	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JILDING	NSTRUCTION 00	(X3) DATE COMPI 08/07	LETED
	PROVIDER OR SUPPLIER			2400 M	DDRESS, CITY, STATE, ZIP CODE ARKET ST ESTOWN, IN 47111		
(X4) ID PREFIX TAG	SUMMARY ST	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3	(X5) COMPLETION DATE
R 0000							
Bldg. 00	Complaint IN00	178850 - Substantiated. s related to the sted at R407. gust 7, 2015 012007	R 0	000			
	Census bed type: Residential: 101 Total: 101 Sample: 3						
	This State findin with 410 IAC 16	g is cited in accordance .2-5.					
R 0407	410 IAC 16.2-5-12	2(b)(1-4)					
LABORATOR	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	<u></u> Е	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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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/07/	ETED
	ROVIDER OR SUPPLIER			2400 M	ADDRESS, CITY, STATE, ZIP CODE ARKET ST ESTOWN, IN 47111		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
Bldg. 00	control program the (1) A system that analyze patterns of symptoms. (2) Provides orient education on infection control, including to (3) Offering health including, but not litransmission and it (4) Reporting compublic health author Based on observe interview, the faction an effective infective	st establish an infection lat includes the following: enables the facility to of known infectious tation and in-service stion prevention and universal precautions. Information to residents, limited to, infection immunizations. Indicate the facility failed to implement ection control surveillance of the treat and prevent the cons for 3 of 3 residents. I bug infestation. and D) I with an anonymous of the facility had a led bugs" in the 200 hall residents B, C and D still	R 0	407	"This plan ofcorrection is submitted as required under State and Federal law. The submission of this Plan of Correctiondoes not constitut an admission on the part of (River Crossing) as to theaccuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction alsodoes not constitute an admission that the findings constitute a deficiency orthat the scope and severity regarding the deficiency cited are correctlyapplied. Any changes to the Community'spolicies and procedures should be considered subsequent remedial measures asthat concept is employed in Rule 407 of the Federal Rules of Evidence and anycorresponding state rules of civil procedure and should	e	08/28/2015

State Form Event ID: EYIT11 Facility ID: 012007 If continuation sheet Page 2 of 10

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/07/2015
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE MARKET ST	
RIVER C	ROSSING ASSIST	ED LIVING		LESTOWN, IN 47111	
(X4) ID		TATEMENT OF DEFICIENCIES	ID DEELY	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE
	1	nths ago" and alerted		be inadmissible in anyproceeding on that basi	
		3 indicated her room was		The Communitysubmits this	
	not treated for o	ver a week and facility		plan of correction with the	
	staff indicated to	her she could sleep in		intention that it be inadmiss	
	her recliner until	her room was treated.		byany third party in any civic	ii or
	Resident B indic	ated she slept in the		Community or anyemployee	<u>e,</u>
	bathroom in her	wheelchair with her head		agent, officer, director,	
	on the sink for 5	days. She indicated her		attorney, or shareholder of Communityor affiliated	the_
		reated three times, most		companies." No other resid	dents
		5, and was told by the		were affected except ones lis	sted
		•		but all other residents potenti	-
	1	control company, "I still		could have been. All affected rooms have been under	l
	have them."			treatment since onset of findi	inas.
				those that continue to have b	- I
	Resident B's ma	ttress and bedding was		bugs will be on a continuous	
	observed with a	sealed plastic cover over		monthly treatment schedule all bed bugs are eliminated in	
		which Resident B		those rooms. The following	'
	_	rchased on her own. The		tracking and audit tools have	
				been put in place to ensure	
		m mattress was observed		compliance with regulations a safety/health of residents and	
	1	ddish-brown to black 0.5		continue indefinitely: Infection	I
	- 1 centimeter (c	m) discolorations along		control binder for bed bugs w	/hich
	the seam of the r	mattress/boxspring.		include; Pest control log that	
				indicates room infected, date infection, area of room infected	I
	Resident B's clir	nical record was reviewed		treatment and treatment date	
	on 8/7/15 at 12:0			floor plan that indicates locat	
		r		of bugs which includes month	
	Numa da Nistar 1	otad 6/25/2015 -4 0:00		year. Daily bed check audit for residents beds will be audited	
		ated 6/25/2015 at 9:00		during weekly bed linen chan	nges,
		'Late entry for 6/20/15		any findings will be documen	ted
	9:00 a.m Assis	stant Director of Nursing		on bed bug audit form and supervisor notified immediate	2lv
	called and stated	staff found bed bug in		All employees with access to	-
				resident rooms are being	

State Form Event ID: EYIT11 Facility ID: 012007 If continuation sheet Page 3 of 10

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/07/2015	
	PROVIDER OR SUPPLIER		2400 M	ADDRESS, CITY, STATE, ZIP COD IARKET ST LESTOWN, IN 47111	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION DATE	
	res [resident] bed [pest control conget to building u Notified staff to drying linens and and to begin bed control company [at] 1 p.m. [pest Confirmed bed bestates unable to sa.mEncourage in recliner or bed clean linens." No additional dobed bugs or treat Resident B's receiventry was dated 8/7/2015 at 2:10 Nurse (LPN) #1 additional documents of the documen	d. Immediately called apany] stated unable to ntil 6/22/15 [after] noon. begin washing and d bagging and tying up bug protocol per [pest of]. Late entry for 6/22/15 control company] here. bugs, given protocol and spray until 6/29/15 and res. that she can sleep of once vacuumed and becumentation regarding aments was located in bord. The last/most recent 7/27/15 at 11:30 a.m. On p.m., Licensed Practical indicated there was no mentation for Resident B. 1:35 a.m., the Interim r (GM) indicated the ave a policy or procedure a provided a copy of apany] Bedbug Chemical as GM indicated, "We use as GM indicated two		in-serviced to include: bed findings, treatment and procedures. This will be completed by August 28,	d bug	

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PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPL 08/07/	ETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ARKET ST		
	ROSSING ASSISTE			ESTOWN, IN 47111		
(X4) ID PREFIX		CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
	residents in the fa	acility currently had bed				
	bug infestations ((Residents B and C).				
	On 8/7/2015 at 1	1:35 a.m., the Interim				
	GM provided inv	voices from the				
	contracted pest c	ontrol company, dating				
	back to January,	2015. The invoices				
	relating to bed bu	ig infestation inspection				
	and/or treatment	did not include which				
	resident rooms w	ere treated, how they				
	were treated, and	or what findings were				
	observed by the t	echnician with each				
	visit. One invoi	ce, dated 7/13/2015, and				
	two invoices, dat	ed 8/4/2015, indicated,				
	"Bed Bug Month	ly Service." Two				
	invoices, dated 6	/29/2015, one invoice,				
	dated 7/24/2015,	and two invoices, dated				
	7/30/2015, indica	ated, "Bed Bug One				
	Shot." The GM	indicated the pest control				
	company could n	ot provide any more				
	specific informat	ion.				
	On 8/7/2015 at 1	2:53 p.m. the Interim				
		e facility did not track or				
		esidents with bed bug				
	•	eatments. The GM				
		ized "recall" to keep				
		ts and residents with bed				
		ted documentation of				
	and and marcu					

State Form Event ID: EYIT11 Facility ID: 012007 If continuation sheet Page 5 of 10

PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	(X3) DATE COMPI	
				ADDRESS CITY STATE ZIP COD		12010
NAME OF I	PROVIDER OR SUPPLIER	L Comment		ADDRESS, CITY, STATE, ZIP COD ARKET ST	E.	
RIVER C	ROSSING ASSISTI	ED LIVING		ESTOWN, IN 47111		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETION DATE
		n the clinical record				
	under Nurse's No	otes.				
	The Clinical Dire	ector/Infection Control				
	Officer was inter	rviewed on 8/7/2015 at				
	_	indicated she did not				
	_	s in the Infection Control				
		y form of surveillance or				
		bug infestations. She				
	· ·	ems like it's involved				
		hallwe have not				
		original source." She				
		nt B sleeping upright in				
		as "her choiceshe did				
	_	lemaWe did not offer				
	place."	e [to stay]no other				
	piace.					
	Qualified Medic	ation Aide (QMA) # 3				
		on 8/7/2015 at 11:46				
	a.m. The QMA	indicated she was not				
		ent B's room had been				
	treated for bed b	ugs earlier in the week				
	and indicated, "I	thought she was cleared				
	[no longer had b	ed bug infestation]."				
		:31 p.m., the GM				
	1 -	l list of five resident				
	names (including	g Residents B, C and D),				

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OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPI 08/07	LETED
PROVIDER OR SUPPLIER		2400 M	ADDRESS, CITY, STATE, ZIP C ARKET ST FSTOWN IN 47111	_	
summary s' (EACH DEFICIEN REGULATORY OR and indicated the who have had be last 4 or 5 month 2. Resident C wa room on 8/7/201 observed sitting mattress and box sides, leaning ag Two large clear by visible inside we and floor. The re room had been to weeks ago". Resident C's clin reviewed on 8/7/ Resident C's Nur 7/22/2015 at 1:00 entry for 7/19/15 hospital, Res not possibly resemble control company confirm 1 bug for resident always s	ED LIVING FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Palist indicated residents d bug infestations "in the ss." Is interviewed in his 5 at 11:07 a.m. He was in a recliner with a bare a springs turned on their ainst the bed frame. Dags with clothing re sitting on the dresser esident indicated his reated for bed bugs "two ical Record was 2015 at 1:50 p.m. rese's Notes, dated D p.m., indicated, "Late upon return from ed bug crawling on arm, e [sic] bed bug [Pest] here7/20/15to und in chair where sleeps [Pest control	2400 M		ODE RECTION HOULD BE	(X5) COMPLETION DATE
treatment of room	n on Friday 7/24/15 for m."				

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PRINTED: 08/21/2015 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	JILDING	<u>00</u>	COMPL 08/07/	ETED
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
RIVER C	ROSSING ASSISTE	ED LIVING		ARKET ST ESTOWN, IN 47111		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	ſΕ	(X5) COMPLETION DATE
	No additional do	cumentation in Nurse's				
	Notes or in Resid	dent C's clinical record				
	was provided to	indicate treatment.				
	8/7/2015 at 12:23 GM. The two last the dresser and fluid at the top will middle of both bout. Resident B	m was observed on 5 p.m. with the Interim rge bags of laundry on loor were observed to be th large rips in the ags, with clothes sticking indicated, "The nurse et me this shirt [indicated wearing]."				
	room on 8/7/201 indicated she was bug infestations facility. Resident observed with a sencasing was observed ish-brown to	as interviewed in her 5 at 10:32 a.m. She s not aware of any bed in her room or in the at D's mattress was sheet over it. No plastic served. Multiple, b black 0.5 - 1 cm ere observed around the tresses.				
	Director indicate bug infestation "a	:40 p.m. the Clinical d Resident D had a bed about six months ago" eatment was done "last				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE : COMPL 08/07/	ETED
	PROVIDER OR SUPPLIER		24	400 M <i>A</i>	DDRESS, CITY, STATE, ZIP CODE ARKET ST		
RIVER C	ROSSING ASSISTI	ED LIVING	C	HAKLE	ESTOWN, IN 47111		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IE PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	week." She indi	cated, "No bugs were					
	found, but they t	reated her room					
	anyway." She ir	ndicated Resident D was					
	not on a monthly	treatment maintenance					
	for bed bugs.						
	Resident D's clin	nical record was reviewed					
	on 8/7/2015 at 2	:05 p.m. Nurse's Notes,					
	dated 8/4/2015 a	t 9:00 p.m., indicated,					
	"Late entry for 7	1/27/15 - Alerted that					
	possible bed bug	g found in bed. [Pest					
	control company	notified to be here					
	7/28/15. [Pest co	ontrol company] here,					
	room treated & b	ougs found. Placed on					
	monthly mainter	nance [signature of					
	Clinical Director	r]."					
	A copy of [pest of	control company]					
		al Procedures, provided					
	_	M on 8/7/2015 at 11:35					
	a.m., indicated, '	'13. Leave all clothing					
	bagged for 2 wee	eks after the initial					
	treatment Bed	Bug encasements should					
	be purchased for	all infested beds this					
	includes the box	spring and mattress to					
	help achieve con	nplete elimination."					
	On 8/7/2015 at 1	:10 p.m., the Interim					
		Director indicated the					

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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>	(X3) DATE SURVEY COMPLETED 08/07/2015
	PROVIDER OR SUPPLIE		2400 N	ADDRESS, CITY, STATE, ZIP CODE MARKET ST LESTOWN, IN 47111	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	plastic, as indic Chemical Proce	elates to the Investigation			

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