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	10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ANSON SENIOR LIVING	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

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R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: October 9, and 10, 2019. Facility number: 014059 Residential Census: 11 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 18, 2019.	R 0000		
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an			

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

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	Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on record review, and interview, the facility failed to provide a copy of the Alzheimer's/Dementia Special Care Unit disclosure form to the residents and/or their representatives for 3 of 3 memory care residents reviewed (Residents 12, 13, and 17). Findings include: During an interview, on 10/10/19 at 9:00 a.m., the Administrator (ADM) provided a copy of the facility's Alzheimer's/Dementia Special Care Unit disclosure form which was dated 10/1/19. On 10/10/19 at 2:08 p.m. the Business Office Manager, (BOM) provided Residents 12, 13 and 17's original Residency Agreement packet, and indicated the ADM handled all resident admissions. A copy of the Alzheimer's/Dementia Special Care Unit disclosure form was not in the Residency Agreement packets. During an interview, on 10/10/19 at 2:15 p.m., the ADM indicated copies of the Alzheimer's/Dementia Special Care Unit disclosure form had not been provided to the memory care residents and/or their representative upon admission.	R 0030	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or before October 31, 2019.** **R 030- Residents' Rights, Alzheimer's/Dementia Special Care Unit Disclosure.** **It is the practice of the community to provide the appropriate disclosure forms to the families and or their representatives of the memory care residents at the time of admission.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **The families/representatives were provided a copy of the Alzheimer's /Dementia Special Care Unit Disclosure form.**	10/31/2019

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			How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **Three residents have the potential to be affected by this deficient practice.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The Executive Director/Designee will provide a copy of the document at the time of signing The Residency Agreement with the family and/or their representative at the time of admission.** **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 Executive Director/Designee will review the admission documentation with a check list to ensure all appropriate documents have been provided and signed by the family and/or representative.** **A monthly QA audit of the new admissions paperwork will be**	

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			conducted by the Executive Director/designee to ensure compliance. The results of the audits will be reviewed by the QA committee. If threshold of 100% is not achieved an action place will be developed to ensure compliance.	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation, interview, and record review, the facility failed to post contact information, address, and telephone numbers, for the local Ombudsman, in an area accessible to residents which had the potential to affect 11 of 11 residents residing at the facility.	R 0033	**R 033- Residents' Rights, The Local Ombudsman Contact Information** **It is the practice of this facility to ensure the appropriate contact information is available to residents, families/ and or**	10/31/2019

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	Findings include: On 10/09/19 at 10:20 a.m. during an initial tour of the facility, a large poster of Resident Rights was observed in an alcove, on the first floor, next to residents' mailboxes. The lower right corner indicated "Local Ombudsman's Contact Information." The area was lined and nothing was written on the lines. On 10/10/19 at 10:30 a.m., a second Resident Rights poster was observed in the dining area of the Memory Care Unit. The Ombudsman information, in the lower right corner, was not filled in. On 10/10/19 at 9:30 a.m., during an interview and observation of the Resident Rights posting, with the Administrator, he indicated the Resident Rights posters should have had the Ombudsman's contact information completed in the designated area of the posting. The facility followed the State regulations for posting the Ombudsman's contact information.		**their representatives.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **The local Ombudsman contact information to include the Name, Address, and Telephone numbers were added to the Resident Rights posters located near the mail boxes as well as in Memory Care dining area.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **Eleven residents have the potential to be affected by this deficient practice.** **All signage and contact information has been reviewed for completion. A copy of the contact numbers to file a complaint is in the admission packet at the time of admission. This information is reviewed and signed for at the time of admission with family or representative.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	

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			practice does not recur; **An in-service was provided to the leadership team to ensure all documentation is completed for compliance.** **Each admission file will be reviewed by the Executive Director/Designee to ensure completeness.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** **A monthly QA audit will be conducted by the Executive Director/ Designee to ensure compliance. The results will be reviewed by the QA committee. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.**	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator.			

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	The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure the Alzheimer's/Dementia Care Director had an earned degree from an educational institution. This deficient practice had the potential to affect 3 of 3 residents who resided on the locked Dementia Care Facility (Residents 12, 13, and 17). Findings include: On 10/10/19 at 9:15 a.m., 10 randomly selected employee files were selected and reviewed. The "Dementia Care Director" row was blank, and indicated "N/A" (not applicable). During an interview, on 10/10/19 at 9:30 a.m., the Administrator indicated, the Director of Wellness (DOW) was the interim Dementia Care Director, and had been for about a month, after the previous Dementia Care Director left.	R 0095	**R 095- Administration and Management** **It is the practice of this community to ensure all directors are properly credentialed.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **A properly credentialed Memory Care Director is employed to ensure compliance.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/31/2019

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	During an interview on 10/10/19 at 3:04 p.m., the DOW indicated he did not have an earned degree, only his License as an LPN (Licensed Practical Nurse).		**taken;** **Three residents had the potential to be affected by the deficient practice.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The Executive Director conducted in-services in regards to the credentials required for the Memory Care Director position.** **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 HR director/designee will conduct a monthly QA audit and as needed upon hire to ensure all required credentials are in place to ensure compliance. The results will be reviewed by the QA committee. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.**	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the			

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	following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure a skin assessment was completed after a fall for 1 of 1 memory care residents randomly reviewed for skin impairment (Resident 17). Findings include: On 10/10/19 at 9:40 a.m., after an observation of Resident 17's left elbow wound, Licensed Practical Nurse (LPN) 9 indicated the resident came into the facility with the wound. On 10/10/19 at 9:47 a.m., the Director of Wellness (DOW) indicated, he was not aware of Resident 17's left elbow wound, but Resident 17 had fallen last night, and probably received it then. On 10/10/19 at 9:54 a.m., Resident 17's medical record was reviewed with the DOW. A Nursing Evaluation and Admission Evaluation, dated 10/4/19, indicated, a small red area on top of left hand, not open, with no other skin conditions noted. A nursing progress note, dated 10/9/19 at 3:45 p.m., indicated, "Resident fell on the floor on MC	R 0216	**R 216- Evaluation Assessments** **It is the practice of this community to conduct a skin assessment after a fall and document in the resident's chart. This documentation remains in the community.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **A head to toe skin assessment was conducted immediately on resident 17. Documentation was provided regarding resident 17 left elbow wound from the fall. Appropriate action/treatment which entailed a thorough nursing assessment as well as follow up from the Nurse Practitioner was taken to ensure the resident's need was met.** **How the facility will identify other residents having the potential to be affect by the**	10/31/2019

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	(memory care) in the activity room trying to get to a table so he can sit with other residents. Resident said that he was trying to get to the table when he tripped over one of the chairs and fell down. During assessment resident complained of no pain and just needed help up off the floor. Resident did have a cane with him that he was using while ambulating. There appears to be no bruising, swelling or bleeding noted and resident did not hit his head. Will continue to monitor resident for any decline in conditions...." A Nursing Fall Evaluation, dated 10/9/19 indicated, Head to Toe Assessment: No skin conditions observed. An Accident Incident Report, dated 10/9/19, indicated, the resident tripped when he tried to walk to the table, no skin injuries noted. The DOW indicated there was no documentation of Resident 17 left elbow wound in the resident's medical chart During an interview, on 10/10/19 at 11:05 a.m., the DOW indicated LPN 9 did not do a complete skin assessment at the time of the fall but charted that she did. On 10/10/19 at 11:27 a.m., Registered Nurse (RN) 10 indicated she worked for (name of) wound care company but was not a certified wound nurse. She assessed Resident 17's left elbow wound and indicated it looked like a scrape and a bruise, definitely an abrasion of some kind. She did not think it was a pressure sore. The wound measured 2.1 x 2.1 centimeters (cm), circular with a peri-wound bruise. It was scabbed over with no drainage. During an interview, on 10/10/19 at 11:45 a.m., LPN		**same deficient practice and what corrective action will be taken;** **One resident was affected by this deficient practice.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **The Director of Nursing/Designee conducted a mandatory in-service to all nursing staff to ensure the policies and procedures of assessments are met.** **One on one education/counseling was provided to Licensed Practical Nurse 9 per policies and procedures/protocol regarding accuracy of assessments.** **The Director of Nursing/Designee conducted an audit of the skin assessments on residents reporting falls or any skin integrity issues to ensure completeness and accuracy.** **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 Director of Nursing/ Designee will conduct a monthly Quality Assessment**	

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	9 indicated Resident 17 fell between 4:00-4:30 p.m., he got his cane caught when he was walking. She filled out the Accident Incident Report and Nursing Fall Evaluation. She did a quick glance at his visible skin, pulled up his pant legs to assess his lower legs, but did not assess his arms. She did not go into depth to assess his skin. She should have taken him back to his room and have him undress to assess his skin but, she rushed the assessment, and shouldn't have. She filled out the documentation inaccurately, and in the future she would take her time to assess the skin and accurately fill out the documentation. On 10/10/19 at 2:50 p.m., Resident 17's chart was reviewed. His diagnoses included, but were not limited to, unspecified dementia without behavioral disturbances, mild cognitive impairment, anxiety disorders, anemia, and hypertension. A current policy, titled, "Wound Care," was provided by the DOW, on 10/10/19 at 1:03 p.m. A review of the policy indicated, " ...Each Resident will be evaluation for skin concerns during routine and change of conditions assessments and as needed for reported skin condition changes...A skin assessment will be completed by the Director of Wellness or Wellness Nurse...as needed for reported skin integrity changes...The Director of Wellness will coordinate and oversee all wound care and skin conditions treatments(s). If required, the DOW will request a Home Health referral for wounds outside the Scope of Service...."		**review of all skin assessments to ensure compliance. The results will be reviewed by the QA committee. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.**	