered or wrapped, labeled and dated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	06/10/2024

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	2. On the clean dishes' storage shelf, plastic storage containers were found stacked with drops of clean liquid between them and larger plastic storage items on the shelf were found with spots of dried debris. 3. In the reach-in freezer, a three (3) pound container of Orange Sherbert was found without an open date. The container had been opened and was not full. 4. In the walk-in cooler, two (2) plastic bags of hard-boiled eggs were found open to the air and without an open date. 5. In the walk-in freezer, a box of dinner rolls was found in a plastic bag, in a box. The box was open, and the plastic bag was open, leaving the dinner rolls open to air. 6. In the pantry, a one (1) pound bag, half full of vanilla wafer cookies was found open to the air. During an interview, on 5/9/24 at 2:10 p.m., Dietary Staff 3 indicated staff needed to cover their facial hair with a net. During an interview, on 5/9/24 at 2:14 p.m., Dietary Staff 3 indicated the plastic containers should not be stored with fluid or debris on them. During an interview, on 5/9/24 at 2:19 p.m., the Dietary Manager indicated food should have an open date when it was opened. A facility policy, titled "Cleaning Dishes," dated as last reviewed in 4/24 and received from the interim Executive Director on 5/10/24 at 11:10 a.m., indicated "...Air-dry all items...."		will be taken: All residents have the potential to be affected. No resident was adversely affected. Culinary staff was re-educated by 5/13/24 including, but not limited to, policies for cleaning dishes, food storage, and food handling. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: Culinary staff was reeducated by 5/13/24 including, but not limited to, policies for cleaning dishes, food storage, and food handling. A review of kitchen by Culinary Manager/Executive Director to ensure compliance and re-education of culinary staff on policies for cleaning, food storage, and food handling by 6/6/24. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: Cleaning dishes, food storage, and food handling monitoring tools will be completed 3 times weekly x 4 weeks, then once weekly x 8 weeks. If 100% threshold is not met, then disciplinary action and new action plan will be completed. Monitoring tool will be completed by Culinary Manager or Executive Director/designee.	

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	A facility policy, titled "Food Storage," dated as last reviewed in 5/23 and received from the interim Executive Director on 5/10/24 at 11:10 a.m., indicated "...Refrigerated, ready-to-eat...food...shall be clearly marked with the date the original container is opened...Refrigeration...All foods shall be covered or wrapped tightly, labeled and dated following the labeling guidelines...Frozen Foods...Foods should be covered or wrapped tightly, labeled, and dated with the date item in being placed in the freezer...Dry Storage...All foods shall be covered or wrapped tightly, labeled and dated...." A facility policy, titled "Food Handling," dated 11/15 and received from the interim Executive Director on 5/10/24 at 11:10 a.m., indicated "...Everyone entering the kitchen shall wear hair nets...."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview and record review, the facility failed to ensure staff signed the	R 0298	What corrective action(s) will be accomplished for those Residents	06/10/2024

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	narcotic logbook, during shift change, to show the narcotics had been counted and were accurate prior to staff handing off the medication cart keys at the end of their shift and the beginning of the new shift for 2 of 2 narcotic books reviewed. (Cart 1 and 2) Finding includes: A facility document, titled "Shift Change Verification of Controlled Substances (8 Hour)," was reviewed on 5/9/24 at 11:02 p.m. The second floor, cart one (1), was missing signatures on 5/5/24 for the evening shift and 5/6/24 for the night shift. The second floor, cart two (2), was missing signatures on 5/2/24 and 5/5/24 for the evening shift, and 5/6/24 for the night shift. During an interview, on 5/9/24 at 11:03 a.m., QMA 4 indicated the narcotic book was to be signed off every shift with the oncoming/off going staff. A facility policy, titled "Controlled Substances," dated as last reviewed 04/23 and received from the Corporate Direct Clinic Services for Senior Living employee on 5/9/24 at 1:00 p.m., indicated "...The Narcotic Sign-In Sheet must be completed at the end of each shift every day...The incoming Nurse or her designee will count all controlled substances being stored at the Community while the outgoing nurse or her designee watches...Both staff members sign that the count sheets and verification have been completed...."		found to have been affected by the deficient practice: No adverse reactions to any Residents from missing signatures on narcotic logbooks. Narcotic counts reviewed and correct. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. No resident was adversely affected. Staff qualified to administer medications will be re-educated by 6/6/2024 on shift change verification of controlled substances policy. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: Staff qualified to administer medications will be re-educated by 6/6/2024 on shift change verification of controlled substances policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: A shift change verification of controlled substances monitoring tool will be completed weekly x 8 weeks, then bi-weekly x 4 weeks.	

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			If 100% threshold is not met, disciplinary action and new action plan will be completed. Monitoring tool will be completed by Director of Nursing/Executive Director/designee.	