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	02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTINA PLACE	1435 CHRISTIAN BLVD FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey Dates: February 17, 18, and 19, 2020 Facility Number: 004017 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on February 21, 2020.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to provide showers, as indicated by the negotiated service plan, for 2 of 2 residents reviewed for showers. (Resident 26 and 9) Findings include: 1. Interview, on 2/18/20 at 11:30 a.m., Resident 26 indicated she does not always receive her showers.	R 0240	R240 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Resident 26 and resident 9 will receive 2 showers a week per company standard.* *Current Staff were in serviced*	04/03/2020

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

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

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	On 2/18/2020 at 1:15 p.m., the clinical record of Resident 26 was reviewed, diagnosis included, but were not limited to, anxiety. A Folstein Mini Mental Exam, dated 12/20/16, indicated Resident 26 was cognitively intact. An Assessment and Negotiated Service Plan Summary, dated 12/30/19 thru 3/30/20, indicated Bathing (ALC [facility] standard is two times per week). The facility will provided Resident 26 with all showers and hygiene. Shower sheets, dated January 2020, indicated Resident 26 received a shower on the following days: January 3, 4, 6, 12, and 22, 2020. The clinical record lacked documentation of any other showers for January 2020. Shower sheets, dated February 2020, indicated Resident 26 received a shower on the following days: February 7, 8, 10, and 17, 2020. The clinical record lacked documentation of any other showers for February 2020. Interview on 2/19/2020 at 10:30 a.m., the Executive Director indicated no other shower sheet were available. The facility does not have a policy on showers, "we go by the Negotiated Service Plan." 2. Interview, on 2/18/20 at 11:45 a.m., Resident 9 indicated she does not always receive her showers. On 2/18/20 at 1:30 p.m., the clinical record for		*regarding shower schedule procedures by Executive Director on 2/19/2020.* -**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;** *An audit was performed on 3/03/2020 by Regional Director of Care Service to identify any other resident who was affected by this deficient practice. Any resident identified will be given 2 showers a week or their preference, and shower schedule updated to reflect showering days. Level of Care will be updated as needed per resident preference and care plan.* -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *Current nursing staff was in-serviced on shower schedule standards by Executive Director on 02/19/2020 to ensure this deficient practice does not recur. Residents care plans will be updated to reflect their preference on number of showers to be given and level of care updated as needed. Showers and refusals will be*	

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	Resident 9 was reviewed, diagnosis included but were not limited to, history of falls. A Folstein Mini Mental Exam, dated 1/14/20, indicated Resident 9 was cognitively intact. An Assessment and Negotiated Service Plan Summary, dated 2/2/20 thru 5/2/20, indicated Bathing (ALC [facility] standard is two times per week). The facility will provide standby help with all showers. Shower sheets, dated January 2020, indicated Resident 9 received showers on the following days: January 1, 8, 15, 22, and 29, 2020. The clinical record lacked documentation of any other showers for January 2020. Shower sheets, dated February 2020, indicated Resident 9 received a shower on the following days: February 7, 8, 10 and 17, 2020. The clinical record lacked documentation of any other showers for February 2020. Interview on 2/19/2020 at 10:30 a.m., the Executive Director indicated no other shower sheet were available. The facility does not have a policy on showers, "we go by the Negotiated Service Plan."		*documented daily on shower sheets and reviewed for compliance.* -**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;** *The Clinical Service Manager is responsible for sustained compliance. The Executive Director and/or designee will monitor shower schedule and shower sheets to ensure they reflect residents preference or company standard on number of showers given each week for 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.* -**By what date the systematic changes will be completed** April 3, 2020	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas			

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	(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 food items located in the facility activity room refrigerator unit were covered, dated, and labeled to indicate to whom the food belonged, potentially affecting 41 of 41 residents residing in the facility. Findings include: On 2/19/20 at 12:25 p.m., during a tour with the Administrator, observed the activity room refrigerator/freezer unit. Observed the following food items in the refrigerator/freezer unit: a. Inside the freezer portion of the unit was a small dish of an unknown frozen substance. The dish lacked a cover, date for when the item was placed into the freezer, and a label to indicate to whom the item belonged. b. Inside the refrigerator portion of the unit was a medium sized paper cup with a plastic lid and straw hanging off to one side of the cup. The cup was half full of an known dark colored liquid. The cup lacked a cover, date for when the item was placed into the refrigerator, and a label to indicate to whom the item belonged. c. Inside the refrigerator portion of the unit was a small sandwich size zip lock plastic bag with 3 pieces of an unknown white substance. The plastic bag lacked a date for when the item was placed into the refrigerator and a label to indicate to whom the item belonged.	R 0273	R273 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *All items observed or identified without dates were disposed of on 2/19/2020 by Executive Director. Current Staff were in serviced regarding proper cleaning procedures by Executive Director on 2/19/2020.* -**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?** *An audit was conducted on 2/19/2020 by Executive Director to ensure all items were dated and stored appropriately. Any found missing or out of compliance were immediately disposed.* -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *Current dietary staff was in-serviced on safe handling of food to include dating and*	04/03/2020

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	d. Inside the refrigerator portion of the unit was a plastic zip lock bag labeled "Colby cheese" and inside the bag were 4 thin slices of Colby cheese. The plastic bag lacked a date for when the item was placed into the refrigerator and a label to indicate to whom the item belonged. e. Inside the refrigerator portion of the unit was an opened 8 ounce plastic container labeled "deli fresh Oscar Mayer chicken breast." The plastic container lacked a date for when the item was placed into the refrigerator and a label to indicate to whom the item belonged. f. Inside the refrigerator portion of the unit was an opened 8 ounce plastic container labeled "deli fresh Oscar Mayer honey uncured ham." The plastic container lacked a date for when the item was placed into the refrigerator and a label to indicate to whom the item belonged. Interview, on 2/19/20 at 12:30 p.m., the Administrator indicated the food items were to be covered, dated when put into the refrigerator/freezer unit, and labeled to indicate to whom the food belonged. All residents in the facility had access to the refrigerator/freezer unit. The facility census was 41. Interview, on 2/19/20 at 1:15 p.m., the Administrator indicated the facility did not have a specific policy regarding food storage; however, the facility was to follow the Retail Establishment Sanitation Requirements regulation. On 2/19/20 at 3:15 p.m., a review of the Retail Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, " ...food shall be protected from		*labeling by Executive Director on 02/19/2020.* -**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?** *The Dietary Manager is responsible for sustained compliance. The Executive Director and/or designee with monitor all food preparation and serving areas 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.* -**By what date the systematic changes will be completed** April 3, 2020	

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	contamination by storing the food as follows ...in packages, covered containers, or wrappings ...wrap food tightly to prevent cross contamination ...refrigerated ...potentially hazardous food ...shall be clearly marked to indicate the date or day by which the food shall be consumed ...or discarded ..."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			
	Based on interview and record review, the facility failed to ensure a resident's assessment accurately reflected the resident's chosen code status for 1 of 7 residents reviewed for assessment accuracy. (Resident 19) Findings include: On 2/17/20 at 2:00 p.m., Resident 19's clinical record was reviewed. Resident 19 was admitted to the facility on 10/13/18. Resident 19's State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order document, dated and signed by Resident 19 on 10/17/18 and dated and signed by the physician on 10/26/18, indicated Resident 19's chosen code status (decision regarding life sustaining resuscitation) was "Do Not Resuscitate."	R 0349	R349 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Resident 19 service plan was updated to reflect the residents chosen code status. Current Staff were in serviced regarding code status procedures by Executive Director on 2/19/2020.* -**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?** *An audit was performed on 3/03/2020 by Regional Director of*	04/03/2020

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	The Folstein Mini Mental Status Exam (as assessment to determine a resident's cognitive status), dated 11/8/18, indicated Resident 19 was cognitively intact. Residents 19's Physician Orders, dated 7/1/19 thru 7/31/19, indicated "Do Not Resuscitate." Residents 19's Physician Orders, dated 8/1/19 thru 8/31/19, indicated "Do Not Resuscitate." Residents 19's Physician Orders, dated 9/1/19 thru 9/30/19, indicated "Do Not Resuscitate." Residents 19's Physician Orders, dated 10/1/19 thru 10/31/19, indicated "Do Not Resuscitate." Residents 19's Physician Orders, dated 11/1/19 thru 11/30/19, indicated "Do Not Resuscitate." Residents 19's Physician Orders, dated 12/1/19 thru 12/31/19, indicated "Do Not Resuscitate." Residents 19's Physician Orders, dated 1/1/20 thru 1/31/20, indicated "Do Not Resuscitate." Resident 19's Assessment and Negotiated Services Plan Summary document, dated 7/8/19, indicated Resident 19 was considered a full code (full life sustaining resuscitation). Resident 19's Assessment and Negotiated Services Plan Summary document, dated 10/4/19, indicated Resident 19 was considered a full code. Resident 19's Assessment and Negotiated Services Plan Summary document, dated 12/31/19, indicated Resident 19 was considered		*Care Services to identify any other resident who was affected by this deficient practice. Any resident identified had their code status updated to reflect their chosen code status.* -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** *All staff was in-serviced on code status standards by Executive Director on 02/20/2020 to ensure this deficient practice does not recur.* -**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?** *The Clinical Service Manager is responsible for sustained compliance. The Executive Director and/or designee with monitor all new residents code status sheets 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.*	

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	a full code. Interview, 2/17/20 at 1:30 p.m., Resident 19 indicated when she was admitted into the facility, she had elected to be a "no code (do not resuscitate)" and that was still her preference. Interview, 2/17/20 at 3:00 p.m., the Director of Resident Services indicated Resident 19 had elected to be a "no code" since her admission. The Assessment and Negotiated Services Plan Summary documents were coded incorrectly. On 2/18/20 at 10:15 a.m., the Director of Resident Services provided a copy of the Care Plan policy, dated 9/29/18, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...each resident's care plan discover, wellness baseline and care plan should address all possible areas of needed and preferred services, including resident care services health-related services ...each resident should receive service and supervision based upon the resident's individual needs and preferences ...these needs and preferences should be determined through the initial assessment and service planning process in the resident's care plan ..."		-**By what date the systematic changes will be completed** April 3, 2020	