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	01/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK AT LUTHERWOODS	1301 N RITTER AVE INDIANAPOLIS, IN 46219

(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 State Residential Licensure Survey. Survey Dates: January 13 and 14, 2020 Facility Number: 011587 Residential: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 21, 2020	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number			

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

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	published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation and interview, the facility failed to post the results of the most recent annual survey of the facility conducted by state surveyors in a place readily accessible to the residents or to any member of the public for 90 of 90 residents. Findings include: An observation was made on 1/13/2020 at 3:29 p.m., of a sign located on a windowsill in the front lobby that stated, "Indiana State Department of	R 0090	**We would like to request paper compliance for all deficiencies.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All Department Managers to be in-serviced on the ISDH regulation regarding the location of the Health Survey Binder by	02/04/2020

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	Health Survey results are located in binder in the windowsill in the Front Lobby". The survey binder was not available on any windowsill in the front lobby. On 1/14/2020 at 10:13 a.m., an observation was made that the survey binder was not located on any windowsill in the front lobby. An interview conducted on 1/14/2020 at 10:13 a.m., with Guest Relations, who is stationed the front desk in the main lobby, indicated she was unaware of where the state survey results binder was located in the facility. An interview was conducted on 1/14/2020 at 10:17 a.m., with the Executive Director (ED). During the interview, the ED located the state survey results binder on a file cabinet behind the guest relations desk. The ED indicated she was aware a sign in the front lobby stated the survey result binder should be located on the windowsill and not behind the front desk.		02.04.2020 **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The Business Office Manager/Designee will be responsible for ensuring the Survey Binder is available in the lobby at all times. Business Office Manager/Designees will be in-serviced by 02.04.20. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and-by what date the systemic changes will be completed.** A CQI Tool will be used to assure compliance is met. The CQI Tool will be implemented beginning 02.04.20, daily x 5 days; weekly x 4 weeks; then monthly until compliance is maintained at 100% for six consecutive months by the	

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			Executive Director and/or Business Office Manager.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly on each shift for 90 of 90 residents. Findings include: The fire drill logs for the first, second, third and fourth quarters of 2019 were reviewed on 1/13/2020 at 2:01 p.m. The facility conducted fire drills as follows:	R 0092	**We would like to request paper compliance for all deficiencies.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The new Maintenance Supervisor was educated on Fire Drills on	02/04/2020

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	1st quarter: shift 1--3/18/19 shift 2--2/25/19 Shift 3--2/26/19 2nd quarter shift 1-none shift 2-none shift 3-none 3rd quarter shift 1--7/25/19 shift 2--7/29/19 Shift 3--7/24/19 4th quarter shift 1--11/22/19 shift 2--11/22/19 Shift 3--10/31/19 There was no documentation in the fire drill log of drills being conducted on any shift during the second quarter of 2019. During an interview on 1/13/2020 at 2:13 p.m., the Executive Director (ED) indicated fire drills should have been conducted on each shift during the second quarter of 2019. During an interview on 1/14/2020 at 10:40 a.m., the ED indicated the Maintenance Director for the facility just resigned. An interview with the Maintenance Director regarding the lack of fire drills for the second quarter of 2019 could not be conducted.		1/29/2020. Fire Drills are to be conducted at a minimum of Quarterly for each shift and Fire Drill Logs maintained. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents have the potential to be affected. F**ire Drills will be conducted each shift by 1.31.20. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The Executive Director/Maintenance Director will be responsible for ensuring Fire Drills are conducted at a minimum of Quarterly for each shift with Fire Drill Log maintained **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed?** A CQI tool will be initialed by 01.31.2020. The CQI Tool will be completed monthly for six months until a threshold of 100% is met.	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure daily weights were obtained and a psych consult was conducted timely as ordered for 1 of 5 residents reviewed. (Resident 54) Findings include: 1. The clinical record for Resident 54 was reviewed on 1/13/20 at 2:30 p.m. The diagnosis for Resident 54 included, but was not limited to, atrial fibrillation. A physician ordered dated 10/14/19 indicated 20 milligrams of lasix was to be administered to Resident 54 daily. Staff was to obtain her weight daily and notify the physician of weight loss of greater than 10 pounds. The November 2019 weight flow sheet indicated Resident 54's weight had not been obtained on 11/21/19 and 11/30/19. The December 2019 weight flow sheet indicated Resident 54's weight had not been obtained on 12/1/19, 12/23/19, and 12/29/19. An interview was conducted with Qualified Nursing Aide (QMA) 5 on 1/14/20 at 8:57 a.m. She indicated the daily weights are obtained daily for Resident 54 and documented on the weight flow sheet. Resident 54's weights on 11/21/19, 11/30/19, 12/1/19, 12/23/19 and 12/29/19 were missed. 2. A physician order dated 11/22/19 indicated Resident 54 was to have a psych consultation.	R 0240	**We would like to request paper compliance for all deficiencies.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? One resident was affected by this deficient practice, MD and family are aware and no new orders received from MD, no adverse affected noted **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Director of Nursing reviewed all charts by 01.30.2020 of residents with physician orders for daily weights and psych services to ensure accordance with physicians orders **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Licensed nurses will be educated regarding telephone orders/physician orders including but not limited to daily weight orders and psych services	02/04/2020

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	The refusal of psych services for Resident 54 dated 12/2/19 indicated "...Resident not interested in service at this time. Clinician will attempt to meet with resident at a later time..." An initial psych assessment dated 1/10/20 indicated Resident 54 was seen and evaluated. Resident 54 reported concerns of "depression, anxiety and adjusting to current phase in life...Active Signs & Symptoms..Anxious, Depressed, Grief, Overwhelmed...Behaviors: isolating..Summary: Resident (54) is alert and oriented with ability make wants and needs known...She reports struggling to adjust to current phase in life such as losing her independence and several close friends. Resident is making an effort to make new friends at facility but would like to receive services to reduce anxiety and adjust to current phase in life.." An interview was conducted with Clinical Services Support (CSS) 4 on 1/14/19 at 11:00 a.m. She indicated psych had attempted to see Resident 54 in December. Resident 54 goes out a lot with family, so was not seen at that time. An interview was conducted CSS 3 on 1/14/20 at 11:46 a.m. She indicated Resident 54's initial assessment was conducted on 1/10/20. She had not been seen by psych prior to 1/10/20 per the psych LSW (license social worker) phone interview. CSS 3 indicated when a psych consultation was ordered for a resident, the turnaround was normally within a couple of weeks to be seen. A physician order policy was provided on 1/14/20 at 1109 a.m., by the CSS 4. It indicated "...Policy: Orders from physicians are used to communicate		by 02.04.2020 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed:** A CQI Tool will be initiated by 02.04.2020, to be completed weekly x 4 weeks; bi-monthly x 2 months; then quarterly for 2 consecutive quarters by the Director of Nursing/Designee until threshold of 100% is met.	

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	instructions required to supervise and maintain a resident's health. The nurse is responsible to contact the physician for resident orders and will document orders received on appropriate order form. The Community is responsible for ensuring each resident receives his or her medication according to the doctor's orders and has documented in the Resident record. Physicians orders may also include, but are not limited to, medication orders , diagnosis, vital signs, precautions, laboratory/diagnostic orders, transfer/discharge orders..." 410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.			
R 0272 Bldg. 00	Based on observation, interview, and record review, the facility failed to serve food from the salad bar at a safe and appropriate temperature with the potential to affect 90 of 90 residents in the facility. Findings include: A tour of the kitchen was conducted on 1/13/20 at 11:35 a.m. During the tour and lunch service, the CM (Culinary Manager) retrieved cold food temperatures from the salad bar in the dining room. The coleslaw temperature was 46 degrees Fahrenheit. The cottage cheese temperature was 50 degrees Fahrenheit. After retrieving the coleslaw and cottage cheese temperatures, Server 2 scooped 2 bowls of coleslaw from the salad bar and served one to Resident 14 and one to Resident 74. An interview was conducted with the CM prior to and after retrieving the salad bar food temperatures. He indicated the salad bar remained	R 0272	**We would like to request paper compliance for all deficiencies.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident number 14 and 74 were affected by this alleged practice, no adverse affects noted. On 1.13.20, at time of deficiency the cottage cheese and coleslaw were removed from the salad bar and were not served. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to	02/04/2020

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	in the dining room between the hours of 10:00 a.m. and 5:30 p.m. They put lids over the food on the salad bar between meals. The salad bar itself was a refrigerated unit, and they retrieved temperatures from the salad bar thermometer twice daily, but not individual foods on the salad bar. The Food Temperature policy was provided by the CM on 1/13/20 at 2:16 p.m. It read, "The facility will prepare and serve food at the proper temperature to prevent food borne illness....Hot foods that are potentially hazardous will leave the kitchen (or steam table) at or above 135 [symbol for degrees] F [Fahrenheit] and cold foods at or below 41 [symbol for degrees] F....Cold food will be held at or below 41 [symbol for degrees] F. If cold food temperature is not maintained, food item will need to be chilled to [symbol for less than or equal to] 41 [symbol for degrees] F before serving."		be affected by the alleged deficient practice, culinary manager was immediately reeducated on appropriate food holding temperatures. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All culinary staff were in-serviced by 1.28.20 on food temperatures, including but not limited to appropriate food holding temperatures and recording. Culinary Manager/Designee will be responsible for monitoring food temp log to assure food safety policy is followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed:** A CQI Tool will be implemented beginning 02.04.20, to be completed 5 days a week x 2 weeks;then weekly x 4 weeks; then monthly until threshold of 100% compliance is maintained for 6 consecutive months.	

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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. Based on observation, interview, and record review, the facility failed to ensure food was stored properly in the dry storage area of the kitchen with the potential to affect 90 of 90 residents in the facility. Findings include: A tour of the kitchen was conducted on 1/13/20 at 11:35 a.m. During the tour, the dry storage room was observed. The flour bin had a scoop inside, resting directly on top of the flour. The oatmeal bin was not covered, open, exposed to air, and not in use. An interview was conducted with the CM (Culinary Manager) during the tour, in the dry storage room. He removed the scoop from the flour bin and closed the lid to the oatmeal bin. He indicated he forgot to close the lid to the oatmeal bin and thought as long as the scoop had a handle, it could be stored inside of the flour bin. The Food Storage Policy was provided by the CM on 1/13/20 at 1:26 p.m. It read, "Individual scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not stored in the food containers, but may be kept covered in a protected area near the containers....Containers with covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods."	R 0273	**We would like to request paper compliance for all deficiencies.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The scoop was immediately removed from the flour bin, no other scoops noted in any other bins. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected, the culinary manager was immediately educated on storage policy. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All culinary staff reeducated/in-serviced by 01.28.20 on food storage including but not limited to appropriate food handling/storage. Culinary	02/04/2020

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			Manager/Designee will be responsible for auditing food bins/scoops for proper storage **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed:** A CQI Tool will be implemented starting 02.04.20, to be completed 5 days a week x 2 weeks; then weekly x 4 weeks; then monthly until threshold of 100% compliance is maintained for 6 consecutive months.	