CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/16/2023		
	PROVIDER OR SUPPLIER			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE NAPOLIS, IN 46227		
WATER	OF INDIANAPOLI	S, THE		INDIA	NAFOLIS, IN 40221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0000							
Bldg. 00	Licensure Survey. To Investigation of Complaint IN00409 the allegations are consumption of Complaint IN00409 the allegations are consumption of Complaint IN00409 the allegations are consumption of Complaint Investigation of Complaint Inv	12,13,14,15, and 16, 2023 20537 55409 267270 :	F 00	000	July 5, 2023  Preparation or execution of the plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond the allegation of noncomplian cited during the Recertification Licensure Survey on June 16 2023. Please accept this plan correction as the provider's credible allegation of complian with Federal Medicare and Medicaid requirements. We respectfully request a desk review.	ement the set to ce n and ,	
F 0661 SS=D Bldg. 00	resident must hav that includes, but following: (i) A recapitulation	ary					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Nicole Fields Administrator 07/08/2023

Any defiency statement 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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07/13/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/16/2023 155409 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227 WATERS OF INDIANAPOLIS, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE course of illness/treatment or therapy, and pertinent lab, radiology, and consultation (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. F 0661 What corrective action(s) will 07/22/2023 Based on interview and record review, the facility be accomplished for those failed to ensure a resident's medications were residents found to have been reconciled before discharge for 1 of 3 residents affected by the deficient reviewed for discharge. (Resident 29) practice? Finding includes: Resident 29 no longer resides in this facility. On 6/25/23 at 9:51 a.m., Resident 29's closed

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clinical record was reviewed. Resident 29

A Resident Discharge Summary, dated 6/6/23,

indicated all Resident 29's medications were sent

home with the resident. The discharge summary

lacked the quantity of each medication, the

discharged to home on 6/6/23.

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How will you identify other residents having the potential

to be affected by the same

deficient practice and what

corrective action will be taken?

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED	
		155409	B. W	ING		06/16/	2023	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			KEYSTONE AVE			
WATER	S OF INDIANAPOL	IS THE			IAPOLIS, IN 46227			
WATER	3 OF INDIANAFOL	III.		INDIAN	AFOLIS, IN 40221			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	dication, the instructions for			Residents who discharge have	e the		
		nd staff signatures. The			potential to be affected by this	;		
	discharge medication	on included, but were not			deficient practice.			
	limited to:							
					What measures will be put ir	ıto		
	- Midodrine (a medication used to treat high blood				place or what systemic			
		g (milligrams), no instructions			changes you will make to			
	for frequency.				ensure that the deficient			
		um (a medication used to treat			practice does not recur?			
		no dosage or instructions for						
	frequency.				The DON or designee will			
	- Apixaban (a blood thinner), no dosage or				reeducate the nurses on the			
	instructions for frequency.				procedure for Documentation			
	- Multivitamin, no dosage or instructions for				Drug Disposition at the time of			
	frequency.				Discharge, specifically including	ng		
		retic medication), no dosage or			inclusion of quantity and			
	instructions for free				instructions for each medication	on.		
		sate sodium (a stool softener)						
	_	uctions for frequency.						
	_	der (a stool softener) 17 grams,			How the corrective action(s)			
	no instruction for fi				will be monitored to ensure t	ihe		
	_	nate (a medication used to treat			deficient practice will not			
		e, chest pain, and heart failure)			recur, i.e., what quality			
		uctions for frequency.			assurance program will be p	ut		
		eroidal anti inflammatory			into place?			
	· · · · · · · · · · · · · · · · · · ·	sage or instructions for			The DON or gualified designs	النبده		
	frequency.				The DON or qualified designe	e WIII		
					audit discharge medication	oko		
	During an interview	w on 6/14/23 at 2:00 p.m., the			reconciliation weekly for 8 wee			
	_	g (DON) indicated the			then monthly times 4 months to validate compliance with feder			
		ent home with the resident. No			and state law. The results of			
		he quantity of each medication			and state law. The results of audit will be reviewed, reporte			
		the medications were available.			and trended for compliance	u,		
	of monuctions for t	ne medications were available.			through the facility Quality			
	3.1-36(b)				Assurance Committee for a			
	3.1-30(0)				minimum of six months then			
					randomly thereafter until			
					1			
					substantial compliance is			
	I		1		achieved.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	ATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155409	B. WI	NG		06/16/	/2023
	PROVIDER OR SUPPLIER  OF INDIANAPOLI  SUMMARY		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227			(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F 0727 SS=E Bldg. 00	§483.35(b) Regist §483.35(b)(1) Exc paragraph (e) or (finust use the servitor at least 8 consists a week.  §483.35(b)(2) Exc paragraph (e) or (finust designate a last the director of reserve as a charge has an average dafewer residents.  Based on record revitaled to provide 8 consists and average dafewer residents.  Based on record revitaled to provide 8 consists (RN) service of 31 days reviewed.  Findings include:  On 6/15/23 at 1:00 grows (DON) provided consists for 5/13/23 to of the Report of Nur. Responsible for Reserviewed period of review of these repollimited to the follow facility census; num of the three work shought shifts; the num of the shifts; the num	ept when waived under f) of this section, the facility ices of a registered nurse ecutive hours a day, 7 days  ept when waived under f) of this section, the facility registered nurse to serve nursing on a full time basis.  director of nursing may nurse only when the facility aily occupancy of 60 or  riew and interview, the facility continuous hours of Registered ces, seven days a week, for 12 d.  p.m., the Director of Nursing pies of the Daily Staffing hrough 6/12/23.  a.m., the DON provided copies	F 07	727	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility is engaged in continuous efforts to recruit and retain licensed nurses in order to conswith RN coverage dictated by CMS. These efforts are documented and available for review. No resident has been negatively impacted by this finding. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be take.  All residents have the potential be affected by this deficient.	n inual mply al	07/22/2023

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155409	B. W.	ING		06/16	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEF	₹			KEYSTONE AVE		
\\\\	S OF INDIANAPOLI	S THE			IAPOLIS, IN 46227		
WATERS	O INDIANAFOLI	O, THE		וואוטואוי			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	worked.				practice.		
	_	riod utilizing both sets of daily			What measures will be put	into	
	staffing reports ind	icated the following:			place or what systemic		
					changes you will make to		
	_	orts lacked documentation to			ensure that the deficient		
	indicate any RN coverage was provided. The				practice does not recur?		
	facility census was 70.						
					The facility will provide 8		
	_	orts lacked documentation to			continuous hours of Register	ed	
	1	verage was provided. The			Nursing services 7 days per		
	facility census was	69.			week.		
	_	orts lacked documentation to			How the corrective action(s	-	
	· ·	verage was provided. The			will be monitored to ensure the		
	facility census was	70.			deficient practice will not		
	0.5/04/00.1				recur, i.e., what quality		
	_	orts lacked documentation to			assurance program will be	put	
	· ·	verage was provided. The			into place?		
	facility census was	69.					
	0 5/00/00 1	. 1 1 11			RN labor audits will be condu		
	_	orts lacked documentation to			by the DON/designee weekly	/	
	I	verage was provided. The			times 8 weeks, then monthly		
	facility census was	/1.			times 4 months to validate		
	On 5/24/22 41	outo lo alrad do ayur			compliance with federal and		
	_	orts lacked documentation to verage was provided. The			law. The results of the audit		
	1				be reviewed, reported and tre		
	facility census was	08.			for compliance through the fa	-	
	On 5/27/22 the	orts lacked documentation to			Quality Assurance Committe a minimum of 6 months then	e ior	
		verage was provided. The					
	facility census was				randomly thereafter until		
	lacinty census was	00.			substantial compliance is achieved.		
	On 5/31/23 the ren	orts lacked documentation to			auneveu.		
	_	verage was provided. The					
	facility census was						
	lacinty census was	· · ·					
	On 6/3/23 the repo	orts lacked documentation to					
	_	verage was provided. The					
		, SIGES TIGS DISTINCE. THE			1		•

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155409		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  16/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	_	rts lacked documentation to verage was provided. The 67.						
	_	rts lacked documentation to verage was provided. The 63.						
	_	orts lacked documentation to verage was provided. The 64.						
	DON indicated the	on 6/15/23 at 1:40 p.m., the facility was to have 8 f RN coverage every day as deral guidelines.						
	undated copy of a p Services which indi services of a registe	a.m., the DON provided an olicy titled Registered Nurse cated, "A facility must use the red nurse for at least 8 day, 7 days a week."						
	3.1-17(b)(3)							
F 0812 SS=E Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.						
	approved or consi federal, state or lo (i) This may include directly from local applicable State a regulations.	le food items obtained producers, subject to						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED	
		155409	B. W	ING		06/16	/2023	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			KEYSTONE AVE			
WATER	S OF INDIANAPOLI	S THE			IAPOLIS, IN 46227			
WAILIN	O INDIANALOLI			INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ng produce grown in facility						
		to compliance with						
	applicable safe growing and food-handling							
	practices.							
		does not preclude residents						
	from consuming foods not procured by the							
	facility.							
	- ,,,,	ore, prepare, distribute and						
		ordance with professional						
	standards for food	d service safety.	Б.0	210			05/00/000	
	D 1 1		F 0	312	What corrective action(s) wil	l	07/22/2023	
	Based on observation, interview, and record				be accomplished for those			
	review, the facility failed to ensure foods were served in a sanitary and safe manner for 6 of 7				residents found to have been	n		
	-				affected by the deficient			
		ns. Staff hair was not covered			practice:			
		n food preparation area and the			No resident was found to be			
		disrepair. (Dietary Aide 2,			affected by this alleged deficie			
	Maintenance Direct	ok 4, Dietary Manager, and			practice. Staff who work in ar			
	Maintenance Direc	tor)			enter the kitchen will have all			
	Findings include:				and head hair properly covere	eu		
	Tillulings include.				and secured per policy and regulation.			
	1 During the initial	l kitchen tour with the Dietary			regulation.			
	_	6/12/23 from 7:32 a.m. to 8:10			The temperature control knob	on.		
	a.m., the following				the steam table was replaced.			
	a.m., the foliowing	was coserved.			The steam table well has been			
	a. The DM was obs	served walking through out the			repaired.	•		
		the breakfast meal was being			Topanoa.			
		as observed to have hair			How other residents having			
		ne right side of the head just			the potential to be affected b			
		10-inch single braid hanging			the same deficient practice v	_		
		e back. The hair braids were			be identified and what			
	observed to not be				corrective action(s) will be			
					taken:			
	b. Dietary Aide 2 w	vas observed walking through						
		where the breakfast meal was			No other residents were foun	d to		
	being served. Dieta	ary Aide 2 was observed to			be affected by this alleged			
	have facial hair (be				deficient practice.			
		fourth inch in length. Dietary						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155409	B. W	ING _		06/16/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S THE			IAPOLIS, IN 46227		
WAILING	OI INDIANA OLI			ייאטואויי			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		was observed to not be			What measures will be put		
	covered.				into place and what systemic		
				changes will be made to			
	-	as observed walking through			ensure that the deficient		
	out the kitchen area where the breakfast meal was being served. Dietary Aide 3 was observed to				practice does not recur:		
	_	-			The Administration and a control of	الثنيية	
	have facial hair (above and below the lips) approximately one-half inch in length. Dietary				The Administrator or designed		
		was observed to not be			reeducate all staff on the police	-	
	covered.	was observed to not be			ensure hair is entirely covered		
	covered.				prevent exposure to food while the kitchen. Staff who are	<del>5</del> 111	
	d. Cook 4 was obse	rved at the steam table where			non-compliant with the policy	will	
		was being served. Cook 4 was			receive additional education a		
	observed to have loose hairs above the ears and				progressive discipline as	114/01	
		eximately one-inch in length.			appropriate.		
		bserved to not be covered.			appropriate.		
		<del></del>					
	2. During a follow t	up kitchen observation, on			The Administrator or designed	will	
	_	a.m. to 12:30 p.m., the following			educate maintenance and die		
	was observed:				staff on the requirement that a		
					kitchen equipment including the		
	a. Dietary Aide 2 w	as observed walking through			steam table should be in good		
		where the noon meal was			repair and operate properly to		
	O	plated and was observed			meet set standards.		
	_	ood tray preparation. Dietary					
		d to have facial hair (beard			Maintenance Supervisor and		
		oximately one-fourth inch in			Dietary Manager will inspect a		
		le 2's facial hair was observed			kitchen equipment including th		
	to not be covered.				steam table monthly to ensure		
	1 5	1 1 11 11 11			they all operate properly as a	part	
		ras observed walking through			of the facility's Preventive		
		where the noon meal was			Maintenance Program and	14 -	
		plated and was observed			document those inspection res	SUITS	
	_	ood tray preparation. Dietary			as appropriate.		
		d to have facial hair (above			How the corrective action(s)	ıla a	
		approximately one-half inch in			will be monitored to ensure t	ne	
	to not be covered.	le 3's facial hair was observed			deficient practice will not		
	to not be covered.				recur:		
	c. Cook 4 was obse	rved at the steam table where					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155409	B. W	ING		06/16/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER				KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE			APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		being temped and plated.			Hair Restraint and Dietary		
		ed to have loose hairs above			Equipment Audits will be		
	the ears and at the neckline approximately				conducted by the		
	one-inch in length. Cook 4's hair was observed to				Administrator/designee weekly	y	
	not be covered.				times 8 weeks, then monthly		
	1 771 3 6	D:			times 4 months to validate		
		Director was observed			compliance with federal and s		
	-	igerator unit located to the left			law. The results of the audit w		
		nit located approximately 4			be reviewed, reported, and tre		
		table where the noon meal was			for compliance through the fac	-	
	_	nintenance Director was cial hair (above the upper lip)			Quality Assurance Committee	ior	
		half inch in length and hair in			a minimum of 6 months then		
		l at the neckline approximately			randomly thereafter until		
		The Maintenance Director's			substantial compliance is achieved.		
	hair was observed to				acilieved.		
	nan was observed b	o not be covered.					
	e. The steam table b	and 4 steam wells holding the					
		ne plating process. The					
	_	rved: The mechanical soft					
	-	pureed greens, and mashed					
	-	e pans were located in the					
	-	well. Those food items were					
	observed to have be						
		; 150 F; and 150 F respectively.					
		<del>-</del>					
	During an interview	at that time, Cook 4 indicated					
	the temperature con	trol knob for the far-left steam					
		en. "It's very difficult to turn					
	-	ast the temperature in order to					
		oriate food temperatures."					
		e starting temps for the foods					
	should have register	red at least 180 F.					
	f. The steam stable	well, located to the right of the					
		arge steam table pan full of					
		table well was damaged at one					
	-	d the food tray from being					
	_	the well and maintain a					
	consistent temperate						
	- sansastoni tomperati						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIEI S OF INDIANAPOLI			3895 S	DDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	During an interview at that time, the Dietary Manager (DM) indicated the steam table well had been broken "for about a year."							
	Maintenance Direc	v, at that same time, the tor indicated "the steam table tired or replaced and it had tleast 3 months."						
		up kitchen observation, on p.m. to 1:15 p.m., the following						
	out the kitchen area being plated and we food tray preparation observed to have far approximately one-	vas observed walking through a where the noon meal was as observed assisting with the on. Dietary Aide 2 was acial hair (beard and mustache) of fourth inch in length. Dietary was observed to not be						
	out the kitchen area being plated and we food tray preparation observed to have fa lips) approximately	vas observed walking through a where the noon meal was as observed assisting with the on. Dietary Aide 3 was acial hair (above and below the one-half inch in length.						
	the noon meal was observed to have lo at the neckline appro	being plated. Cook 4 was lose hairs above the ears and roximately one-inch in length.						
		e Director was observed rigerator unit located to the left						

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155409		A. BUILDING B. WING	00	COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIER S OF INDIANAPOLIS, THE	3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	of the stove/oven unit located approximately 4 feet from the steam table where the noon meal was being held. The Maintenance Director was observed to have facial hair (above the upper lip) approximately one-half inch in length and hair in front of the ears and at the neckline approximately one-inch in length. The Maintenance Director's hair was observed to not be covered.  4. During a follow up kitchen observation, on 6/14/23, at 8:45 a.m., the kitchen steam table was observed. The steam table had 4 steam wells. The far-left well was missing the control knob and the well to the right was damaged which prevented the food pans to firmly sit in the well and maintain a consistent temperature.  5. During a follow up kitchen observation, on 6/14/23 from 11:45 a.m. to 12:20 p.m., the following was observed:  a. Dietary Aide 2 was observed walking through out the kitchen area where the noon meal was being prepared and plated and was observed assisting with the food tray preparation. Dietary Aide 2 was observed to have facial hair (beard and mustache) approximately one-fourth inch in length. Dietary Aide 2's facial hair was observed to not be covered.  b. Dietary Aide 3 was observed walking through out the kitchen area where the noon meal was being prepared and plated and was observed assisting with the food tray preparation. Dietary Aide 3 was observed to have facial hair (above and below the lips) approximately one-half inch in length. Dietary Aide 3's facial hair was observed to not be covered.  c. The Maintenance Director was observed				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE COMPLETION
TAG	working on the refr of the stove/oven un feet from the steam being held. The Ma observed to have fa approximately one-front of the ears and one-inch in length. hair was observed to d. The DM was obskitchen area where prepared and plated have hair braids loc head and above the observed to not be one-inch of water the was holding a medi mechanical soft chi d. The steam table vapproximately one-temped at 118 F. The initial food term of the initi	erved walking through out the the noon meal was being . The DM was observed to ated on the left side of her ear. The DM's hair was covered.  far left well control knob was a contained approximately nat temped at 130 F. The well compared the size of the size of the which temped at 159 F.  well, 3rd from left had inch of water in the well and the well was holding a ble pan of chicken parmesan.	TAG	DEFICIENCY	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155409	B. W	ING		06/16/	2023
NAME OF F	ADOLUDED OD GUDDU IER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF			3895 S	KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	covered.						
	b. Dietary Aide 3 w	as observed walking through					
	out the kitchen area where the noon meal was						
	being plated and wa	as observed assisting with the					
	food tray preparation	on. Dietary Aide 3 was					
	observed to have fa	cial hair (above and below the					
		one-half inch in length.					
	•	cial hair was observed to not be					
	covered.						
	During an interview	v on 6/13/23 at 2:05 p.m., the					
	_	aff hair was supposed to be					
	covered while in the kitchen.						
	_	v, on 6/14/23 at 3:05 p.m., the					
		M) indicated she was unaware					
	that the steam table	was not fully functional.					
	During an interview	v, on 6/16/23 at 12:30 p.m., the					
	_	facility was unable to locate					
	the steam table man	-					
	D :	(11(122 + 12.50 - 4					
	_	w, on 6/16/23 at 12:50 p.m. the steam table was to be					
		entative maintenance at least					
	monthly and as nee						
	monthly and as nee	aca.					
	On 6/14/23 at 10:30	a.m., the Administrator					
	provided a copy of	the Nutritional Services					
		£ 1.2 Dress Code policy, dated					
	· ·	ted it was the current policy in					
		A review of the document					
	-	sent a safe, sanitary and					
	•	ancefood employees wear a					
	_	n covers all hair completely.					
	-	be used for employees with					
	facial hair"						
	On 6/15/23 at 10:04	a.m. the ADM provided a copy					
			I				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/16/2023
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR of the Preventive M Safety Code Docum indicated it was the facility. A review of an issue is urgent in immediatelyDietasteam table - check operationcheck the check for leaks"	ermostat, switches and wiring,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	of the Serving Food 2010, and indicated by the facility. A re all steam table un proper heat mainten shall be reported to steam table will be	a.m., the DNS provided a copy and Beverages policy, dated it was the current policy in use eview of the policy indicated, " its shall be checked to assure nanceproblems with heating Maintenance immediatelythe turned on before serving to so ensure proper heating"			
	undated copy of Mo for Meal Service po current policy in use the policy indicated in covered steam tal	s a.m., the DNS provided an onitoring Food Temperatures licy and indicated it was the e by the facility. A review of , "all hot foods will be kept ble pans on the steam table"			
	Food Establishment Title 410 IAC 7-24, indicated, "food e restraints, such as h netsthat are design keep their hair from foodequipment sh repair and condition requirementsshall	p.m., a review of the Indiana Sanitation Requirements, effective November 13, 2004, mployees shall wear hair ats, hair coverings or ned and worn to effectively contactingexposed all be maintained in a state of a that meets the be kept intact, tight, and nee with manufacturer's			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO JILDING	onstruction 00	(X3) DATE COMPL	
		155409	B. W	ING		06/16/	/2023
	PROVIDER OR SUPPLIEI		<u> </u>	3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	3.1-21(i)(2) 3.1-21(i)(3)						
F 0814 SS=C Bldg. 00		and Refuse Properly pose of garbage and refuse					
	Based on observation review, the facility container top lids a closed when not in dumpster container of 2 observations.  Findings include:  1. During the initiate Manager (DM), on a.m., the dumpster the parking area from observed. The dum Two of two lids were The dumpster container of two lids were the parking area from observed to not dumpster were multidebris. The ground area was littered with plastic eating utens and other unidentified dumpster was a woodserved to be brown observed between the ground next to the other that time, while at the unidentifiable staff.	on, interview, and record failed to ensure the dumpster and a side panel door were kept use and failed to ensure the area was free of debris, for 2  I facility tour with the Dietary 6/12/23 from 8:15 a.m. to 8:20 container area, located across om the kitchen's back door, was apster container had 2 top lids. The observed to not be closed, ainer also had two sliding side of two sliding side panel doors at be closed. Inside the tiple filled trash bags and other distribution surrounding the dumpster in the debris (used plastic gloves, ils, plastic cups, paper plates it debris (used plastic gloves, ils, plastic cups, paper plates in the oden fence. Two boards were seen with trash and debris the broken boards and the dumpster container area. At the dumpster area, an immember was observed carrying stic trash bag that was filled	F 08	814	What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice:  No resident was found to be affected by this alleged deficient practice. The trash and debris picked up between the broken boards and on the ground next the dumpster container. The broken boards in the fence we replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other residents we found to be affected by this alleged deficient practice. What measures will be put into plat and what systemic changes will be made to ensure that the deficient practice does not recur:  The maintenance Supervisor of designee will inspect the dumparea for trash and debris and if fence to ensure it remains in goondition as a part of the facility monthly Preventive Maintenar	ent was totto ere s nt d l vere tt nce he or oster the good ty's	07/22/2023
	with trash. The sta	ff member threw the untied pened dumpster container and			Program and document those inspection results as appropria		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155409	B. W	ING		06/16/	/2023
			<u> </u>	CTPPPT :	ADDRESS CITY STATE ZIR COP		
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF INDIANADOLI	O THE			KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	5, IHE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	then returned to the	facility. The staff member			If any issues are discovered, t	hey	
	failed to close the o	pened dumpster lids or sliding			will be addressed and resolve	d	
	side panel door.				immediately. The Maintenand	e	
					Supervisor/designee will revie	W	
	During an interview	v at that time, the DM indicated			with the Administrator the		
	the dumpster lids as	nd doors were to be kept			inspection results.		
	closed. The area ar	round the dumpster was to be			How the corrective action(s)		
	kept free of debris.	-			will be monitored to ensure t		
					deficient practice will not		
	No other staff were	visible near the dumpster area			recur:		
	during that time.				Dumpster and Fence Audits w	/ill	
					be conducted by the		
	2. A follow up dun	npster container area			Administrator/designee weekly	V	
	observation with th	e DM, was conducted on			times 8 weeks, then monthly	•	
	6/14/23 at 8:50 a.m	. Behind the dumpster was a			times 4 months to validate		
	wooden fence. Two	bo boards were observed to be			compliance with federal and s	tate	
	broken with trash a	nd debris observed between			law. The results of the audit w		
	the broken boards a	and the ground next to the			be reviewed, reported and tre	nded	
	dumpster container				for compliance through the fac		
					Quality Assurance Committee	-	
	No staff were visible	le near the dumpster area.			a minimum of 6 months then		
					randomly thereafter until		
	On 6/14/23 at 10:30	0 a.m., the Administrator			substantial compliance is		
	provided a copy of	the Nutritional Services			achieved.		
	Operations Policy #	‡2.19 Trash Disposal policy,					
	dated 5/24/15, and	indicated it was the current					
	policy in use in the	facility. A review of the					
	document indicated	l, "The food service					
	department will dis	pose of trash appropriately and					
		ster area for cleanliness and					
	_	ntsthe food service					
	department are disp	oose of all trash from the food					
	service department	in enclosed trash bagsthe					
	food service departs	ment will assure dumpster lid					
	_	osing of trash and no trash is					
	on ground surround						
	_						
	On 6/16/23 at 10:45	5 a.m., a review of the Retail					
		t Sanitation Requirements -					
		, effective November 13, 2004,					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155409	B. W	ING		06/16/	/2023
				CTREET	DDDFGG CITY CTATE ZID COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\A/ATEDO		S THE			KEYSTONE AVE		
WATERS	OF INDIANAPOLI	5, INE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated, "recepta	acles and waste handling units					
	for refuse, recyclabl	les and returnables shall be					
	kept covered with ti	ght-fitting lids or doors if kept					
	outside"						
	3.1-21(i)(5)						
F 0883	483.80(d)(1)(2)					ļ	
SS=D		umococcal Immunizations					
Bldg. 00	• , ,	za and pneumococcal					
	immunizations						
	• ',','	uenza. The facility must					
		nd procedures to ensure					
	that-						
		the influenza immunization,					
		ne resident's representative					
		n regarding the benefits and					
	•	cts of the immunization;					
	` '	s offered an influenza					
		ober 1 through March 31					
	annually, unless th						
	•	dicated or the resident has					
	-	unized during this time					
	period;						
	(iii) The resident o						
	•	s the opportunity to refuse					
	immunization; and						
	• •	medical record includes					
		at indicates, at a minimum,					
	the following:						
	(A) That the reside						
	-	s provided education					
		efits and potential side					
		a immunization; and					
	• •	ent either received the ation or did not receive the					
		ation or did not receive the ation due to medical				ļ	
	contraindications					ļ	
	contraindications (	orreiusai.					
	6403 00/4//0/ D	umagagal diages. The				ļ	
	3483.80(a)(2) Pne	eumococcal disease. The					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155409	A. BUILDING B. WING	00	COMPLETED 06/16/2023
		100408	<u> </u>	<u> </u>	00/10/2023
NAME OF I	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP COD  S KEYSTONE AVE	
WATERS	S OF INDIANAPOLI	S, THE		ANAPOLIS, IN 46227	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
	to ensure that-	op policies and procedures			
		the pneumococcal			
	(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding				
	I	otential side effects of the			
	immunization;				
		is offered a pneumococcal			
	immunization, unless the immunization is medically contraindicated or the resident has				
	already been imm	unized;			
	(iii) The resident of	r the resident's			
		s the opportunity to refuse			
	immunization; and				
	' '	medical record includes			
		at indicates, at a minimum,			
	the following:				
	(A) That the reside				
		s provided education			
		efits and potential side			
		coccal immunization; and ent either received the			
		munization or did not			
		nococcal immunization due			
	· ·	ndication or refusal.			
			F 0883	What corrective action(s) w	iII 07/22/2023
	Based on interview	and record review, the facility		be accomplished for those	0,7,22,2023
		cine administration guidelines		residents found to have been	en
		al vaccine. The pneumococcal		affected by the deficient	
	vaccine was not giv	ren for residents who had		practice?	
		e the vaccinations for 3 of 8			
		or vaccines. (Resident 5,		Resident #5 has consented t	
	Resident 26, Reside	ent 52)		received a physician's order	
				pneumococcal conjugate to b	pe
	Findings include:			administered.	
	1. On 6/14/23 at 10	:40 a.m., Resident 5's clinical		Resident #26 has consented	to
	record was reviewe	d and indicated the following:		and received a physician's or	rder
				for the pneumococcal conjug	ate to
	Resident 5's immun	ization records indicated		be administered	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409  IDENTIFICATION STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227  INDIANAPOLIS, IN 46227  IDENTIFICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY IN TAG IN THE APPROPRIATE DEFICIENCY IN T			X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  WATERS OF INDIANAPOLIS, THE  INDIANAPOLIS, IN 46227   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any	AND PLAN	OF CORRECTION		A. B	UILDING	00			
WATERS OF INDIANAPOLIS, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL Regulatory or LSC IDENTIFYING INFORMATION TAG  (Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227  (EACH OERICTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  Resident #52 has consented to and received a physician's order			155409	B. W	'ING		06/16/20	023	
WATERS OF INDIANAPOLIS, THE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227  (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any	NAME OF I	DDOVIDED OD CUIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  (X5) COMPLETION DATE  Resident #52 has consented to and received a physician's order	NAME OF P	rkovidek UK Supplier	<b>C</b>						
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  PREFIX PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any	WATERS	S OF INDIANAPOLI	S, THE		INDIAN	IAPOLIS, IN 46227			
Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any TAG Resident #52 has consented to and received a physician's order	1 1					PROVIDER'S PLAN OF CORRECTION			
Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 Resident #52 has consented to and on 3/13/17 but lacked documentation of any and received a physician's order		`				CROSS-REFERENCED TO THE APPROPRIA	TE (		
polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any  Resident #52 has consented to and received a physician's order	TAG				TAG	DEFICIENCY)		DATE	
and on 3/13/17 but lacked documentation of any and received a physician's order			-			Decident #52 has consented to			
						** *			
			•			1			
or 20) vaccines.			rececui conjugate (1 C v 13, 13,				110 10		
be definitioned.		of 20) vaccines.				be duministered.			
Resident 5's diagnoses included, but were not How will you identify other		1							
limited to, chronic obstructive pulmonary disorder residents having the potential		· ·					al		
(COPD, a group of diseases that cause airflow to be affected by the same						-			
blockage and breathing-related issues),  deficient practice and what		_	-			I	_		
hypertension (high blood pressure), and type 2 corrective action will be taken?						corrective action will be take	en?		
diabetes mellitus (a chronic condition that affects		· ·							
the way the body processes blood sugar).  All residents immunization history			<del>-</del> .				tory		
Resident 5 had an admission date of 5/18/23 and and consents were reviewed.									
was of 65 years of age or older.  Consenting residents have		was of 65 years of a	ige or older.						
2. On 6/14/23 at 11:00 a.m., Resident 26's clinical received the Pneumococcal vaccine and/or subsequent		2 On 6/14/22 at 11	100 a.m. Pasidant 26's alinical						
2. On 6/14/23 at 11:00 a.m., Resident 26's clinical vaccine and/or subsequent record was reviewed and indicated the following: pneumococcal conjugate.						I ·			
priedmococcai conjugate.		record was reviewed	d and marcated the following.			priedmococcai conjugate.			
Resident 26's immunization records indicated  What measures will be put into						What measures will be put in	nto		
Resident 26 received a pneumococcal place or what systemic						T -			
polysaccharide 23 vaccine on 2/26/17 and on changes you will make to									
1/8/19 but lacked documentation of any ensure that the deficient			_						
subsequent pneumococcal conjugate vaccines. practice does not recur?		subsequent pneumo	coccal conjugate vaccines.			practice does not recur?			
Resident 26's diagnoses included, but were not Documentation in the resident'		_				Documentation in the resident	ť		
limited to, alcoholic cirrhosis of the liver (alcohol medical record of the	ļ								
induced hardening and swelling of the liver information/education provided		_	9						
making it less able to function), type 2 diabetes regarding the benefits and risks of	ļ	_					ks of		
mellitus, hypertension, and coronary immunization and the	ļ		•						
atherosclerosis (the build-up of fats, cholesterol, administration or the refusal of or	ļ	,	•						
and other substances in the walls of arteries medical contraindications to the	ļ						ne		
causing obstruction of blood flow). Resident 26 vaccine(s).						vaccine(s).			
had an admission date of 4/11/23 and was under	ļ		ate of 4/11/23 and was under			The makes			
the age of 65.  The policy and procedure for pneumococcal immunization was		the age of 65.					was		
3. On 6/14/23 at 11:15 a.m., Resident 52's clinical reviewed with the Quality	ļ	3 On 6/14/23 at 11	:15 a m Resident 52's clinical			1 -	was		
record was reviewed and indicated the following:  Assurance Committee. Social	ļ						,		
Services Designee receives	ļ	13001a Was leviewe	and mareaced the following.				·		
Resident 52's immunization records indicated consent at the time of admission.		Resident 52's immu	inization records indicated			_	ion.		

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPLETED	
		155409	B. W	ING		06/16/2	2023
				CTREET	ADDRESS OF A STATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF INDIANADOLI	O TUE			KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Resident 52 receive	d a pneumococcal conjugate			The admission nurse receives	the	
	vaccine of an unkno	own type on 5/26/1979 but			order as consented by the		
	lacked documentation	on to clarify the type of			resident or authorized		
	conjugate vaccine g	iven and lacked			representative and the		
	documentation of a	ny subsequent pneumococcal			pneumococcal immunization is	s	
	polysaccharide vacc	eines.			administered as ordered.		
					How the corrective action(s)		
	Resident 52's diagno	oses included, but were not			will be monitored to ensure t	the	
	limited to, type 2 di	abetes mellitus and			deficient practice will not		
	hypertension. Resid	ent 52 had an admission date			recur, i.e., what quality		
	of 2/1/23 and was u	nder the age of 65.			assurance program will be p	ut	
					into place?		
		a.m., the DON provided a list of					
	residents who smok	e in the facility; the list			The DON or qualified designe	e will	
	_	t 5, Resident 26, and Resident			audit for pneumococcal		
	52 as residents who	smoke.			immunizations weekly for 8		
					weeks, then monthly times 4		
	_	on 6/15/23 at 11:25 a.m., the			months to validate compliance	•	
		pneumococcal vaccinations			with federal and state law. Th	ie	
	should be given per	CDC guidelines.			results of the audit will be		
					reviewed, reported, and trende	ed for	
		p.m., the DON provided a			compliance through the facility		
	1 *	1/17, and titled, "Influenza and			Quality Assurance Committee		
		unization", and indicated it			a minimum of six months then	1	
		ently in use. The policy stated			randomly thereafter until		
		of this facility to minimize the			substantial compliance is		
		quiring, transmitting, or			achieved.		
		ications from Influenza and					
	Pneumococcal pneu	imonia."					
	0 (4)						
		a.m., a review of the CDC					
	_	lowing website regarding					
	pneumococcal vacc						
	1	ov/vaccines/vpd/pneumo/dow					
	_	cine-timing.pdf), updated on					
		Adults older than 65 years old					
		e of the PPSV 23 should have					
		of either the PCV 20 or PCV 15.					
		of age with diagnoses					
	including but not lin	mited to, diabetes mellitus or					

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Event ID:

8F7M11

Facility ID: 000537

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155409	B. WING			06/16/2023		
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	smoking who have	had a dose of PPSV 23 should						
	also have a dose of either PCV 20 or PCV 15.							
	3.1-13(a)							

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