		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/29/2022	
	ROVIDER OR SUPPLIER	COMMUNITY OF ANDERSON		1118 W	ADDRESS, CITY, STATE, ZIP COD CROSS ST SON, IN 46011		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE	
Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December, 27, 28, and 29, 2022		R 0000				
	Facility number: 0: Residential Census: These State Resider						
	accordance with 41						
R 0214 Bldg. 00	each resident sha admission and sha semiannually and change in the resi often at the reside	ency of the individual needs of Il be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. shall evaluate the nursing					
	Based on interview failed to ensure each individual needs co and/or semi-annuall (Resident 17, 24, 25). Findings include: 1. Resident 26's clir 12/27/22 at 2:30 p.r. but were not limited chronic obstructive.	and record review, the facility in resident had an evaluation of impleted upon admission y for 7 of 7 residents reviewed 5, 26, 31, 100 and 102). The side of the facility of	R 02	214	R 214 – Evaluation Deficiency a. A current assessment and negotiated service plans were immediately completed, signed and placed in resident medical record, for the current resident charts in question. b. All residents have the potential to be affected by this deficiency. Audit completed on resident records to ensure compliance.	d, 's	01/31/2023

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

(X6) DATE

TITLE

Diana Guinn Executive Director 01/16/2023

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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COMF	E SURVEY LETED 0/2022
PRIMRO	ı	COMMUNITY OF ANDERSON	1118 V ANDER	ADDRESS, CITY, STATE, ZIP C V CROSS ST RSON, IN 46011	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	in September 2022. semi-annual evalua completed by a lice 2. Resident 31's clin 12/27/22 at 3:32 p.n but were not limited anxiety. The resided 1/15/13. The record evaluation of individuants anytoperiod. 3. Resident 24's clin 12/27/22 at 3:00 p.n but were not limited. The resident admitted The resident admitted the record lacked a preadmission evaluation. 4. Resident 25's clin 12/28/22 at 11:17 a but were not limited. The resident admitted the resident admitted the record lacked a individual needs collicensed nurse in the sexion of the resident admitted the record lacked a individual needs collicensed nurse in the sexion of the resident admitted the record lacked a individual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the sexion of the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the record lacked a lindividual needs collicensed nurse in the lacked a lindividual needs co	ment was due to be completed The record lacked a tion of individual needs ensed nurse since admission. The record was reviewed on m. Current diagnoses included, d to, atrial fibrillation and ent admitted to the facility on d lacked a semi-annual dual needs completed by a time in the last six month The current diagnoses included, d to, hypertension and anxiety, end to the facility on 9/27/22. The admission and/or ation of individual needs end by a licensed nurse since The facility on 9/14/18. The semi-annual evaluation of mical record was reviewed on m. Current diagnoses included, d to, anxiety and depression. The facility on 9/14/18. The semi-annual evaluation of mical record was reviewed on m. Current diagnoses included, d to, anxiety and signed by a the last six month period. The current diagnoses included, d to, anxiety, hypertension, and dent admitted to the facility on and lacked an admission or mation of individual needs ed by a licensed nurse since		c. Primrose policy "I Service Plan" was reviewed and updated minimum of semi-annustate regulation) or who significant changes in sneeds/preferences occensure compliance with noted policy. d. DON will complete audit log weekly x4 we monthly x3 to ensure completed at the quality meetings. e. The systemic change in specific plan in systemic planual completed by Janual 2023.	ewed he resident gotiated as the provided to first 30 ew ted, and a e Plan is ent's tiated be at a sally (or per enever service cur. DON will h above e chart eks and compliance. ance gs to be assurance unges will	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 9/2022	
	PROVIDER OR SUPPLIER	COMMUNITY OF ANDERSON	1118 W	ADDRESS, CITY, STATE, ZIP CO CROSS ST RSON, IN 46011	DD .	_
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	reviewed on 12/29/diagnoses included, hypertension and veadmitted to the fact discharged on 11/20 semi-annual evaluation completed by a lice month period prior. 7. Resident 102's clareviewed on 12/29/diagnoses included, fibrillation and hyperadmitted to the faction 10/13/22. The revaluation of indivilicensed nurse during discharge. During an interviewed Administrator indicevaluations and sere completed as needed current evaluations and 17. During an interviewed Administrator indicevaluations and 17. During an interviewed Administrator indicevaluations and 17. During an interviewed Administrator indicevaluations and 17. "Negotiated Service on 12/29/22 at 12:3"All parties should Service Plan as indices.	osed clinical record was 22 at 10:16 a.m Discharge but were not limited to, ertigo, The resident had ility on 12/20/20 and 6/22. The record lacked a tion of individual needs nsed nurse during the six to the 11/26/22 discharge. osed clinical record was 22 at 11:00 a.m. Discharge but were not limited to, atrial othyroidism. The resident lity on 7/27/20 and discharged record lacked a semi-annual dual needs completed by a ng the six months prior to 7, on 12/29/22 at 10:28 a.m., the ated the facility had identified vice plans had not been d. The facility did not have for Residents 26, 31, 24, 25, 7, on 12/29/22 at 12:20 p.m., the ated the facility did not have ons of need for the six month dent 100 and 102's discharge. 1, 1/19/22, facility policy titled, e Plan", provided by the DON 9 p.m., indicated the following: d sign the revised Negotiated factedThe new assessment vice Plan should be placed in ceal Record"				

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	JLTIPLE CO JILDING	ONSTRUCTION 00	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	B. WI		00	12/29/	
			J			12/20/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
PRIMRO	SE RETIREMENT (COMMUNITY OF ANDERSON			SON, IN 46011		
(X4) ID	SUMMARY S	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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0216 Bldg. 00	ATO IAC 16.2-5-2(Evaluation - Nonco (c) The scope and shall be delineated manual, but at a massessment shall following: (1) The resident 's mental status. (2) The resident 's activities of daily li (3) The resident 's admission and ser (4) If applicable, the self-administer mental status (d) The evaluation writing and kept in Based on interview failed to ensure resimedication had a cunadministration assess residents reviewed if medication. (Resident Self-administration in Residents with medications", provint 12/27/22 indicated or residents self-administration self-administrations self-admi	c)(1-4)(d) compliance content of the evaluation d in the facility policy ninimum the needs include an evaluation of the s physical, cognitive, and s independence in the ving. s weight taken on miannually thereafter. he resident 's ability to edications. shall be documented in the facility. and record review, the facility dents who self administered irrent self medication ssment completed for 2 of 3 for self administration of ents 31 and 24) ed facility document titled,	R 02	TAG	1. R 216 – Evaluation Noncompliance a. The resident's charts in question were reviewed. The self-administering medication assessment was immediately completed, signed, and placed the resident medical record for current resident's charts in question. b. All residents have the potential to be affected by this noncompliance. An audit will be completed on each current resident medical record to enscompliance. c. Primrose policy "Resider Management and Self-Administration of Medications" was reviewed with the potential of the second	d in the the ure	01/31/2023
	-	nt had a current 12/2022 order			change. Residents who are		
		edication. The clinical record			assessed as safe to manage a	and	
	i i jacked a selt admini	ISTRATION OF MEGICATION	1		L COULDAMINICIAN THAIN AWA		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 9/2022
	PROVIDER OR SUPPLIER	COMMUNITY OF ANDERSON	1118 W	ADDRESS, CITY, STATE, ZIP C V CROSS ST RSON, IN 46011	OD	
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	at 1:40 p.m., Reside self-administered he them in her room. medications just pripill holder and bag she had been doing 2. Resident 24's clin 12/27/22 at 3:00 p.m. but were not limited. The record lacked a self-administer medication assess. During an interview Resident 31 indicat medication, which are room. During an interview Administrator indic current assessments medication for Resident Manager of Medication", pro at 12:39 p.m., indication in the resident who a self administer permitted to keep the apartment/room"	nical record was reviewed on m. Current diagnoses included, d to, hypertension and anxiety. In order for the resident to dication or a self administration is sment. In order for the resident to dication or a self administration is ment. In order for the resident to dication or a self administration is ment. In order for the resident to dication or a self administration her she kept safely stored in her In order for the resident to dication, and the self-administration of its dents and a self-administration of its dents and self-administration ovided by the DON on 12/29/22 attend the following: In a session of the resident to dication well be their own medication in their own		medications will be per keep their medications own apartment/room. d. DON will complete audit log weekly x4 we monthly x3 to ensure of DON will bring compliant concerns and or finding reviewed at the quality meetings each month. e. The systemic chabe completed by Januar 2023.	e chart eks and compliance. ance gs to be assurance	
R 0217 Bldg. 00	410 IAC 16.2-5-2(Evaluation - Defic (e) Following com					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		12/29/2022
NAME OF T	DDOMDED OD GUDDI 101	D	STREET A	ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIEI			CROSS ST	
PRIMRO	SE RETIREMENT	COMMUNITY OF ANDERSON	ANDEF	RSON, IN 46011	-
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL B. I. S.C. IDENTIFYING INFORMATION	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION ropriately trained staff	TAG	JEE TOLERON.	DATE
		lentify and document the			
		ovided by the facility, as			
	follows:	, , , , , , , , , , , , , , , , , , ,			
	(1) The services of	offered to the individual			
	1 ' '	appropriate to the:			
	(A) scope;		1		
	(B) frequency;				
	(C) need; and				
	(D) preference;				
	of the resident.				
	1 ' '	offered shall be reviewed and			
	revised as appropriate and discussed by the resident and facility as needs or desires				
		e facility or the resident may			
	request a service	-			
	· ·	pon service plan shall be			
	1 ' '	by the resident, and a copy			
	1 -	n shall be given to the			
	resident upon req	_			
		on and documentation of			
	services provided	l is needed if evaluations			
	subsequent to the	e initial evaluation indicate			
	no need for a cha	_			
	l ` '	on of medications or the			
	l ·	ential nursing services, or	1		
		a licensed nurse shall be	1		
		ication and documentation of	1		
	the services to be	·	D 0217	1 D 217 Evaluation	01/21/2022
		and record review, the facility ch resident had a signed and	R 0217	1. R 217 – Evaluation	01/31/2023
		ed service plan for 7 of 7		Deficiency a. A current review was dor	ne on
		(Resident 17, 24, 25, 26, 31, 100		each service plan of current	001
	and 102).			residents. A new service plan	was
	<i></i>			immediately completed, signe	
	Findings include:			and placed in resident medica	
	-			record, for the current residen	
	1. Resident 26's clin	nical record was reviewed on		charts in question.	
	_	m. Current diagnoses included,	1	b. All residents have the	
	but were not limited	d to, diabetes mellitus and		potential to be affected by this	

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STATEMEN	IT 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
			B. W	NG		12/29/	2022
				OTTO FEET A	A PROPERTY OF A THE STAN COR		
NAME OF F	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DDIMBO	OF DETIDEMENT				CROSS ST		
PRIMRO	SE RETIREMENT	COMMUNITY OF ANDERSON		ANDER	SON, IN 46011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	chronic obstructive	pulmonary disease. The			deficiency. Audit completed or	ı all	
	record lacked a curi	rent, individualized service plan			resident records to ensure		
	signed by the facility representative and the				compliance.		
	resident and/or their representative.				c. Primrose policy "Negotia	ted	
					Service Plan" was reviewed		
	2. Resident 31's clinical record was reviewed on				without change. All parties sho	ould	
	12/27/22 at 3:32 p.r	m. Current diagnoses included,			then sign the revised Negotiate	ed	
	but were not limited	d to, atrial fibrillation and			Service Plan as indicated. The		
	anxiety. The record	d lacked a current,			new assessment and Negotiat	ed	
	individualized servi	ice plan signed by the facility			Service Plan should be placed	in	
	representative the re	esident and/or their			the Resident's Medical Record	l.	
	representative.				d. DON will complete chart		
					audit log weekly x4 weeks and		
	3. Resident 24's clinical record was reviewed on				monthly x3 to ensure compliar	ice.	
	12/27/22 at 3:00 p.r	m. Current diagnoses included,			DON will bring compliance		
	but were not limited	d to, hypertension and anxiety.			concerns and or findings to be		
	The record lacked a	current, individualized service			reviewed at the quality assura	nce	
	plan signed by the f	facility representative and the			meetings.		
	resident and/or their	r representative.			e. The systemic changes wi	II	
					be completed by January 31,		
		nical record was reviewed on			2023.		
		.m. Current diagnoses included,					
		d to, anxiety and depression.					
		current, individualized service					
		facility representative and the					
	resident and/or their	r representative.					
		nical record was reviewed on					
		.m. Current diagnoses included,					
		d to, anxiety, hypertension, and					
		ord lacked a current,					
		ice plan which was signed by					
		ntative and the resident and/or					
	their representative.	•					
	C T 11 11001						
		osed clinical record was					
		22 at 10:16 a.m Discharge					
	-	, but were not limited to,					
		ertigo. The record lacked an					
	individualized servi	ice plan signed by the facility					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/29/2022		
	PROVIDER OR SUPPLIER	COMMUNITY OF ANDERSON	1118 W	ADDRESS, CITY, STATE, ZIP COI / CROSS ST RSON, IN 46011	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO! CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION
TAG		t LSC IDENTIFYING INFORMATION he resident and/or their	TAG	Janes, v		DATE
	12/29/22 at 11:00 a included, but were and hypothyroidism individualized servi	inical record was reviewed on a.m. Discharge diagnoses not limited to, atrial fibrillation a. The record lacked an ce plan signed by the facility he resident and/or their				
	During an interview, on 12/29/22 at 10:28 a.m., the Administrator indicated the facility had identified evaluations and service plans had not been completed as needed. The facility did not have current signed and dated service plans for Residents 26, 31, 24, 25, and 17.					
	Administrator indic	y, on 12/29/22 at 12:20 p.m., the ated the facility did not have esident 100 and 102's				
	"Negotiated Service	y, 1/19/22, facility policy titled e Plan", provided by the DON 9 p.m., indicated the following:				
	Service Plan as indi	d sign the revised Negotiated catedThe new assessment vice Plan should be placed in cal Record"				
R 0350	410 IAC 16.2-5-8.					
Bldg. 00	discharge: (1) for a minimum facility and five (5)	s must be retained after period of one (1) year in the				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		12/29/	2022
				CENTER	ADDRESS STEW STATE STR COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
DDIM DO	OF DETIDEMENT	OOMMUNUTY OF ANDERSON			CROSS ST		
PRIMRO	SE RETIREMENT	COMMUNITY OF ANDERSON		ANDER	RSON, IN 46011		
(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
	Based on interview	and record review, the facility	R 0.	350	1. R 350 – Clinical record		01/31/2023
	failed to maintain th	he clinical records for			nonconformance		
	discharged resident	s for 1 of 3 residents reviewed			a. An immediate review has	;	
	for maintenance of	closed medical records.			been completed on every		
	(Resident 101)				discharged resident.		
					b. All residents who have		
	Findings include:				discharged have the potential	to	
					be affected by this		
		ted facility document titled,			nonconformance. Audit compl	eted	
	"Discharges within the last 90 days", provided by				on all resident records to ensu	re	
	the Administrator o	on 12/27/22 at 10:30 a.m.,			compliance.		
	indicated Resident	101 had discharged to another			c. Primrose policy "Resider	nt	
	residential facility of	on 9/30/22.			Record Retention Guide Polic	y"	
					was reviewed without change.		
	During an interview	v, on 12/29/22 at 9:15 a.m., the			Primrose retains Resident Me	dical	
	Administrator indic	cated the facility did not have a			Records for 7 years. This police	у	
	closed clinical reco	rd for Resident 101. The			apples to residents who reside	e in	
	resident's complete	clinical record had been sent			Primrose communities.		
	to the receiving fac-	ility when he was discharged.			d. DON will complete chart		
					audit log weekly x4 weeks and	d	
	Review of a current	t, 4/1/22, facility policy titled			monthly x3 to ensure compliar	nce.	
	"Resident Record R	Retention Guide Policy",			DON will bring compliance		
	provided by the DC	ON on 12/29/22 at 12:39 p.m.,			concerns and or findings to be	:	
	indicated the follow	ving:			reviewed at the quality assura	nce	
					meetings.		
		Resident Medical Records for			e. The systemic changes w	ill	
	7 years. If State Re	egulation require greater than 7			be completed by January 31,		
	years, Primrose wil	l follow State Regulations"			2023.		
R 0407	410 IAC 16.2-5-12						
5 11 00	Infection Control -						
Bldg. 00	1 ' '	st establish an infection					
		nat includes the following:					
	1 ' '	enables the facility to					
	l • •	of known infectious					
	symptoms.						
	1 ' '	tation and in-service					
		ction prevention and control,					
	including universa						
	(3) Offering health	n information to residents,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/29/2022	
	ROVIDER OR SUPPLIER	COMMUNITY OF ANDERSON	1118 V	ADDRESS, CITY, STATE, ZIP COD V CROSS ST RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	including, but not be transmission and it (4) Reporting compublic health author Based on interview failed to develop an program to include to analyze patterns of symptoms. Findings include: During an interview Administrator indical locate an infection of analysis of patterns, infections other than to be reported to the in either a computer However, there had period of time and edifferently. The fact information. Review of an undate provided by the Administrator indicate prescribed nine time during the period of the computer of the co	imited to, infection immunizations. municable disease to prities. and record review, the facility disparent to enable the facility of known infectious. In a system to enable the facility of known infectious. In a covidant to enable the facility of known infectious. In a covidant to enable the facility of known infectious. In a covidant to enable the facility of known infectious. In a covidant to enable the facility of known infectious. In a covidant to enable the facility of known infectious were to enable the facility could not enable the facility. In a short the enable the facility of the enable to enable the enable the enable the enable the enable to enable the ena		1. R 407 – Clinical Record Noncompliance a. The facility immediately completed an infection control program to efficiently log and infection. b. The facility has the potent to be affected by this noncompliance. c. Primrose policy "Resident/Staff Infectious Conditions" was reviewed with change. Additionally, "QA/Saff Committee Policy" was review without change. An infection control system is in place for tracking infections. Monthly Competings are held with management to review infection control. d. The DON will complete infection control audits weekly weeks and monthly x3 to ensign compliance. DON will bring compliance concerns and or findings to be reviewed at the quality assurance meetings. e. The systemic changes we be completed by January 31, 2023.	DATE 01/31/2023 If trend Intial hout fety ved IA on y x4 ure
		trol the spread of infection disease for all residents"			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		12/29/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t			CROSS ST		
PRIMRO	SE RETIREMENT (COMMUNITY OF ANDERSON			RSON, IN 46011		
(X4) ID	SUMMARY	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'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0409 Bldg. 00	required to have a including history or infectious disease resident shows not an infectious stage admission and years admission and years admission and years and infectious stage admission and years are statement for 4 of 7 17, 25, 31, and 102. Findings include: 1. Resident 31's clir 12/27/22 at 3:32 p.r. but were not limited anxiety. The record statement for the part year 2021-23. Resident 25's clir 12/28/22 at 11:17 are the past year 2021-23. Resident 17's clir 12/28/22 at 10:08 are but were not limited dementia. The record statement for the part 4. Resident 102's cl 12/29/22 at 11:00 are included, but were and hypothyroidism and hypothyroidism.	Noncompliance sion, each resident shall be a health assessment, of significant past or present is and a statement that the previous of tuberculosis in the east verified upon early thereafter. In and record review, the facility dents had an annual health residents reviewed (Resident process). In a current diagnoses included, and the condition of the condition of the current diagnoses included, and the condition of the current diagnoses included, and the curr	R 0	409	1. 1. R 409 – Infection Control Noncompliance a. A current annual health statement was immediately obtained for the current reside in question. b. All residents have the potential to be affected by this deficiency. Audit completed or resident records to ensure compliance. c. Primrose policy "Prescrit Medication Orders" was review without change. All orders are reviewed/renewed annually or State regulations by the physician/prescriber. d. DON will complete chart audit log weekly x4 weeks and monthly x3 to ensure compliance concerns and or findings to be reviewed at the quality assural meetings. e. The systemic changes wi be completed by January 31, 2023.	n all per wed per d nce.	01/31/2023

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
			B. WI	NG		12/29/2022	
NAME OF PROVIDER OR SUPPLIER PRIMROSE RETIREMENT COMMUNITY OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1118 W CROSS ST ANDERSON, IN 46011				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Administrator indice evaluations and service completed as neede an annual health stand 17. During an interview Administrator indice	7, on 12/29/22 at 10:28 a.m., the ated the facility had identified vice plans had not been d. The facility did not have tement for Residents 31, 25, 7, on 12/29/22 at 12:20 p.m., the ated the facility did not have tement for Resident 102.					

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