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	12/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MONROE PLACE	2770 S ADAMS RD BLOOMINGTON, IN 47403

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December 26 and 27, 2019 Facility number: 004016 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on December 31, 2019.	R 0000		
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			

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

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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	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 ensure 12 fire drills were held during the year of 2019. This had the potential to affect 47 of 47 residents who reside in the facility. Findings include: On 12/26/19 at 11:00 a.m., the interim Administrator provided the facility's fire drills performed in 2019. The facility's fire drill record was reviewed. The record lacked documentation of fire drills being held for 8/2019, 9/2019, and 10/2019. Interview, on 12/26/19 at 11:30 A.M., the interim Administrator indicated fire drills were not held for 3 months of the year. Those months were 8/2019, 9/2019, and 10/2019. On 12/26/19 at 12:00 p.m., the interim Administrator indicated the facility follows the State guidelines for fire drills.	R 0092	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *On 12/27/2019, the Maintenance Technician was re-trained on the requirement for a total of 12 Fire drills in a year that incorporate quarterly drills on different shifts by Assisting Administrator.* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *An audit was completed by Executive Assistant to ensure state required forms and training present on 12/27/2019.* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** *Fire Drills will be provided on various times monthly 2/1/2020.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Maintenance Technician is responsible for sustained compliance by reviewing Fire Drills*	02/01/2020

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			and monitoring to ensure At least twelve (12) drills shall be held every year. *The Executive Director and/or designee will audit Fire Drills weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.* *Monitoring will be ongoing.* **By what date will the systemic changes be completed?** *02/01/2020*	
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 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			

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	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 interview and record review, the facility failed to ensure a specific job orientation related to the duties of which they were hired had been completed for 1 of 5 employees reviewed for specific job orientation. (Licensed Practical Nurse 2) Findings include: Licensed Practical Nurse (LPN) 2's personnel file was reviewed on 12/27/2019 at 10:00 a.m. LPN 2's employment start date was 7/1/2019. The personnel file lacked documentation of a job specific orientation, related to the duties of an LPN, had been provided and completed by LPN 2 upon hire. Interview, on 12/27/2019 at 10:57 a.m., the Administrative Specialist indicated LPN 2 did not have a completed job specific orientation related to the duties of an LPN in her personnel file. On 12/27/2019 at 11:05 a.m., the interim Administrator indicated the facility did not have a	R 0119	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Employee 2 specific orientation, related to the duties of an LPN was completed on and placed in file on 01/14/2020* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** *An audit was completed by Executive Assistant to ensure state required forms and training present on 12/30/2019.* **What measures will be put into place or what systemic**	02/02/2020

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	policy related to having a job specific orientation completed and maintained in the employees' personnel file.		**changes the facility will make to ensure that the deficient practice does not recur.** *The administrative staff will be in serviced by the Executive Director on state required forms and training for employees by 1/14/2020.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Executive Director is responsible for sustained compliance. ED and/or designee will complete employee file audit to determine presence of required forms and training on new employees within 1 week of hire, weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 month. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.* **By what date will the systemic changes be completed?** 02/02/2020	
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			

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	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 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 interview and record review, the facility failed to ensure a newly hired staff member	R 0121	**What corrective action(s) will be accomplished for those**	02/02/2020

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	received a two-step tuberculin (TB) skin test at the time of employment or within one month prior to employment for 1 of 5 newly hired employees (Licensed Practical Nurse 1) and failed to ensure a second step TB test was administered within 1 to 3 weeks after the first step for 1 of 5 newly hired employees. (Licensed Practical Nurse 2) Findings include: 1. Licensed Practical Nurse (LPN) 1's personnel file was reviewed on 12/27/2019 at 9:45 a.m. LPN 1's employment start date was 7/31/2019. The personnel file lacked documentation of a first and second step TB test being given within one month prior or at the time of LPN 1's employment start date. Interview, on 12/27/2019 at 10:47 a.m., the Director of Nursing (DON) indicated LPN 1 did not have the required two-step TB test administered upon hire. 2. Licensed Practical Nurse (LPN) 2's personnel file was reviewed on 12/27/2019 at 10:00 a.m. LPN 2's employment start date was 7/1/2019. The personnel file indicated the first step TB test was administered on 8/2/2019, and read on 8/4/2019. The personnel file lacked documentation of a second step TB test being given within 1 to 3 weeks after the first step was administered. Interview, on 12/27/2019 at 10:58 a.m., the Director of Nursing (DON) indicated LPN 2 did not have the required two-step TB administered on time upon hire and did not have a prior negative TB test within the last year.		**residents found to have been affected by the deficient practice?** *Licensed Practical Nurse (LPN) 1 employee's file was previously audited by Care Service Manager on 11/5/2019 LPN 1 received a first step PPD on 11/11/2019 and read on 11/14/2019 with 0MM results. LPN 1 received a second step PPD on 11/25/2019, and read on 11/27/2019 with 0MM results. Licensed Practical Nurse (LPN) 2 employee's file was previously audited by Care Service Manager on 11/5/2019. LPN 2 received a first step PPD on 11/5/2019 and was read on 11/8/2019 with 0MM results. LPN 2 received a second step PPD on 11/22/2019, and read on 11/25/2019 with 0MM results. Care Services Manager was in-serviced on policy concerning Tuberculosis screening by Regional Director of Care Services on 1/9/2019* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** *On 1/10/2020 and audit of the employee files for completion of TB testing was completed by Care Service Manager. Employee PPDs up to date and in compliance.* **What measures will be put into place or what systemic changes the facility will make**	

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	On 12/27/2019 at 10:30 a.m., the DON provided the facility's policy, "TB [Tuberculosis] Testing" with an effective date of 9/1/2016, with a revised date of 8/22/2017, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... TB testing will be completed per state regulations for ... staff ..."		**to ensure that the deficient practice does not recur.** *Current Nurse Staff to be in-serviced on 1/20/2020 by the Care Services Manager on Tuberculosis screening policy.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Care Services Manager (CSM) is responsible for sustained compliance. The CSM and/or Designee will perform audit of employee records to ensure PPD are provided. Audits will be conducted 5 employee files/week for 4 weeks, then 3x/week for 4 weeks, then 1 weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.* **By what date will the systemic changes be completed?** *02/02/2020*	
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			

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	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 comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure the entry parking area, entry lawn, and central courtyard were kept in clean condition. This had the potential to affect 47 of 47 resident who reside at the facility. Findings include: On 12/26/19 at 10:25 A.M., the facility's entry parking area was observed to be littered with cigarette butts, a partially eaten apple, and discarded examination gloves. The grass lawn area, at the facility's entryway, was littered with cigarette butts. On 12/26/19 at 10:40 A.M., the facility's central courtyard was observed to be littered with cigarette butts, discarded tissues and paper items, and discarded rubber gloves. On 12/27/19 at 9:05 A.M., the facility's entry parking area was observed to be littered with cigarette butts, a partially eaten apple, and discarded examination gloves. The grass lawn area, at the facility's entryway, was littered with cigarette butts. On 12/27/19 at 9:15 A.M., the facility's central courtyard was observed to be littered with	R 0148	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *On 12/27/2019 the Maintenance Technician was in-serviced concerning sanitation responsibilities including grounds keeping by Assisting Administrator.* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *On 12/27/2019 The Maintenance Technician (MT) removed all visible liter from parking area, front entryway, and both courtyards.* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** *On 1/7/2019 the current Staff was*	02/01/2020

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	cigarette butts, discarded tissues and paper items, and discarded rubber gloves. During an interview, on 12/27/19 at 10:00 A.M., Resident 8 indicated the central courtyard area was littered with cigarette butts and discarded tissue papers. This was displeasing to her. During an interview, on 12/27/19 at 10:15 A.M., the facility interim Administrator indicated the facility's entry parking area was littered with cigarette butts, a partially eaten apple, and discarded examination gloves. The grass lawn area, at the facility's entryway, was littered with cigarette butts, and the facility's central courtyard was littered with cigarette butts, discarded tissues and paper items, and discarded rubber gloves.		*in-service on the by Care Service Manager (CSM) on responsibilities of picking up trash and monitoring of residents in the courtyards. On 1/10/2020.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Maintenance Technician is responsible for sustained compliance by cleaning liter from all grounds on each working day. The Executive Director and/or designee will audit grounds weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.* ***By what date will the systemic changes be completed**?* *02/01/2020*	
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 staff labeled and stored food in a sanitary manner for 1 of 1 kitchen. This had the potential to affect 47 of 47 residents who reside in the facility.	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	02/02/2020

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	Findings include: During a kitchen tour, on 12/26/19 at 11:00 a.m., the following was observed: 1. Two large ice cream containers were observed to be opened without indication of an open date. 2. Two large plastic bags of frozen cinnamon rolls and frozen chocolate chip cookie dough were observed opened, without indication of an open date and expiration date. Interview, at that time, the Assistant Chief indicated the age of the cinnamon rolls and cookie dough could not be determined without a expiration date. 3. Three pudding desserts were observed in the reach-in refrigerator without indication of preparation date. The Assistant Chief indicated there should be a label on each dessert. On 12/27/19 at 12:30 p.m., the Administrator provided the facility's policy, "Leftovers and Prepared foods," dated 4/17/17, and indicated it was the policy currently being used. A review of the policy indicated, "... food is to be frozen ... place in an airtight container, and label and date before freezing ..." On 12/30/16 at 12:34 p.m., a review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT MANUAL: 410 IAC 7-24-191," dated November 13, 2004, indicated, "... refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day		*Immediately upon finding the two large undated ice cream containers, two undated plastic bags of frozen cinnamon rolls and frozen chocolate chip cookie dough, and three undated pudding desserts were disposed of on 12/26/2019.* **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** *On 12/27/2019 an audit was conducted to ensure all items were dated and stored appropriately. Any found missing or out of compliance were immediately disposed.* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** *On 1/27/2019, the Assisting Administrator trained the Assistant Chef Regarding the requirements for food labeling and storage of foods to ensure safe sanitary conditions.* *On 1/27/2019 the Executive Director in serviced the Dietary Manager and assisted in re-training the dining staff on the requirements for labeling and storage of foods to ensure safe sanitary conditions.*	

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	by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in subsection (a) and: (1) the day the original container is opened in the retail food establishment shall be counted as day one (1); and (2) the day or date marked by the retail food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety ..."		*0n 1/14/2019 Dietary is receiving additional training by the Senior Director of Dining.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** *The Dietary Manager is responsible for sustained compliance. The Executive Director and/or designee with monitor kitchen for labeling of open food products 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks. Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months.* **By what date will the systemic changes be completed?** 02/02/2020	