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	05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00293914. Complaint IN00293914 - Substantiated. State Residential Findings are cited at R55, R144, and R354. Survey dates: 5/21 and 5/22/2019 Facility number: 010234 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on May 30, 2019.	R 0000		
R 0055 Bldg. 00	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on observation, interview and record review the facility failed to provide privacy during an assessment, preformed by the Nurse Practitioner in a hallway, for 1 of 1 residents during a random observation of an assessment. (Resident E) Finding includes:	R 0055	R055 1.Nurse Practitioner was educated on 5/22/19 by the ED regarding Residents' rights and the provision of privacy during care and assessment. She verbalized understanding. 2.Current residents have the	07/05/2019

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

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	The record for Resident E was reviewed on 05/22/19 at 8:30 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure) hypothyroidism (a slow acting thyroid) and Alzheimer's disease. During a random observation of the dining room, on 05/21/19 at 11:43 a.m., the Nurse Practitioner was performing an assessment of Resident E in the hall way off the dining area. This assessment included the monitoring of vital signs and monitoring of a foam brace on the resident's lower extremity. The doors to the dining area were open. Residents were seated in the dining area, a nurse, nursing assistant and one dietary staff were in the hall and able to observe the assessment. In an interview, immediately following the observation of the assessment, the Nurse Practitioner indicated she should not have assessed Resident E in a public area. A facility document provided by the Memory Care Director, on 05/22/19 at 1:00 p.m., titled "Resident Rights" indicated, "...honor each resident...treating them with respect and dignity at all times...each resident has the right to, at a minimum...Personal privacy...." A facility document provided by the Executive Director on 5/22/19 at 3:35 p.m., titled "APPENDIX E INDIANA STATE DEPARTMENT OF HEALTH-RESIDENT'S RIGHTS" indicated, "...Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for...Physical Examinations...."		potential to be affected by this alleged deficient practice. 3.Staff re-educated on 6/17/2019 by the ED regarding residents' rights and the provision of privacy during care and assessment. Nurse Practitioner group owners were contacted on 6/11/19 by the Regional Director of Care and educated on the significance of their staff adhering to residents' rights and privacy regulations while providing care in our community. 4.ED is responsible for continued compliance. ED or designee will be monitor staff during rounds for compliance. Rounds will be made daily for 7 days then weekly for 6 weeks and then monthly for 6 months. These rounds will be reviewed at monthly QI meeting. Continued review will be based on 6 months of sustained compliance. 5.Completion: 7/5/19	

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	This Residential tag relates to Complaint IN00293914.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview the facility failed to conduct 12 fire drills in a year. This deficient practice has the potential to effect 44 out of 44 residents residing in the facility. Finding includes: The fire drill records were provided by the Facility Administrator on 05/22/19 at 10:00 a.m. Fire drill records for February 2019 and April 2019 were not	R 0092	R092 1.Unable to resolve missing fire drills for February and April of 2019. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Maintenance tech and ED re-educated on 6/11/19 by the Regional Director of Care	07/05/2019

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	provided. The Executive Director indicated they are not able to located these records. In an interview on 05/22/19 at 12:30 p.m., the Memory Care Coordinator indicated the facility did not have a policy for fire drills, they follow the state regulations.		regarding the Indiana State regulation for fire drills in a residential community. Community is current for May and June as of 6/21/20119. Fire department was invited to attend/lead in May 2019. 4.ED is responsible for on-going compliance. Fire drills will be reviewed at Monthly QI meeting and monthly safety meeting on-going to ensure compliance. 5.Completion: 7/5/19	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties			

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	shall conform with written job descriptions. Based on record review and interview the facility failed to have staff trained in first aid on 3 of 21 shifts reviewed for staff trained in first aid. Finding includes: The first aid records for all staff working between 5/12/19 to 5/19/19 were reviewed on 05/22/19 at 1:00 p.m. The records indicated between the hours of 10:00 p.m. and 6:00 a.m. on 5/12/19, 5/15/19 and 5/17/19 there were no staff trained in first aid, on these shifts. Information for employee cardiopulmonary resuscitation, first aid and other records/policies were requested, in writing, of Executive Director during the entrance conference and missing information for employee records, policies and inservices was requested, verbally, again on 5/22/19 at 2:25 p.m. The facility was unable to provide missing information by the time of exit.	R 0117	R117 1.The schedule was reviewed and revised on 6/13/2019 by the ED to ensure that 1 awake staff person with current CPR and First aid was on each shift. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Employee file audit was completed on 6/17/2019 by the business office manager to review current employee CPR/First Aid status. A CPR with First Aid class was completed on 6/13/19 for staff members without current CPR and/or First Aid and for staff members whose certifications are soon to expire. 4.The ED is responsible for on-going compliance. The business office manager or designee will audit employee files monthly on-going to ensure that staff have current CPR and First Aid certifications. Resident Care Coordinator or Designee will compare schedule to staff who are both first aid and CPR trained to ensure compliance. Audits will be reviewed in monthly QI. Continued review will be based on 6 months of sustained compliance. 5.Completion: 7/5/19	07/05/2019
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the			

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	facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interview the facility failed to provide documented orientation for jobs specific training for 1 of 5 new employees reviewed for employee records. (Administrative Coordinator/Concierge) Finding includes:	R 0119	R119 1.Job specific orientation was completed for the Administrative Coordinator/concierge on 6/16/2019 by Executive Director. 2.Current residents have the potential to be affected by this alleged deficient practice.	07/05/2019

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	The employee records were reviewed on 5/22/19 at 1:00 p.m. The record for the Administrative Coordinator/Concierge did not contain a job specific orientation. In an interview, on 05/22/2019 at 2:25 p.m., the Director of Nursing indicated the facility was unable to locate any job specific orientation for the Administrative Coordinator/Concierge. Information for employee records/policies were requested, in writing, of Executive Director during the entrance conference and missing information for employee records, policies and inservices was requested, verbally, again on 5/22/19 at 2:25 p.m. The facility was unable to provide missing information by time of exit.		3.Employee file audit was completed on 6/18/2019 by the business office manager to ensure current employees had a job specific orientation completed. The Business office manager is responsible to ensure that a job specific orientation is completed for each newly hired employee. 4.The ED is responsible for sustained compliance. The Business office manager or designee will audit new employee files monthly on-going to ensure that employees have proper job specific orientation completed. This will be reviewed at monthly Qi meeting. Continued audit review will be based on 6 months on sustained compliance. 5.Completion: 7/5/19	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours			

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	of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview the facility failed to ensure 1 of 5 new employees had a documented 2-step Tuberculosis skin test in the employee record. (the Administrative Coordinator/Concierge) Finding includes: The employee records were reviewed on 5/22/19 at 1:00 p.m. The record for the Administrative Coordinator/Concierge did not contain a health screen or 2-step Tuberculosis (TB) skin test. In an interview, on 05/22/2019 at 2:25 p.m., the Director of Nursing indicated the facility was unable to locate the 2-step TB test for the Administrative Coordinator/Concierge.	R 0120	R120 1.2 step TB skin test was initiated for the Administrative coordinator/concierge on 5/30/19 by the RCC. Employee TB Skin test Audit completed 6/17/19 for current staff. 2.Current residents have the potential to be affected by this alleged deficient practice. 1.ED and RCC re-educated on regulation regarding employee TB testing on 6/11/19 by the Regional Director of Care. Business office Manager re-educated on 6/11/2019 by the ED on regulation regarding employee TB testing. 2.CSM is responsible for sustained compliance. Business	07/05/2019

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			office Manager will notify CSM or designee upon hire of new employees and that TB skin test is required. CSM or designee will ensure 2 step TB testing is completed for newly hired employees. Newly hired employees will be reviewed at monthly QI meeting for TB compliance. Continued review will be based on 6 months of sustained compliance. 3.Completion: 7/5/19	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review the facility failed to maintain a clean environment, failed to maintain a sanitary bath room for 1 of 1 resident (Resident C), failed to keep pets out of the dining area and failed to ensure pets were not relieving themselves inside the facility. These deficient practices have the potential to affect 44 out of 44 residents currently residing in the facility. Findings included: 1. During an observation of Resident C's personal restroom, on 05/21/19 at 10:27 a.m., dried feces was observed on the inner rim of the toilet seat, and the seat had light brow colored smears. Certified Nursing Assistant (CNA) 6 was immediately notified. At that time,CNA 6 indicated the toilet should	R 0144	R144 1.New Maintenance Technician and Housekeeper were hired and trained on proper maintenance and cleaning for the facility. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Staff re-educated by Executive Director on 6/13/2019 regarding sanitation, the need for the community to be clean, orderly, and in a state of good repair. Staff educated on pet policy and pet sanitation. 4.ED or designee is responsible for sustained compliance. Maintenance Technician or designee will follow routine maintenance plan and document	07/05/2019

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	have been cleaned by house keeping. CNA 6 then exited the room. At 10:30 a.m., CNA 7 entered the room. At that time CNA 7 indicated she would not use a toilet like that. She was unsure of when house keeping would come around to clean the bathroom. 2. During a general observation of the facility at 11:15 a.m., on 5/21/19, a red smear was found on a white column outside the first floor dining room, scattered debris was found throughout the first floor carpeting, black stains were observed on the first floor carpet in the hall leading from the elevator to the Executive Director's back office door and multiple scrapes and smudges along the lower half of the walls and doors were observed. 3. During a dining observation on 05/21/19 at 11: 45 a dog was observed in the dining room. At that time residents were in the dining room, drinks and food were present. 3. During an interview with the Director of Nursing, on 05/21/19 at 11:50 a.m., the same dog that had been observed in the dining room, squatted at the base of the stairs, next to the Director of Nursing, and urinated on the carpet. At that time the Director of Nursing indicated Sadie was her dog and she was responsible to ensure the dog was taken outside to urinated/defecate. 4. At 12:02 p.m., on 5/21/19 a brown item resembling a piece of sausage was found on the stairs. The Director of Nursing (DON) indicated it was a piece of sausage. The cleaning schedule and housekeeping policy was requested, of the DON at that time.		in TELS. Housekeeper or designee will follow a weekly cleaning schedule and maintain a record of work completed in a binder. This information will be reviewed at monthly QI meeting. Continued QI review will be based on 6 months of sustained compliance. 5.Completion: 7/5/19	

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	5. At 12:08 p.m., on 5/21/19 during an observation of the second floor hall way the carpet was noted to have debris throughout the hall and 2 clear medication cups were found on the rail outside of room 213. In an interview, at 12:11 p.m., CNA 8 indicated the cups should not have been left there. 6. During an observation of the third floor common areas, beginning at 12:13 p.m., on 5/21/19, white specks and debris were found on the laminate flooring throughout the area. Some of the white specks were movable and some were stuck to the floor. 7. At 12:15 p.m., on 5/21/19 a liquid spill was observed on the floor of the third floor dining area. CNA 6, CNA 7, Licensed Practical Nurse (LPN) 9 and CNA 10 walked past the spill and did not attempt to clean it up. LPN 9 was notified of the spill at 12:16 p.m. In an interview with CNA 7 and LPN 9, at 12:17 p.m., they both indicated it was the responsibility of all staff to keep the floors clean. 8. At 12:31 p.m., on 5/21/19, a medication cup was found on the stairs between the first and second floors. Housekeeping policies and schedules were requested of the Director of Nursing on 5/21/19 at 12:02 p.m. and of the Maintenance Person again on 5/22/19 at 10:57 a.m. On 5/22/19 at 10:01 a.m. the Memory Care Director indicated she only had a mission statement and provided the document at that time. The facility document was titled, "WELCOME TO			

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	ENLIVANT" and indicated, "...MAINTAINING A SAFE WORKING ENVIRONMENT...We are committed to providing a clean, safe and healthy environment for all our residents...You are responsible for...following...and complying with all applicable federal, state and local codes and regulations...." A document provided by the Director of Nursing, on 05/21/19 at 2:00 p.m., titled "PET AGREEMENT" indicated, "...4. Care and Control of the Pet. At all times, You shall be responsible for the care and control of your pet...Your pet shall be on a leash or otherwise properly restrained. You must directly supervise your pet at all times...pets are not allowed in the dining room at any time...." This document was signed on 11/30/18 by both the Director of Nursing and the Facility Executive Director. The Residential tag relates to Complaint IN00293914.			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure kitchen equipment was maintained in clean condition and good repair and failed to dispose of expired items for 1 of 1 Kitchen observed. This deficient practice had the potential to affect 44 of 44 residents who received meals from the kitchen. Findings include:	R 0154	R154 1.Ecolab, Hobart and SafeCare were commissioned to repair equipment that was deficient. Kitchen was thoroughly cleaned and organized on 5/24/2019. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Kitchen Staff and DSM were	07/05/2019

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	1. During a tour of the kitchen on 5/21/19 at 9:58 a.m., with the Dietary Services Manager (DSM) the thermostat which measured the temperature of the dishwasher rinse cycle was observed not to register a water temperature at any time during the cycle. During an interview, at that time, the DSM indicated the gauge should have moved to show a temperature of 180 degrees during the rinse cycle. He did not have any other way to verify the water temperature at that time. 2. A kitchen towel covered in a dark brown substance was observed stuffed under the griddle top of the oven. The DSM indicated the drip pan under the griddle top was broken and the towel was placed there to prevent grease from pouring onto the floor. He had reported this to the facility maintenance man but he had been terminated before addressing the issue. 3. During an observation of the dry storage area on 5/21/19 at 10:13 a.m., with the DSM, seven 46 fluid ounce containers of prune juice with a manufactures expiration date of 2/25/19 were found. The DSM indicated they should have been disposed of. 4. During an observation of food preparation on 5/21/19 at 12:08 p.m., The DSM was unable to verify the temperature of prepared food. He indicated the thermometer battery was dead, he was unable to find a replacement battery and he did not have access to another thermometer. A facility document titled, "Daily Food Production/Substitution Log/Temperature Log", provided by the Memory Care Director on 5/22/19 at 1:18 p.m., indicated food temperatures be		re-educated by ED on 5/24/2019 regarding proper sanitation practices in the kitchen. Maintenance Technician was educated on equipment maintenance on 6/14/2019. 4.The ED is responsible for continued compliance. The DSM or designee will maintain weekly cleaning schedules and ensure kitchen equipment maintenance schedules are being followed. ED will audit kitchen, equipment and cleanliness weekly X 4 weeks, then bi-weekly for 2 months then monthly X 3 months. Audits will be reviewed in monthly QI. Continued review will be based on 6 months of sustained compliance. 5.Completion 7/05/2019	

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	05/22/2019

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	recorded at the time of service. A facility document titled, "Guidelines for shelf life / Use-By Dating of Food Items", revised on 1/19/18, provided by the Memory Care Director on 5/22/19 at 1:18 p.m., indicated, " ...Juices ...5 Days ...."			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview the facility failed to provide an accurate list of medications for 1 of 1 resident transferred to a hospital. (Resident C) Finding includes: The record for Resident C was reviewed on 05/21/19 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's with dementia, depression and delusions. A physician's order list for February 2019	R 0354	R354 1.Resident no longer resides in the community. 2.Current residents have the potential to be affected by this alleged deficient practice. 3.Staff re-educated by Resident Care Coordinator on 5/27/2019 regarding where to locate residents' current medical information including medication list. System for locating the most recent medication list was	07/05/2019

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	indicated Resident C was on the following scheduled medications until February 7, 2019: buspirone (a medication for anxiety) 10 milligrams (mg) twice a day. divalproex (a medication used for mood disorders) 125 mg sprinkle capsules twice a day donepezil (a medication used for Alzheimer's disease)10 mg once a day at bedtime furosemide (a diuretic) 20 mg once a day potassium chloride (a potassium supplement) 10 milliequavalents (meq) once a day Risperdal Consta (an antipsychotic) 12.5 mg by injection every two weeks sertraline (an antidepressant) 100 mg once a day in the morning trazodone (an antidepressant and sedative) 100 mg once a day at bedtime vitamin B-12 1000 micrograms (mcg) once a day in the morning A Patient Summary Report from [Name of Hospital] indicated Resident C presented to the hospital on 02/06/19 around 10:00 p.m. Resident C's current scheduled medication list on 02/07/19, provided by the sending facility, was: bumetanide (a diuretic) 2 mg once a day donepezil 10 mg once a day at bedtime Risperdal 0.5 mg by mouth once a day sertraline 100 mg once a day trazodone 100 mg once a day at bedtime vitamin B-12 1000 mcg once a day Risperdal 0.25 mg by mouth daily at 4:00 p.m. Risperdal 1 mg by mouth once a day at bedtime In an interview, on 05/21/19 at 10:01 a.m., Resident C's family member indicated the assisted living staff had provided an incorrect medication list to the hospital.		streamlined by the Resident Care Coordinator. 4.CSM or designee is responsible for sustained compliance. CSM or designee will review records of residents who have been transferred to ensure that the most current medical information was sent with the transfer form. This information will be reviewed at monthly QI meeting. Continued review of transfer records and QI review will be based on 6 months of sustained compliance. Completion: 7/5/19	

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	In an interview, on 05/22/19 at 11:45 a.m., the Director of Nursing indicated when a resident was sent to the hospital the most recent medication orders were sent in the transfer paperwork. She was aware of the incorrect medication list having been sent to hospital. The most recent three months of medication records was to be in a binder separate from the residents' charts. The most recent medication list was to be given to the receiving facility. When Resident C went to the hospital, staff must of took an old medication list from the chart, instead of the binder that contained the correct information, and sent it to the hospital. This Residential tag relates to Complaint IN00293914.			