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	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF ZIONSVILLE EAST	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: January 24, 2023. Facility number: 012263 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 7, 2023.	R 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
R 0002 Bldg. 00	410 IAC 16.2-5-0.5(b) Scope of Residential Care - Offense (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule. Based on observations, interviews and record reviews, the facility failed to ensure they did not admit a resident (Resident 76) who required skills and services beyond the scope of practice for the Residential setting for 1 of 7 residents reviewed. Findings include: On 1/24/23 at 9:56 a.m., Resident 76 was observed. He was reclined, with the head of his hospital bed elevated. He rested on a low air loss mattress. A catheter drainage bag was noted to the open side of his bed and the corner of the bag rested on the	R 0002	1. Immediate actions taken for those residents identified. a. Resident was voluntarily discharged to skilled nursing facility on 2/16/2023 at 11am. 2. How the facility identified other residents. a. No other residents effected as extra staff was brought on the neighborhood to help tend to this resident. 3. Measures/systems put in place.	02/16/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Executive Director	02/20/2023

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	floor. There was a small amount of dark yellow urine noted in the bag. There was a Hoyer lift (a mechanical cradle lift used for residents who are often totally dependent of staff for transfers) in his room. Resident 76 was unable to answer questions. During an interview on 1/24/23 at 9:58 a.m., Certified Nursing Assistant (CNA) 9 indicated Resident 76 was a new admission and since he came to the facility, he had been totally dependent on staff for everything. He could not get out of bed by himself, could not use the bathroom by himself, and could barely help dress himself with assistance. Sometimes he could feed himself, but often forgot his food was in front of him or was too weak to feed himself. CNA 9 indicated even though he was on hospice, the hospice aids only helped a couple days a week. So in the meantime, he was totally dependent and often needed both aides to help with his daily care which took time away from assisting other residents. During an interview on 1/24/23 at 10:00 a.m., Qualified Medication Aid (QMA) 10 indicated he could not locate a hospice binder for Resident 76 and upon review of his current physician orders, did not see an order for the resident's catheter, therefore there were not instructions for care or monitoring. He indicated that would be up to hospice to manage. On 1/24/23 at 10:42 a.m., Resident 76's medical record was reviewed. A Service Plan, dated 1/19/23, indicated he required the use of a Hoyer lift for transfers, required total assistance for bathing to be completed by hospice twice a week, and required physical assistance from staff to consume meals.		a. All residents will be assessed prior to move in. Residents who exceed level of care rubric and parameters will not be admitted. 4. How will the corrective action be monitored. a. WD and ED will assess all potential residents and deny admission if they exceed our scope of care and level of care rubric. 5. Due Dates a. 02/16/2023	

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	The record lacked documentation of any physician orders for his indwelling catheter. The record lacked documentation of his Hospice plan of care. During an interview on 1/24/23 at 2:15 p.m., the Director of Health Services (DHS) indicated Resident 76 was a new admission who had been accepted because of an end-of-life program they implemented called Beacon of Hope. While she wanted to be able to provide for him in his last days, he had required more skilled care than the Residential setting typically allowed. For example, there were no orders for his catheter since that was a skilled service provided by Hospice. So should something happen, they would need to contact Hospice to come replace it, monitor and assesses it. During an interview on 1/24/23 at 2:48 p.m., the Administrator (ADM) indicated he and the DNS had not been 100% confident in the decision to admit Resident 75. The Beacon of Hope program would have been a better fit for Resident 76 if he were in the actively dying process. Since he had not transitioned to that point, the care he required was more skilled than the Residential setting could provide. During the survey entrance conference on 1/24/23 at 9:10 a.m., a copy of the facilities policy on residential admittance and continued stay at residential level was requested and provided by the ADM. The policy was titled, "Admission Policy," and indicated, " ...the community shall not accept an individual seeking admission unless the individual's needs can be adequately and appropriately met within the scope of the Community's Program Statement ... and not be			

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	requiring continuous nursing care services ...." On 1/24/23 at 2:50 p.m., the DNS provided a copy of current facility policy titled, "Indwelling Catheter Maintenance Observations," dated 12/5/22. The DNS indicated the policy addressed and provided guidance for Residential nursing staff on how to observe and monitor a catheter but because it was a skilled service, they did not perform catheter care tasks. The policy indicated, "The purpose is to provide an observation process to measure adherence to proper maintenance procedures for an indwelling catheter. The goal is to reduce infection rates, determine education needs, meet any regulatory requirements and provide metrics for quality improvement goals ...."			
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.			

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	(6) If the facility is required to submit an 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 interview and record review, the facility failed to ensure the Alzheimer's/Dementia Special Disclosure, State form 48896, was completed by December 31st annually. Findings include: On 1/24/23 at 9:30 a.m., the Dementia Care Disclosure form was requested for review. On 1/24/23 at 11:00 a.m., the Executive Director (ED) provided a copy of the Dementia Care Disclosure form, dated 1/7/21, which listed the facility's former facility name, from a prior ownership. During an interview, on 1/24/23 at 2:58 p.m., the ED indicated he did not believe a Dementia Care Disclosure had been completed for 2022. He was not aware it had to be filed every year. The facility did not have a policy, they followed the State Regulations.	R 0030	1. Immediate actions taken for those residents identified. a. Dementia Care Disclosure form was completed and submitted 1/24/23. 2. How the facility identified other residents. a. All residents in memory care neighborhood effected. 3. Measures/systems put in place. a. Executive Director will submit completed form before December 31st annually. 4. How will the corrective action be monitored. a. Regional Support and home office compliance team leader will remind all licensed ED's running memory cares in Indiana to submit forms on or before December 31st annually. 5. Due Dates a. December 31st annually. Current deficiency corrected 1/24/2023.	01/29/2023
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,			

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	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 shall conform with written job descriptions. Based on interview, and record review, the facility failed to ensure a minimum of one awake person, with a first aid certificate and CPR (Cardio-Pulmonary Resuscitation) was always on site for each shift. This deficient practice had the potential to affect 80 out of 80 Residents who resided in the facility. Finding include: On 1/24/23 at 3:30 p.m., the licensed nursing staff schedule for the week of 1/15/23 through 1/21/23 was reviewed and revealed the following: a. On 1/15/23 and 1/21/23, no personnel were on duty that were trained in first aide for 3 of 3 shifts. b. On 1/16/23, 1/17/23, 1/19/23, and 1/20/23, there were no personnel trained in first aid on the second and third shift. c. On 1/18/23, no personnel were on duty during the second shift trained in first aide.	R 0117	1. Immediate actions taken for those residents identified. a. Audit completed for all staff to identify who is CPR and First Aid Certified. 2. How the facility identified other residents. a. All residents effected. 3. Measures/systems put in place. a. Certified training will be organized and implemented for each shift lead or charge person. 4. How will the corrective action be monitored. a. WD/RCS/Property Administrator will maintain up to date records of who is First Aide/CPR certified to assure there is adequate staff certified on each and every shift. Spreadsheet will	03/01/2023

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	d. There were no personnel present that were trained in CPR on duty during the third shift on 1/16/23, 1/20/23, and 1/21/23. During an interview on 1/24/23 at 4:40 p.m., the Executive Director (ED) indicated, the facility follows the state rule for CPR and first aid. He indicated there was no policy for CPR/First Aid.		be updated upon new hires and annual reminders will be established per employee. 5. Due Dates a. 3/1/2023	
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 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			

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	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 in-service education and training, related to Residents' Rights and Abuse for 4 of 5 employees reviewed, and Dementia training for 3 of 5 employees reviewed. Findings include: A review of personnel records was conducted on 1/23/23 at 3:30 p.m. During the review, 4 of 5 employees lacked documentation of education for abuse prevention, resident rights and dementia training. Certified Nurse Aid (CNA) 29's employee file was reviewed. His employee file indicated he was hired 2/17/19. His employee file indicated he lacked annual training for abuse prevention and resident rights. CNA 35's employee file was reviewed. Her employee record indicated she was hired on 3/7/22. Her employee file indicated she lacked annual training for abuse prevention, resident rights, and dementia training. The Memory Care Director's employee file was reviewed. Her employee file indicated she was hired on 11/28/22. Her employee file indicated she lacked training for abuse prevention, resident rights, and dementia training.	R 0120	1. Immediate actions taken for those residents identified. a. Audit was completed to identify staff who are delinquent on online trainings and annual compliance trainings for dementia, resident's rights and abuse. 2. How the facility identified other residents. a. All residents effected. 3. Measures/systems put in place. a. Group/team trainings will commence quarterly to ensure all team members are up to date. Self-directed online training will be supplanted by group trainings and copies of tests, training documents and signatures of completion will be individually filed for staff. 4. How will the corrective action be monitored. a. Initial trainings must be completed prior to working the floor and up to date records will be audited quarterly by property admin team. 5. Due Dates a. Next scheduled group training will be held March 8th, 2023. This will get current team	03/08/2023

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	QMA (Qualified Medication Assistant) 30's employee file was reviewed. Her employee file indicated she was hired on 7/1/22. Her employee file lack training for abuse prevention, resident rights, and dementia training. During an interview on 1/24/23 at 4:40 p.m., the Executive Director (ED) indicated, the facility follows the state rule for new employees and annual training. He indicated employees used Relias for training and they did not always complete the required training. He indicated there was no policy for the required employee training.		members in compliance with annual trainings.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will			

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	depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure employee tuberculin testing, by the 2-step method, chest x-ray or tuberculin screening was completed and documented in the employee record for 3 of 5 randomly selected, new hire employees, reviewed for tuberculin testing Qualified Medication Aide (QMA) 29, Certified Nursing Assistant (CNA) 35 and Memory Care Director). Findings include: On 1/24/23 at 4:40 p.m., the employee file was reviewed for QMA 29. His employee file indicated he was hired on 2/27/19. His file lacked documentation of a 2-step tuberculin test, documentation, chest x-ray (CXR), or a tuberculin screening. CNA 35's employee file was reviewed. Her file indicated she was hired on 3/7/22. Her file lacked documentation indicating a 2-step tuberculin test, CXR or tuberculin screening was completed.	R 0121	1. Immediate actions taken for those residents identified. a. List created of staff who are not in compliance and a TB clinic will be established for all new or current staff on or before 3/15/23. 2. How the facility identified other residents. a. All residents could be effected. 3. Measures/systems put in place. a. Property Administrator will obtain all copies of TB tests from Empower HR prior to orientation if completed at an offsite location. 4. How will the corrective action be monitored. a. All current and new staff's TB information will be entered into a tracking form to be monitored by WD/RCS. 5. Due Dates a. 3/15/2023	03/15/2023

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	The Memory Care Director's employee file was reviewed. Her file indicated she was hired on 11/28/22. Her file lacked documentation to indicate that she received a 2-step tuberculin test, CXR or tuberculin screening. During an interview on 1/24/23 at 4:40 p.m., the Executive Director (ED) indicated, the facility follows the state rule for tuberculin screening. He indicated there was no policy for tuberculin screening.			
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review, and interview, the facility failed to provide documentation of general orientation, for 3 of 5 employees (Qualified Nursing Assistant (QMA) 29, new hire employees, Certified Nursing Assistant (CNA) 35	R 0123	1. Immediate actions taken for those residents identified. a. Audit was completed on all employee files to identify what information was missing.	03/08/2023

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	and the Memory Care Director. The Memory Care Directors' file was lacking documentation of job specific orientation. Findings include: On 1/24/23 at 4:40 p.m., the facilities employee files were reviewed. QMA 29 was hired on 2/27/19. His personnel file lacked documentation of general orientation to the facility. CNA 35 was hired on 3/7/22. Her employee file lacked documentation of general orientation to the facility. The Memory Care Director was hired on 11/28/22. Her employee file lacked documentation of general orientation to the facility and lacked documentation of job specific orientation. During an interview on 1/24/23 at 4:40 p.m., the Executive Director (ED) indicated, the facility follows the state rule for general and job specific orientation. He indicated there was no for general or job specific orientation.		2. How the facility identified other residents. a. All residents were affected. 3. Measures/systems put in place. a. Quarterly audits will be put in place for existing files and new employees' files will have all necessary information within. A checklist of all documents needed that will be placed in each employee file has been uploaded for evidence. 4. How will the corrective action be monitored. a. Quarterly audits by lead reception and property administrator. 5. Due Dates a. Second week, of the third month of each quarter, for perpetuity.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and			

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	comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure resident's environments remained free from the potential for accidents when bedrails were applied but not monitored or maintained in a safe operating condition for 3 of 3 residents reviewed for bedrails, (Residents 76, 70 and 72). Findings include: On 1/24/23 at 9:52 a.m., Resident 70's empty bed was observed. It was an older style brown metal hospital bed and had two half bed rails installed on the right frame which extended the full length of the bed. There was a half rail installed on the left side of the bed. When assessed, the bedrail wobbled significantly and was observed to be very lose. It moved loosely up and down and back and forth, which in turn created a large gap between the mattress and the rail. Similarly, on 1/24/23 at 9:54 a.m., Resident 72's empty bed was observed with two half rails on either side. The rails were loose, and wobbled up and down, back and forth, and created a large gap between the mattress and the rail. On 1/24/23 at 9:56 a.m., Resident 76 was observed. He was reclined, with the head of his hospital bed elevated. He rested on a low air loss mattress (LAL) and there were half side rails to both sides of his bed. The LAL mattress was easily pushed and gave way to pressure, which caused a larger than required gap between the mattress and the bedrail. On 1/24/23 at 11:07 a.m., Residents 70 and 72 were	R 0148	1. Immediate actions taken for those residents identified. a. All bedrails have been removed from beds and families and residents educated. 2. How the facility identified other residents. a. All apartments and beds in Memory Care and AL were walked and assessed for rails. 3. Measures/systems put in place. a. All current and incoming residents' beds will be free from bedrails. 4. How will the corrective action be monitored. a. Wellness Director and Resident Care Supervisor (referred to as WD/RCS moving forward) will assess new move ins and new hospital beds to assure that bedrails are not installed. 5. Due Dates a. 2/16/2023	02/16/2023

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	observed in the main activity lounge. Resident 70 was reclined, almost in a laying down position, in a broad wheelchair. Her eyes were closed, and she did not open her eyes to her name. She was very small and appeared frail. Resident 72 was observed seated in an upright broad chair in front of a table. Her eyes were closed, and she did not open her eyes to her name. Although she appeared to be tall, she was thin and frail. On 1/24/23 at 11:15 a.m., Resident 76, 70, and 72 medical records were reviewed for the indication and use of bedrails. The records lacked documentation of physician's orders for side rails. The records lacked initial and/or ongoing assessments of the side rails. The records lacked indication for the use of the side rails either for mobility/safety and or restraint. During an interview on 1/23/24 at 1:35 p.m., Certified Nursing Assistant (CNA) 11 indicated, neither Residents 70, nor 72 could use the bed rails. They were in place to help keep them in bed so they would not fall out. Did not know if they were loose or who was supposed to check them. During an interview on 1/24/23 at 2:08 p.m., a representative from Compassus Hospice, Resident 72's contracted Hospice provider, indicated, bed rails were only installed on hospice bed if requested and ordered. Most families requested them to be placed to help keep residents from falling out of bed. Since Hospice staff was not with the resident's 24 hours a day 7 days a week it would be the facility staff's responsibility to monitor them and assess them regularly for safety			

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	and to make sure they were in good repair. On 1/24/23 at 2:20 p.m., Resident 70, 72, and 76's bed rails were assessed and observed with the Director of Health Services (DHS) Upon inspection the DNS indicated the rails were too loose and even after she attempted to hand tighten the rails, they remained lose. She indicated it was her understanding that bedrails were not permitted for use in Assisted Living, and she could see the potential for accidents by way of entrapment between the mattress and the rails. On 1/24/23 at 2:54 p.m., the Administrator (ADM) indicated it was the facility's policy to appropriately assess and use mobility bars in the Residential setting, bed bedrails were not permitted. On 1/24/23 at 3:00 p.m., the ADM provided a copy of current facility policy titled, "Bedside Mobility Aids," revised 2/4/22. The policy indicated, "The purpose of the bedside mobility aids is to promote a safe and restraint free environment, while at the same time acknowledging individual resident's mobility needs. Our communities allow for the use of certain bedside mobility aids with an appropriate healthcare provider order ... Side rails of any length are not allowed ... if the resident is on hospice, and hospice is providing a bed, the need and any bedside mobility aid used must comply with this policy ...."			
R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and			

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	administration of oxygen. Based on observation, interview, and record review, the facility failed to ensure a resident's oxygen canisters were stored safely for 1 of 1 residents reviewed for oxygen canister safety (Resident 16). Findings include: On 1/24/23 at 9:58 a.m., Resident 16 was observed sitting in her recliner, watching television. Her door was open and 25 large oxygen canisters were in her room; one was in a rolling canister holder, 7 were together against her sofa and the wall, and 17 oxygen canisters were separated, free standing. An oxygen (O2) concentrator was observed. It was turned on, set at 2 liters (L) without humidity, and an unbagged nasal cannula (NC) was attached to it. The NC was laying on her sofa. During an interview, on 1/24/23 at 10:00 a.m., Resident 16 indicated she only used O2 when she got up out of her recliner. During an interview, on 1/24/23 at 10:44 a.m., Resident 16 was asked about the NC on her sofa, she indicated she didn't know much about the O2. She didn't know if she should have been wearing the NC while in the recliner. The nurses brought in the O2 canisters and left them in her room. The NC was still observed unbagged on her sofa, still connected to the running O2 concentrator. During an interview, on 1/24/23 at 12:30 p.m., the Property Administrator (PA) indicated each resident was responsible for their own O2. During an interview, on 1/24/23 at 2:06 p.m., the Wellness Director (WD) indicated Resident 16 came out of her room for her meals in the dining	R 0153	1. Immediate actions taken for those residents identified. a. Resident was placed on hospice and oxygen company changed. Resident how has portable concentrator with 3 back up tanks in metal rack. 2. How the facility identified other residents. a. Only neighboring apartments would be effected incase of disaster with oxygen tank. Problem has been resolved for those 3 possible residents. 3. Measures/systems put in place. a. WD will educate all leadership and clinical staff that any and all oxygen tanks need to be placed in secure locations. 4. How will the corrective action be monitored. a. WD and ED will monitor any current or new resident on oxygen to assure tanks are secured. 5. Due Dates 2/27/23	02/27/2023

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	room. Sometimes, she was unable to attend meals in the dining room because she was out of O2 canisters, she used about one per day. She indicated Resident 16 did not have a small portable oxygen concentrator because they were on back order. The O2 canisters should have been stored in a metal rack. During an interview, on 1/24/23 at 2:30 p.m., the WD indicated the O2 canisters were not secure and should have been in a metal rack to keep them from falling. The way the O2 canisters were now, were not safe. She indicated the O2 company would not come often enough to change them out. The facility should not have so many O2 canisters in the resident's room. During an interview, on 1/24/23 at 3:04 p.m., the Executive Director (ED) indicated, sometimes, the resident was unable to come to meals because she didn't have any O2. He did not know why she didn't have a portable O2 concentrator. Resident 16's family was "stuck" in a contract with the O2 company for 2 years. Regarding the O2 canisters, he indicated, " ...We don't want it, she doesn't need it, it is not safe ...." The ED indicated he had not talked with the O2 supplier about getting canister racks to store the O2 canisters safely. We cannot chain them up and her apartment was across from the beauty salon too. During an interview, on 1/24/23 at 3:33 p.m., a Representative for Oxygen and Medical Equipment indicated Resident 16 was not under any contract with the company and they had portable oxygen concentrators. They would need a physician's order for the resident to receive it. Now, Resident 16 received 25 O2 canisters per month on the fourth Friday. Since she was running out of the large portable O2 canisters			

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	before her next delivery time. They had a couple of options have would have been better for her. A home fill O2 system (a large O2 concentrator that can fill small portable O2 tanks) or a portable O2 concentrator with a pulse dose (smaller, light-weight). There was no information in her record that showed the company received any calls to find out about further options. The Oxygen Representative indicated the O2 canisters she received each month were not liquid O2, but compressed gas. They should have been stored in a cylinder rack because they are under a lot of pressure. They cannot be free standing. If the top of the cylinder would come off, the canister was under enough pressure to go through a wall. On 1/24/23 at 3:55 p.m., Resident 16's record was reviewed. Resident 16's diagnoses included, but were not limited to, hypertension (high blood pressure), osteoporosis (fragile/brittle bones), lung mass, and dementia (progressive loss of intellectual function with memory loss). Her physician's orders included, but were not limited to 2 liters (L) oxygen, dated 8/11/21, record O2 levels twice a day and change oxygen tubing monthly on the 15th, dated 6/15/22. A current policy, titled, Oxygen Safety, Cleaning, and Care," dated 10/17/23, was provided by the Executive Director (ED) on 1/24/23 at 12:40 p.m. A review of the policy indicated, " ...the Caregiver may be assigned to take care of residents who are receiving oxygen and should be familiar with the equipment used and basic safety and comfort measures ...All tanks must be stored upright on an outside wall in a rack provided by the Durable Medical Equipment Company ...."			

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. A. Based on observation, interview and record review, the facility failed to ensure the kitchen was maintained under generally clean and sanitary conditions, the ice machine was in good repair, a reach in refrigerator was free from leaks, and a pest infestation of gnats for 2 of 2 observations. These deficient practices had the potential to effect 80 of 80 residents served from the kitchen. B. Based on observation, interview, and record review, the facility failed to clean a popcorn machine, used for activities for 2 of 2 observations and failed to ensure food was covered when transported on carts from the kitchen, through two long hallways to the dining room for 1 of 1 dining observations. Findings include: A. On 1/24/23 at 9:10 a.m., an initial kitchen tour was conducted with the Kitchen Manager (KM). Upon entrance into the kitchen, several small flying insects were noted near the dish washing area. The KM indicated they were gnats and the staff had been trying to get rid of them for a while, but nothing seemed to help. The dry storage room was to be neat and orderly, however the floors were discolored and sticky. The KM indicated the floors needed to be stripped and rewaxed.	R 0273	1. Immediate actions taken for those residents identified. a. Popcorn machine cleaned, ice machine dumped and cleaned, fridges repaired, walls and shelves, floors and piping have been scrubbed clean and degreased. 2. How the facility identified other residents. a. All residents effected. 3. Measures/systems put in place. a. Cleaning checklists are being utilized along with preventative maintenance plan for equipment. Additional staffing positions for dietary have been opened and posted online to try to hire more help. Current staff's daily responsibilities have been reviewed and adjusted to comply with code. All food items will have lids or be covered when leaving the dining room. 4. How will the corrective action be monitored. a. Daily cleaning checklists will be monitored by executive chef and sous chef, once a sous chef is hired. Executive director will inspect cleaning checklists bi-weekly along with surprise	03/01/2023

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	The tall standing reach-in refrigerator, which was noted to have several bulk size condiments and salad dressing containers, was observed to leak from the ceiling of the fridge so that there was a standing puddle of water at the bottom. The rubber seal of the fridge was ripped and hung lose in disrepair. The internal temperature of the fridge was 52 degrees. The KM indicated this was the first she was aware of the concern as she had been off work for several days so she asked the Dining Room Manager (DRM). The DRM indicated she had noticed the leaking water Sunday evening but had not had a change to pull items out or clean up the since she was filling in for the aids, and trying to keep up in the dining room. On the food preparation line there was a small reach in refrigerator, although there was no food stored in it at that time, it was noted to be littered with spilled shredded cheese strips and other food crumbs. Next to the small refrigerator, there was a metal storage/shelf cabinet. The surface of the shelf was observed to be wet with an unidentified spill, and there was a red bucket with an unidentified dark brown and thick looking substance with what appeared to be a paint scraper. There was other unidentified food crumbs on the shelf. Directly above the cabinet sat the toaster and an open bag of bread as the toaster station was still in use for breakfast service. The KM indicated the area needed to be wiped down, and the bread bag should be closed if left unattended. Behind the deep fryer was a long metal pipe. The pipe was caked over with layers of grease and unidentified debris. Behind the fryer and stove appliances the floors were built up with grease,		audits monthly for perpetuity. 5. Due Dates a. Bi-weekly review from ED for all cleaning checklists, Daily cleaning checklists completed daily, monthly audits TBD. b. Preventative Maintenance schedule and cleaning schedules uploaded as well.	

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	grime and other debris. The KM indicated the kitchen was deep cleaned at least every month, but since they were short staffed, it probably wasn't done as often as it should be. The standing ice machine was observed to have a copious amount of hard water build up in all its edges and seals. There were streaks and stains down both front sides, some streaks were white, others were rust colored. Inside the machine, at the bottom of the plastic lid, which came into contact with ice cubes when the door was lifted, there was a copious amount of buildup of a grey/black and greenish color. The KM indicated the Maintenance Department was responsible for cleaning the ice machine, and the KM had requested that it be cleaned weeks ago but was never completed. In general, the walls and surfaces of the equipment and counters were all observed to have stains, food crumbs or other debris and in need of being wiped down. The KM indicated, since all the servers had been let go, the kitchen staff no longer had the time in-between meal preparation to keep up with some of the smaller daily tasks that the servers had helped complete. In the dish washing area, there were several gnats flying around. The KM indicated they did have a company that came out on a regular basis to spray, they had even put tape strips down and sometimes poured bleach down the drains, but nothing seemed to help. On 1/24/23 at 11:15 a.m., a second kitchen visit was conducted to observe the preparation of a pureed meal. At the back of the kitchen, near the walk in			

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	refrigerator, the KM set up her puree station. Although she prepared the meal with no concerns related to purree, there were several flying insects which surrounded her station. Four were counted on the wall less than 2 feet away from her food preparation. When items were moved on the metal storage shelf several more gnats flew into the air. On 1/24/23 at 1:15 p.m., the KM provided a blank copy of a Weekly Cleaning Schedule. She indicated the items on the sheet were for the cook to complete on a weekly basis, but since she was short staffed and they had lost servers, she did not have time to compete all the tasks between meal services. The KM indicated the servers also used to help with these task and ensure the logs and cleaning During an interview on 1/24/23 at 3:00 p.m., the Administrator (ADM) indicated there was a problem with gnats and general cleaning in the kitchen. Unfortunately, a decision that was out of his hand resulted in the termination of all dietary servers, and staff had been struggling to fill that void. The ADM indicated, he had even needed to go help wash dishes one night and wondered why there were still so many gnats in the middle of January. He indicated part of the problem was that the kitchen needed to be deep cleaned on a more regular schedule, but they just didn't have the staff. During an interview on 1/24/23 at 3:26 p.m., DRM indicated, since all the dietary aide/server positions had been cut it was very difficult to keep up with daily tasks, let alone deep cleaning schedules. For example, she pointed to the main dining room floors, where food crumbs were scattered throughout the dining room. She indicated she needed to vacuum the dining room			

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	before dinner, but she was still busy catching up from lunch and needed to put away clean dishes. On 1/24/23 at 2:45 p.m., the ADM provided a copy of current facility policy titled, "Sanitation Practices: Culinary," revised 1/18/23. The policy indicated, "The license holder or designated person in charge shall inform and educate a new food service worker as the employee health requirements specific in law: 1. Safety of water and ice 2. Condition & cleanliness of food contact surfaces 3. Prevention of cross contamination 4. Maintenance of hand washing/sanitizing 5. Labelling, storage & proper use of toxic compounds 6. Employee health condition 7. Pest control ...." On 1/24/23 at 2:45 p.m., the ADM provided a copy of current facility policy titled, "Mealtime Duty List for the Dietary Aid," revised 6/8/22. The ADM indicated although the policy was still current, there were no longer and Dietary Aids, so these tasks had to be picked up and filled in by everyone else as best as possible. The policy indicated, "The Dietary aide will prepare the satellite kitchens for meal series. This includes filling and turning on the steam tables (breakfast only) soup, armer, refilling the coffee and juice machines, the hydration stations and filling fresh sanitizer buckets for each meal period. The Dietary aide will bring down refrigerate cold items, transport and transfer hot items to steam table for breakfast and transport plated meals down for lunch and dinner. The dietary aid e will provide correct portion utensils for all food items for service as outlined on the meal census log. The Dietary aide will review the resident meal menu choices and the mechanical, purees and any other special diets that have been ordered with the wellness staff prior to meal service. The Dietary			

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	aid will complete all compliance logs, display the menus for the day, display the week at a glance menu including week at a glance for special diets ordered and post meal census for wellness staff to reference during meal periods. The Dietary aide will communicate with the main kitchen via walkie talkie for additional items needed during the meal service. The Dietary aide will go to the main kitchen to retrieve all additional items ordered/needed during meal periods. The Dietary aid will cut food if needed. The Dietary aide is responsible for all product rotation, the dating and labeling of all products and the satellite kitchen sanitation and weekly deep cleaning completion ...." B1. On 1/24/23 at a.m., a large popcorn machine, was observed on the countertop, in the activity area. The glass was covered in grease streaks, popcorn kernels and residue was present in the bottom of the machine, along the edges of the grid area. The corners of the machine had popped corn piled approximately 2 inches deep. The kettle had husks and grease adhered to the metal surface. On 1/24/23 at 10:05 a.m., during an interview, the Activities Assistant 5 indicated he was responsible for cleaning the popcorn machine. He tried to clean it about every other time he used it. It had last been used yesterday. On 1/24/23 at 2:45 p.m.,during a second observation, the popcorn machine was observed in the activity kitchen area. It had been emptied out of popped corn but remained uncleaned, there were a lot of kernels and husks stuck to the kettle and in the bottom of the machine. Glass was covered with grease and oil streaks from top to bottom. On 1/24/23 at 4:40 p.m., the Executive Director			

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		A. BUILDING 00 B. WING	01/24/2023

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	(ED) provided a current policy, dated 9/19 and last reviewed 9/15/22, titled, "Standard Operating Procedure." This policy indicated "The purpose of this policy is to ensure that supplies used by Life Enrichment are properly sanitized and maintained to ensure resident safety...Life Enrichment staff will sanitize activity supplies monthly. Life Enrichment staff are responsible for sanitizing activity supplies monthly and when viably soiled (example: bingo cards/chips. poker chips, pool sticks, bowling balls, volley balls, etc.). Consider doing this more regularly during cold and flu season...." During an interview, on 1/24/23, the ED indicated they did not have a policy specific to the popcorn machine. Life Enrichment was responsible for keeping their equipment clean. B2. On 1/24/23 at 11:54 a.m.,, during a dining observation, in the main dining room, Housekeeper 7 was observed as she brought 8 prepared meals from the kitchen to the dining room on a 3 tier cart. The plates were covered with a clear plastic dome lid. Bowls of Cole slaw, mozzarella and tomato salad, and condiment cups of tarter sauce were not covered. On 1/24/23 at 11:58 a.m., Dishwasher 8 was observed as he left the kitchen with a 3 tier cart which contained 2 meals. The plates were covered with clear plastic dome lids. Individual bowls of Cole slaw, tarter sauce, and mozzarella tomato salad were not covered as he pushed the cart through two long hallways to reach the main dining room. During an interview, on 1/24/23 at 12:05 p.m., Housekeeper 7 indicated she was employed at the facility in the housekeeping department. She was			

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	not a server. All food should have been covered when delivered from the kitchen to the dining room. On 1/24/23 at 4:40 p.m., during an interview, the Executive Director (ED) indicated they did not have a policy for uncovered foods. All foods should have been covered before they left the kitchen, such as a tray of deserts should have a paper cover over the top, especially since the kitchen was so far from the dining room in this building.			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year			

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	of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview, and record review, the facility failed to ensure the kitchen/dining departments were sufficiently staffed to maintain the kitchen and dining room under generally clean and sanitary conditions. This deficient practice had the potential to effect 80 of 80 residents who were served from the kitchen. Findings include: On 1/24/23 at 1:15 p.m., the KM provided a blank copy of a Weekly Cleaning Schedule. She indicated the items on the sheet were for the cook to complete on a weekly basis, but since she was short staffed and they had lost servers, she did not have time to compete all the tasks between meal services. The KM indicated the servers also used to help with those tasks and ensure the logs and cleaning schedules were filled out. During an interview on 1/24/23 at 3:00 p.m., the Administrator (ADM) indicated there was a problem with gnats and general cleaning in the kitchen. Unfortunately, a decision that was out of his hand resulted in the termination of all dietary servers, and staff had been struggling to fill that void. The ADM indicated, he had even needed to go help wash dishes one night and wondered why	R 0274	1. Immediate actions taken for those residents identified. a. Job postings were refreshed and posted online for dishwasher, kitchen assistant manager, sous chef, and cook. These added positions will assist with staying in compliance for staffing. 2. How the facility identified other residents. a. All residents effected. 3. Measures/systems put in place. a. Each meal shift will have one dietary manager, another member of the dietary department or manager, wellness team members as assigned (minimum one per shift) and one leadership team member. Where the additional interdisciplinary team members are absent or insufficiently staffed for the shift, additional dietary team members or leadership team members will support dining services. 4. How will the corrective action be monitored. a. Adequate food service staff	02/28/2023

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	there were still so many gnats in the middle of January. He indicated part of the problem was that the kitchen needed to be deep cleaned on a more regular schedule, but they just didn't have the staff. During an interview on 1/24/23 at 3:26 p.m., the DRM indicated, since all the dietary aide/server positions had been cut it was very difficult to keep up with daily tasks, let alone deep cleaning schedules. For example, she pointed to the main dining room floors, where food crumbs were scattered throughout the dining room. She indicated she needed to vacuum the dining room before dinner, but she was still busy catching up from lunch and needed to put away clean dishes. On 1/24/23 at 9:10 a.m., an initial kitchen tour was conducted with the Kitchen Manager (KM). Upon entrance into the kitchen, several small flying insects were noted near the dish washing area. The KM indicated they were gnats and the staff had been trying to get rid of them for a while, but nothing seemed to help. The tall standing reach-in refrigerator, which was noted to have several bulk size condiments and salad dressing containers, was observed to leak from the ceiling of the fridge so that there was a standing puddle of water at the bottom. The rubber seal of the fridge was ripped and hung lose in disrepair. The internal temperature of the fridge was 52 degrees. The KM indicated this was the first she was aware of the concern as she had been off work for several days, so she asked the Dining Room Manager (DRM). The DRM indicated she had noticed the leaking water Sunday evening but had not had a change to pull items out or clean up since she was filling in for the aids and trying to keep up in the dining room.		shall be on duty to ensure that proper food preparation, serving and sanitation. Executive Chef will control schedule and ensure that each shift is covered by a dietary supervisor. 5. Due Dates a. 2/28/2023	

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	On the food preparation line there was a small reach in refrigerator, although there was no food stored in it at that time, it was noted to be littered with spilled shredded cheese strips and other food crumbs. Next to the small refrigerator, there was a metal storage/shelf cabinet. The surface of the shelf was observed to be wet with an unidentified spill, and there was a red bucket with an unidentified dark brown and thick looking substance with what appeared to be a paint scraper. There were other unidentified food crumbs on the shelf. Directly above the cabinet sat the toaster and an open bag of bread as the toaster station was still in use for breakfast service. The KM indicated the area needed to be wiped down, and the bread bag should be closed if left unattended. Behind the deep fryer was a long metal pipe. The pipe was caked over with layers of grease and unidentified debris. Behind the fryer and stove appliances, the floors were built up with grease, grime and other debris. The KM indicated the kitchen was deep cleaned at least every month, but since they were short staffed, it probably wasn't done as often as it should be. In general, the walls and surfaces of the equipment and counters were all observed to have stains, food crumbs or other debris and in need of being wiped down. The KM indicated, since all the servers had been let go, the kitchen staff no longer had the time in-between meal preparation to keep up with some of the smaller daily tasks that the servers had helped complete. In the dish washing area, there were several gnats flying around. The KM indicated they did have a			

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	company that came out on a regular basis to spray, they had even put tape strips down and sometimes poured bleach down the drains, but nothing seemed to help. On 1/24/23 at 11:15 a.m., a second kitchen visit was conducted to observe the preparation of a pureed meal. At the back of the kitchen, near the walk-in refrigerator, the KM set up her puree station. Although she prepared the meal with no concerns related to puree, there were several flying insects which surrounded her station. 4 were counted on the wall less than 2 feet away from her food preparation. When items were moved on the metal storage shelf several more gnats flew into the air. On 1/24/23 at 2:45 p.m., the ADM provided a copy of current facility policy titled, "Sanitation Practices: Culinary," revised 1/18/23. The policy indicated, "The license holder or designated person in charge shall inform and educate a new food service worker as the employee health requirements specific in law: 1. Safety of water and ice 2. Condition & cleanliness of food contact surfaces 3. Prevention of cross contamination 4. Maintenance of hand washing/sanitizing 5. Labelling, storage & proper use of toxic compounds 6. Employee health condition 7. Pest control ...." On 1/24/23 at 2:45 p.m., the ADM provided a copy of current facility policy titled, "Mealtime Duty List for the Dietary Aid," revised 6/8/22. The ADM indicated although the policy was still current, there were no longer and Dietary Aids, so these tasks had to be picked up and filled in by everyone else as best as possible. The policy indicated, "The Dietary aide will prepare the			

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	satellite kitchens for meal series. This includes filling and turning on the steam tables (breakfast only) soup, armer, refilling the coffee and juice machines, the hydration stations and filling fresh sanitizer buckets for each meal period. The Dietary aide will bring down refrigerate cold items, transport and transfer hot items to steam table for breakfast and transport plated meals down for lunch and dinner. The dietary aid e will provide correct portion utensils for all food items for service as outlined on the meal census log. The Dietary aide will review the resident meal menu choices and the mechanical, purees and any other special diets that have been ordered with the wellness staff prior to meal service. The Dietary aid will complete all compliance logs, display the menus for the day, display the week at a glance menu including week at a glance for special diets ordered and post meal census for wellness staff to reference during meal periods. The Dietary aide will communicate with the main kitchen via walkie talkie for additional items needed during the meal service. The Dietary aide will go to the main kitchen to retrieve all additional items ordered/needed during meal periods. The Dietary aid will cut food if needed. The Dietary aide is responsible for all product rotation, the dating and labeling of all products and the satellite kitchen sanitation and weekly deep cleaning completion ...."			