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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST CHARLESTOWN, IN 47111

(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 the Investigation of Complaint IN00423990. Complaint IN00423990 - State deficiency related to the allegation is cited at R0145. Survey dates: February 5 and 7, 2024 Facility number: 012007 Residential Census: 83 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 12, 2024.	R 0000		
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, interview, and record review, the facility failed to ensure that equipment was maintained in a safe and operational condition for 1 of 3 call pendents observed in use for active function of calls for assistance. (Resident B) Findings include: During an observation on 2/7/24 at 8:55, Resident H wheeled her wheelchair upto the nurse. The resident indicated her pendent had been going off for a while and no one came to help her. At 8:55	R 0145	1. Resident's pendant was immediately inspected and verified all settings in the nurse call computer were correct and re-saved. The pendent was retested and verified it was a fully functioning pendant once it was identified it had malfunctioned. 2.) A complete whole community audit was completed on 2/13/2024 and assured that every resident had a fully functioning pendant and was able to call for assistance. 3.) All licensed nursing staff	03/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richard Pedersen	Executive Director	02/22/2024

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	a.m., LPN 4 asked the resident to see her pendent. The pendent was flashing a red light to indicate the button for assistance was pushed. The LPN indicated she had not received a call on her radio that the resident needed help. She reset the pendent and checked her radio and ensured it was on. At 8:56 a.m., the pendent was re-pushed to trigger for help and the resident went back to her room. At 9:05 a.m., CNA 5 walked up the hallway towards LPN 4 and did not mention or indicate her awareness of the resident's pendent alarm. At 9:14 a.m., the LPN collected the resident's pendent (that was still flashing red) and walked to the nurses station to see if the pendent was working. At 9:15 a.m., CNAs 2 and 5 were by the nurses station. The two CNAs indicated they were not alerted of the resident's pendent alarm. The computer screen was checked in the nurses station and the resident's name was not indicating the resident's pendent was alerting. The nursing staff indicated the resident's call was never received. During an observation on 2/7/24 at 9:19 a.m., Resident H's pendent was checked and it was not working. The DON indicated that they have had problems with the pendents. Some of the pendents had been recalled. There use to be call cords in the residents' livingrooms, but they were removed. They have been having problems with the system for 5 months. They do not know witch ones are malfunctioning until the system stopes. There was a glitch and certain ones were recalled, they do not know which ones until they stop working. There was no back up plan prior to a pendent failure. She has seen it happen a few times. During an interview on 2/7/24 at 9:22 a.m., the ADON (assistant director of nursing) indicated		educated that residents should be encouraged to leave pendent at community when they leave for any medical appointments. All licensed nursing staff educated pendants need to be checked for functionality including signal received at pager and nurse call computer and documented with readmission note on all readmissions. Maintenance Director/Designee will check the nurse call system for maintenance alerts 5x/week for 2 weeks, 3x/week for 4 weeks, 2x/ week on going to assure every device is operational. Any variance would be immediately addressed. Maintenance will test 25% of all pendants each quarter to ensure pendants are working properly. QAPI committee will review determine need for continuing audits. 4.) ED or designee to verify nurse call system has been checked for maintenance alerts 5/week for 2 weeks, 3x/week for 4 weeks, 2x/ week on going. QA committee to monitor ongoing nurse call device audits. Nurse administration to review all readmission notes to ensure pendent documentation is included.	

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	Resident H had just returned two days ago from a long stay away. She figured the resident's pendent quite working due to her being out of the facility for a long time. They had noticed problems after a resident had left the facility and after returning. They have had a huge recall on the residents' pendents. During an interview on 2/7/24 at 10:52 a.m., Resident F indicated his alert pendent did not work when he needed assistance. CNA 2 indicated Resident F's pendent did not work after the batteries were replaced. In the last four months there were at least four other residents that had pendents that failed to work after the batteries were replaced. Only three of the residents still resided in the facility. During an interview on 2/7/24 at 10:55 a.m., Resident E indicated she had fallen about a month ago and did not have her pendent. At the time of her fall, her pendent had been returned to the company due to prior occurrence of it no working. The call cord had been removed from her livingroom when they received the call pendents. She had fallen in the livingroom/kitchen area. She started yelling and no one came, so she was able to get help by working her way over to the door and yelling for help. During an interview on 2/7/24 at 10:59 a.m., LPN (licensed practical nurse) 3 indicated the new call system was very "finicky" the parts are not quality. The pendent normally worked on the screen, the facility had been working on fixing the screen. Related to Resident H, the resident's pendent needed to be demagnetized and reactivated since she had been out of the facility for a long period.			

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	During an interview on 2/7/24 at 11:02 a.m., the DON (director of nursing) indicated the facility had been doing safety checks on residents with a history of falls when they knew the pendent was not working. The replacement pendents only come in after the facility sends in the malfunctioning system. The call lights from the residents' livingrooms were pulled when the new system was in place months ago. During an interview on 2/7/24 at 1:16 p.m., the Administrator indicated if the pendent was not working indicated it was the staffs responsible for ensure pendants were reset after the resident returned from to the facility. After being out for long periods. The administrator indicated he has been working with the company and most of the pendants had product failure and there had currently been 21 of them sent back and his maintenance man has left to go pick them up. The only rhyme or reason has been when the batteries were replaced. This deficiency relates to Complaint IN00423990.			