PRINTED: 09/16/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			08/10/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				8809 M	ADISON AVENUE		
CRESTWOOD VILLAGE SOUTH APARTMENTS LLC			INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
			R 00	000	The Plan of Correction is neith	er	
		State Residential Licensure			an agreement with nor an		
	-	ncluded the Investigation of			admission of wrong doing by the		
	Complaint IN00357	140.			facility or its staff members. Rather, it is submitted for		
	Complaint INIO0257	146 - Unsubstantiated due to			•		
	lack of evidence.	140 - Onsubstantiated due to			compliance purposes. This facility alleges substantial		
	Survey dates: August 9 and 10, 2021 Facility number: 013367 Residential Census: 77 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review completed on August 11, 2021.				compliance with this plan of		
					correction as of August 23,202	1	
					and requests paper compliance		
					for this survey.	o .	
R 0273	410 IAC 16.2-5-5.1(f)						
	Food and Nutritional Services - Deficiency						
Bldg. 00	• • • • • • • •	ation and serving areas					
	(excluding areas in	n residents ' units) are					
		ordance with state and					
		d safe food handling					
	standards, includir	ng 410 IAC 7-24.					
	B 1 1 1 1		R 02	273	All dining staff preparing food w	Will	08/22/2021
		on, interview, and record			wear a hair covering.		
	-	failed to ensure dietary staff's			All dining staff with facial hair v		
		prevent exposure to food This had the potential to			prepare food will wear beard n	eis.	
		-			Any resident eating in the dinir	na	
	affect 77 of 77 residents residing in the facility who received food from the kitchen.				room had the potential to be		
who received food from the kitchen.		Tom the Riterion.			affected.		
	Findings include: On 8/9/21 from 10:00 a.m. to 10:35 a.m.,				anosta.		
					Beard nets were ordered immediately.		
					-		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED				
ANDILAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			B. WING		08/10/2021		
			D. 11			00/10/	2021	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
			8809 MADISON AVENUE					
CRESTWOOD VILLAGE SOUTH APARTMENTS LLC				INDIAN	APOLIS, IN 46227			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	· ·	y Manager (DM) in the						
		ation area where the breakfast			Use of hair covering and bear	d		
		d at the steam table and was		nets will be monitored by observation according to the				
		nrough out the kitchen area.						
		ial mask that covered the nose			following schedule: Observed			
		e DM had facial hair,			daily for the next 3 weeks. The			
		½ inch in length, located in he edge of the mask and			observed 3 times a week for the following 3 weeks. Finally, periodic observations at least once a week for the next month.			
		The DM's facial hair was						
	observed to not be o							
	33321.04 10 1101 00 0				and a monitor allo note mon			
	On 8/9/21 from 10:00 a.m. to 10:35 a.m.,				The final observation will be			
		rvices 1 in the kitchen food			completed by October 31, 202	1.		
	preparation area wh	ere the breakfast meal was						
	being held at the steam table and where soup was							
	being prepared for t	he noon meal, and was						
	walking through ou	t the kitchen area. Dining						
	Services 1 was wear	ring a baseball cap and had						
	-	, 3 inches in length, hanging						
	below the baseball cap. Dining Services 1's							
	loose hairs were observed to not be covered.							
	0.000016 10.15							
	On 8/9/21 from 10:15 a.m. to 10:35 a.m., observed Dining Services 2 in the kitchen food							
	~							
	preparation area where the breakfast meal was being held at the steam table and where soup was							
	being prepared for the noon meal, and was							
	walking through out the kitchen area. Dining							
	Services 2 had waist length braided hair. Dining							
	Services 2's hair was observed to not be covered.							
		15 a.m. to 10:35 a.m.,						
	_	rvices 3 walking through out						
		luding the food preparation						
	_	s being prepared for the noon						
	meal and he was observed plating the noon meal. Dining Services 3's hair was observed to not be covered. On 8/9/21 from 12:55 p.m. to 1:05 p.m.,							
	0.71 110111 120							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	<u>00</u>	COMPLETED 08/10/2021				
NAME OF PROVIDER OR SUPPLIER CRESTWOOD VILLAGE SOUTH APARTMENTS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8809 MADISON AVENUE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	the following day's in Services 4 wore a far nose and mouth area facial hair, approxin located in front of the mask and under the was observed to have at the neckline that we below the donned has facial hair and loose be covered. On 8/9/21 from 12:5 observed Dining Set the kitchen and food noon meal was being wore a facial mask to mouth area. Dining approximately 1 ½ if front of the ears to the Services 5's facial has covered. On 8/9/21 from 12:5 observed the DM in area where the soup following day's mean meal was being plat mask that covered the DM had facial hair, length, located in fronthe mask and under facial hair was observed. During an interview Administrator indicator.	rvices 5 walking through out I preparation area where the g plated. Dining Services 5 hat covered the nose and Services 5 had facial hair, nches in length, located in the edge of the mask. Dining air was observed to not be						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED			
			B. WI	NG		08/10/2021			
							-		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE				
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CRESTWOOD VILLAGE SOUTH APARTMENTS LLC				INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO		E COMPLETION			
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	DM indicated all k	tchen staff's hair was to be							
	covered while in th	e kitchen and all residents							
	residing in the facil	ity received food items from							
	the kitchen.								
	On 8/9/21 at 10:40	a.m., the DM provided an							
	updated copy of the Effectiveness of Hair								
	Restraint policy and indicated it was the current								
	policy in use by the facility. A review of the								
	policy indicated, "food employees shall wear								
	hair restraints, such as hats, hair coverings or								
	nets, beard restraintsthat cover body hair that								
	are designed and worn to effectively keep their								
	hair from contactingexposed food"								
	On 8/9/21 at 2:00	p.m., a review of the Indiana							
	Food Establishment Sanitation Requirements,								
Title 410 IAC 7-24, effective November 13,									
2004, indicated, "food employees shall wear									
hair restraints, such as hats, hair coverings or									
	nets, beard restraintsthat are designed and worn								
	to effectively keep their hair from								
contactingexposed food"									

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