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	03/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on January 24, 2023. Survey dates: March 23, 2023. Facility number: 012263 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 3, 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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Executive Director	04/16/2023

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

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	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 in-service education and training related to abuse and dementia was provided upon hire for 3 of 5 employees reviewed for employee training. Findings include: On 3/23/23 at 9:30 a.m., the Post Survey Revisit (PSR) was opened during a brief entrance conference with the Executive Director (ED) and Wellness Director (WD). At that time, all plan of correction (POC) documentation was requested. The POC for the Employee in-service training indicated, " ...Audit[s] was[were] completed to identify staff who are delinquent on online trainings and annual compliance trainings for dementia, resident's rights and abuse. Group/team	R 0120	R-120 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 training will commence monthly to ensure all team members are up to date. Self-directed online training will be supplanted by group trainings and copies of tests, training	05/01/2023

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	trainings will commence quarterly to ensure al 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. Initial trainings must be completed prior to working the floor and up to date records will be audited quarterly by property admin team ...." During an interview on 3/23/23 at 11:03 a.m., the ED indicated, he had not made a "traditional" POC binder for the corrections, but all the concerns areas had been addressed by the appropriate department heads and fixed. The WD had been in charge of ensuring employee in-service and training was corrected. On 3/23/23 at 11:35 a.m., three newly hired employees were randomly selected for upon hire in-service training. The Activity Director, (AD) was hired on 1/10/23. He was observed throughout the survey process facilitating activities and decorating and visiting with residents. Cook 6's hire date was not provided, but the WD indicated he was worked for a couple weeks. Cook 6 was observed through out the survey period working in the kitchen on the line and brought food items to the main dining room area as well. Certified Nursing Aid (CNA) 10 was hired on 2/15/23. All 3 employee files lacked documentation that Resident Abuse/Neglect training had been completed upon hire, prior to starting work. Further, all 3 employee files lacked documentation		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 for resident rights, abuse and neglect will be held April 20th, 2023. Annual Dementia will be held one month from initial training. This will get current team members in compliance with annual training.	

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	that 6 hours of dementia training had been initiated, prior to starting work. During an interview on 3/23/23 at 2:55 p.m., the WD indicated, she was unable to located or identify that abuse or dementia training had been completed or initiated. She did not have audits or education schedules as indicated in the POC. This deficiency was cited on 1/24/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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 depend on the risk of infection with			

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	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 tuberculosis (TB) testing or screening was completed and documented in the employee record for 3 of 5 randomly selected employees reviewed for TB. Findings include: On 3/23/23 at 9:30 a.m., the Post Survey Revisit (PSR) was opened during a brief entrance conference with the Executive Director (ED) and Wellness Director (WD). At that time, all Plan of Correction (POC) documentation was requested. The POC for the Employee TB testing indicated, " ...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 ... Property Administrator will obtain all copies of TB tests from Empower HR prior to orientation if completed at an offsite location ... All current and new staff's TB information will be entered into a tracking form to be monitored by Wellness Director (WD) ..."	R 0121	R-121 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 4/15/23. 2. How the facility identified other residents. a. All residents could be affected. 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. Wellness director to maintain master binder in her office with all up to date tests. 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	05/01/2023

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	During an interview on 3/23/23 at 11:03 a.m., the Executive Director indicated, he had not made a "traditional" POC binder for the corrections, but all the concerns areas had been addressed by the appropriate department heads and fixed. The WD had been in charge of ensure employee TB testing was corrected. On 3/23/23 at 11:35 a.m., five employees were randomly selected for TB screening review. On 3/23/23 at 12:45 p.m., the WD provided the five requested employee files as well as three 3-ring binders and a stapled Excel Spreadsheet of Employee TB documentation. At that time the WD indicated additional documentation could also be located in the employee file. The WD had started a binder of TB documentation without knowing the Property Administrator had started a binder as well, and the third binder was from the previous management documentation. Therefore, some items may be missing or duplicated as it remained unorganized. Qualified Medication Aid (QMA) 8 was hired on 3/30/22. Her 1st step PPD was not placed until 5/2/22, 2 months after starting work. There was no evidence of a second step. QMA 9 was hired on 9/23/22. Her 1st step TB test was given on 9/21/22. There was no evidence that the first step had been read, or the second step had been placed. The Activity Director (AD) was hired on 1/10/23. His 1st step TB test was given on 1/2/23 and read on 1/4/23. There was no evidence that a second step had been placed.		WD/RCS. 5. Due Dates a. 5/1/2023 a. All residents in memory care neighborhood were affected.	

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	During an interview on 3/23/23 at 2:55 p.m., the WD indicated QMA 8 had only been given a 1-step upon her hire due to the fact she had documentation of a negative skin test within the last 12 months. The documentation was not on file, but the WD had obtained the documentation and provided a copy. QMA 8's TB test was documented as a "Baseline 1st Step" which was placed on 12/7/21 and read on 12/9/21, however there was no evidence of a second step. The WD indicated the TB test from her previous employer was considered an annual assessment, although the form did not specify such. The WD indicated, similarly, QMA 9 had only been given a 1-step upon her hire due to documentation of a negative skin test within the last 12 months. The documentation was not on file, but the WD had obtained the documentation and provided a copy at that time. The document indicated QMA 9 had received a second step TB test as a new hire on 2/2/22 and was read on 2/5/22. There was no evidence of the 1-step TB test. The WD indicated, she had not been in charge of ensuring the AD received his TB testing, since he did not fall under her responsibility of nursing staff, instead it was the Life Enrichment Department's responsibility to ensure his testing was completed. The WD indicated he received a TB test from a previous employer on 8/12/22 and she provided a copy at that time. There was no evidence of a second step. On 3/23/23 at 3:35 p.m., the ED provided a copy of current facility policy titled, "TB Infection Control Plan," revised 11/22. The policy indicated, " ...The purpose is to provide uniform guidelines for all employees and residents in the community to			

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	maintain infection control measures for tuberculosis, a communicable disease ... 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 (% TU, PPD) ... 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 screen for tuberculosis. The first tuberculosis skin test must be read prior to the employee starting work ...." This deficiency was cited on 1/24/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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. Based on observation, interview, and record review, the facility failed to ensure systemic corrective actions were implemented to maintain the kitchen under clean and sanitary conditions when a broken refrigerator remained in use, reach in refrigerators were not cleaned, standing water on the floors during food preparation, grease build up behind a deep fryer and on the 4-burner stove while in use, and a metal storage rack had not been cleaned for 2 of 2 observations of the kitchen Findings include: On 3/23/23 at 9:30 a.m., the Post Survey Revisit	R 0273	R-273 1. Immediate actions taken for those residents identified. a. Popcorn machine cleaned, ice machine dumped and cleaned, fridges repaired several times yet one continues to leak condensation (repair called in) stand up cooler with melted gasket has been removed from the kitchen, new ice machine is being ordered as well, walls and shelves, floors and piping have been scrubbed clean and degreased. 2. How the facility identified other residents.	06/09/2023

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	(PSR) was opened during a brief entrance conference with the Executive Director (ED) and Wellness Director (WD). At that time, all Plan of Correction (POC) documentation was requested. The POC for the kitchen stated, " ...fridges repaired, walls and shelves, floors and piping have been scrubbed clean and degreased ... Cleaning checklists are being utilized along with preventative maintenance plan for equipment ... Current staff's daily responsibilities have been reviewed and adjusted to comply with code ... Daily cleaning checklists will be monitored by executive chef ... Executive Director will inspect cleaning checklists bi-weekly along with surprise audits monthly for perpetuity ...." On 3/23/23 at 10:15 a.m., an initial kitchen tour was conducted with the Dining Room Manager (DRM), as the Kitchen Manager (KM) was not there. The DRM was observed as she prepared drinks from the reach-in service refrigerator. The seal of the refrigerator was observed to still be in disrepair and the DRM indicated the refrigerator was still leaking and had not been repaired. The KM and/or the Maintenance Director (MD) were supposed to have ordered a part, but that had not been done. The inside of the refrigerator was observed. Although there was no standing water on the bottom shelf, it did appear to be wet, and the DRM indicated water would still puddle up, so she wiped down the shelf as often as she could. Water was observed to trickle down the refrigerator wall on the left panel and dripped from the plastic drainpipe at the top of the unit. A metal, circular vent on the ceiling of the refrigerator was observed to be rusted and covered with debris that blew in the moving air. The DRM indicated it needed to be cleaned but she did not have the tools to remove it. The DRM		a. All residents effected. 3. Measures/systems put in place. a. Cleaning checklists are being utilized by day and evening kitchen staff. New executive chef to start 4/17/23. 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 audits monthly for perpetuity. The Executive Director will keep his sanitation checklist in plan of correction file. 5. Due Dates a. Monthly review from ED for all cleaning checklists. Daily cleaning checklists completed daily, monthly audits done by regional or executive chef. b. Preventative Maintenance is scheduled with maintenance director and executive chef is reminded of said maintenance.	

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	indicated the refrigerator had remained in use since the last survey visit. Items in the refrigerator at this time include but were not limited to, various pitches of beverages, icing, pre-prepared individual pudding cups and cartons of milk. On the food preparation service line, there were two small reach-in refrigerators located under a condiment shelf. Although there was no food stored in the units at that time, it remained littered with food crumbs, shredded cheese bits, and shredded bits of lettuce. The Pipe behind the deep fryer and 4-burner stove was observed. A thick layer of grease build up was observed, and there were several lines of grease that dripped onto the floor. A flattened carboard box was observed on the floor to the left of and behind the fryer. Grease splatter was observed on the cardboard box. There were several standing puddles of water noted throughout the kitchen floor. One puddle was located next to the reach-in service refrigerator, next to a metal storage rack of clean, dry pots and pans. The DRM indicated the water was probably from the leaking refrigerator. There were two additional puddles of standing water over drains which appeared to not drain. There was a blue plastic milk crate under the employee handwashing sink with soiled, wet and discolored towels and rags. Several Gants were noted to fly around the sink. A grated metal storage rack was observed in the back of the kitchen near the walk-in refrigerator. The shelf did not appear to have been cleaned or organized, wiped down or disinfected. When items were moved on the shelves, several Gnats			

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	were noted to fly away from the disturbance. During an interview on 3/23/23 at 10:24 a.m. Cook 6 indicated he had recently been hired. He had been working in the kitchen for a couple weeks but had never been shown a cleaning log or schedule. He had only been instructed to clean up what he could, as he could. During an interview on 3/23/23 at 10:26 a.m., Cook 7 indicated, there were no cleaning schedule, or daily logs which were being filled out, but all the kitchen staff had been directed to clean up at the end of their shift. During an interview on 3/23/23 at 10:50 a.m., the DRM indicated, she did not know where the cleaning logs were, but checked the KM office. There was a clipboard hanging on the wall outside of the office with blank daily logs but dated for the calendar year 2022. The DRM indicated they were old and not used any more. She could not locate any cleaning logs. During an interview on 3/23/23 at 11:03 a.m., the ED indicated, he had not made a "traditional" POC binder for the corrections, but all the concerns areas had been addressed by the appropriate department heads and fixed. The ED indicated he had not kept documentation of his audits, surprise kitchen visits, staff education and/or other related materials. Without documentation of the efforts made to correct the kitchen concerns, the kitchen was observed a second time with the ED on 3/23/23 at 11:05 a.m. The above areas were observed. The ED indicated he did not know the refrigerator had not been repaired, or that the reach-in service refrigerators were not wiped out. He removed the			

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	carboard off the floor from beside the fryer. When he observed the dripping grease from the pipe, the ED indicated they had ensured the pipes were deep cleaned and degreased, but it appeared to have built back up without regular cleaning. The metal storage rack was observed, and the ED indicated it still needed to be wiped down and organized. On 3/23/23 at 3:35 p.m., the ED provided a copy of morning and evening kitchen staff responsibility checklist. The checklist was untitled, and undated. Instructions on the checklist included, but were not limited to, a weekly special task schedule, and additional tasks such as " ... clean all surfaces and equipment on the line with hot soapy water ... lowboy cooler and freezer (doors, gaskets, inside,) ... sweep and mop floor including under equipment ... clean door gaskets on all kitchen refrigerators, clean and polish back wall of cook line, pull out all equipment and clean floors underneath ...." This deficiency was cited on 1/24/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			