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	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT SOLANA	7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240

(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. This visit included the Investigation of Complaints IN00374250 and IN00387209. Complaint IN00374250 - Substantiated. State deficiencies related to the allegations are cited at R0052. Complaint IN00387209 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 5, 6, 7, and 8, 2022 Facility number: 013164 Residential Census: 105 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on December 12, 2022.	R 0000	This Plan of Correction is submitted as required under Federal and State regulations and statues applicable to assisted living 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 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect a resident with a traumatic brain injury from neglect when the resident left the facility, without staff knowledge, and was out of the facility for 16-20 minutes for 1 of 3 residents	R 0052	It is the practice of this facility to always prevent resident elopement from facility. All residents have the potential to be affected; however, there was no	01/06/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Glidden	Executive Director	12/26/2022

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	reviewed for neglect. (Resident B) Resident B was found off the facility premises, by a staff member, and returned via a personal vehicle. Finding includes: During an observation, on December 07, 2022 at 1:47 p.m., it was noted the facility was located 0.3 miles off Keystone Avenue. Keystone Avenue had a speed limit of 45 miles per hour and the street to enter the facility premises had four (4) lanes of traffic: 2 heading north and 2 heading south. Access to the facility was found at the back of the independent living cottage neighborhood. A document, titled "Indiana State Department of Health Survey Report System," dated 04/09/22, indicated "...Resident...followed another resident outside via front door...resident easily redirected back into community. Resident assessed...Initiated investigation...." The record for Resident B was review on 12/07/22 at 10:44 a.m. Diagnoses included, but were not limited to, traumatic brain injury, anxiety, and intracranial hemorrhage (bleeding inside the skull). A facility document, titled "Traditions at Solana-Verification of Incident Investigation/Administrative Summary," indicated "...res (resident) followed another res outside...Date of Incident 4/9/22...Reviewed security footage, Resident followed another resident out of the building. Per security footage resident was out of the building between 16-20 mins (minutes). Nursing saw res off premises and returned him to building safely...." The form was signed by the former Executive Director and there was no date provided on the date line by the		actual harm to none. In-servicing will be completed with staff concerning elopement. An Elopement risk of all AL residents will be assessed by Wellness Director/Designee. Elopement Risk assessments will be monitored by Administrator/Designee. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for 5 months, on-going thereafter and taken at QA monthly for review.	

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	signature. There were no staff interviews included in the investigation to provide information as to where the resident was found or who found the resident. During a telephone interview, on 12/7/22 at 10:57 a.m., the guardian/POA (Power of Attorney) for Resident B indicated he was notified Resident B had gotten out of the facility and was located on Keystone Avenue (0.3 miles from the facility) by a staff member. The staff member returned the resident to the facility in their personal vehicle. It happened on a weekend and the usual staff (which worked during the week) were not in the facility, it was the weekend staff. Usually, the receptionist kept an eye on the resident, but the weekend staff were not familiar with the resident, and he could "present himself well" and was able to exit the facility. The resident had a traumatic brain injury, and he did not make good choices/decisions. During an interview, on 12/07/22 at 11:25 a.m., the Director of Nursing indicated he was not sure how far the resident went. He was off the facility premises but was not sure if it was where the parking lot ends or where the housing edition ends. He would provide a phone number of an employee with more information. During a telephone interview, on 12/07/22 at 2:55 p.m., LPN 4 indicated she was no longer employed at the facility, but she was the weekend supervisor when Resident B eloped from the facility. She indicated she could not remember exactly what happened, but the resident did get out of the facility and from the text messages with the DON, a family member was on the way to the facility. She was at the front desk. She did not find him or bring him back to facility. She indicated the			

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	Director of Nursing had the information. During an interview, on 12/07/22 at 3:33 p.m., the Director of Nursing indicated LPN 4 was in communication with him when Resident B eloped out of the facility. He was told "they brought him back "and thought it was LPN 4 which returned the resident. He was informed the resident was off the premises, but she was the supervisor and he thought she would have the information of who found the resident, where the resident was found, and who brought the resident back to the facility. A facility policy, titled "Resident Rights," dated as revised in February 2022 and provided by the Regional Clinical Nurse on 12/08/22 at 11:59 a.m., indicated "...Residents have the right to be free from...neglect...." This State Finding relates to Complaint IN00374250.			
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			

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	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 interview and record review, the facility failed to conduct monthly fire drills for 2 of 12 months (December 2021 and November 2022) and to provide documentation to show the fire department had been invited or involved in the fire dills every six months (March 2022) for the 12-month review of fire drills. Finding includes: The fire drills for the past 12 months were reviewed on 12/06/22. There was no documentation provided to show the facility had conducted a fire drill in December 2021 or November 2022. There was also no documentation to show the fire department had been invited to participate in a fire drill in March of 2022. During an interview, on 12/06/22 at 10:17 a.m., the Executive Director indicated the fire department was not invited in March 2022 and there were no fire drills held in December of 2021 or November of 2022. She did not know why. During an interview, on 12/06/22 at 10:32 a.m., the Maintenance Director indicated fire drills were to be completed monthly and each shift should be done 4 times a year. The policy addressing fire dills was requested. The facility was not able to provide a policy.	R 0092	It is the practice of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. All residents have the potential to be affected; however, there was no actual harm to none. In-servicing will be completed with the Maintenance Director on frequency of and varying times of fire drills. As well as inviting the local fire department twice per year to participate in the fire drills. Times of fire drills will be monitored by Administrator or designee for 6 months and taken to QA monthly for review.	01/06/2023

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	During an interview, on 12/08/22 at 9:56 a.m., the Regional Clinical Nurse indicated the facility followed the state regulations addressing fire drills.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure an accurate and complete background check was completed for 1 of 3 new employees reviewed for employee records. (The Memory Care Director) Finding includes: The employee records were reviewed on 12/06/22 beginning at 4:00 p.m. The Memory Care Director was hired on 8/04/22. The facility provided a document from the Indiana State Police. The document, dated 12/05/2022, for the Memory Care Director, indicated "...INCONCLUSIVE RESULTS-FINGERPRINT RECOMMENDED...Your Limited Criminal History Report cannot be delivered...The information provided...delivered inconclusive results...." During an interview, on 12/07/22 at 12:10 p.m., the Regional Clinical Nurse indicated the facility followed state regulations related to background checks. The Memory Care Director should have been fingerprinted to get a complete background	R 0116	It is the practice of this facility to run Indiana State Police Repository on each employee. The Memory Care Director is no longer employed with our company. All residents have the potential to be affected; however, there was no actual harm to none. In-servicing will be completed with the business office manager regarding the practice of running background checks before hiring an employee. A complete employee audit has been conducted with no issues found. A Quality Assurance tool has been developed and implemented to monitor new employee files to ensure that each employee's personnel file contains an acceptable criminal background check which has been completed by the Indiana State Police Repository. This tool will be	01/06/2023

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	report. A facility policy, titled "Resident Neglect, Abuse and Misappropriation of Property," dated as revised in February 2022 and provided by the Corporate Support Nurse on 12/08/22 at 10:11 a.m., indicated "...Employment screening is done on all potential employees to assure that the community does not employ individuals...Who have been found guilty of crimes against a dependent population in a court of law, which includes abuse, neglect, or mistreating residents...."		completed by the Administrator and/or their designee weekly for four weeks, then monthly for 5 months and taken to QA monthly for review.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			

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	Based on record review and interview, the facility failed to ensure each shift was cover with staff certified in first aid for 2 of 21 shifts reviewed for first aid coverage. (December 3 and 4, 2022) Finding include: The employee CPR and First Aid records and staffing schedule for November 28 to December 05, 2022, were reviewed on 12/06/22 beginning at 4:00 p.m. The facility was found to be without an employee certified in First Aid on the night shift on December 03, 2022, and December 04, 2022. A policy addressing CPR and First Aid coverage was requested. The facility was not able to provide a policy. During an interview, on 12/08/22 at 9:56 a.m., the Regional Clinical Nurse indicated the facility followed the state regulations addressing CPR and First Aid coverage.	R 0117	It is the practice of this facility to ensure that there is a nursing staff member on each shift that is First Aid certified. All residents have the potential to be affected; however, there was no actual harm to none. In-service will be completed with the business office manager regarding the practice of obtaining a valid copy of the First Aid certificate. A complete employee audit has been conducted with no issues found. A Quality Assurance tool has been developed and implemented to monitor employee files to ensure that each nursing employee's personnel file contains a First Aid certificate. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for 5 months and taken to QA monthly for review.	01/06/2023
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure 1 of 1 Resident Care Assistant	R 0118	It is the policy of this facility to ensure that the nursing staff are	01/06/2023

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	held a valid certification to practice as a Certified Nurse Aide (CNA) for 1 of 5 employees reviewed for employee records. (Employee 3) Finding includes: The timecard showing hours worked for Employee 3 was reviewed on 12/08/22. The document showed Employee 3 worked in the facility 19 shifts in November 2022 and three (3) shifts in December 2022. On 12/08/22 at 11:16 a.m., the "Indiana Professional Licensing Agency" web site was checked for an active certification or license to practice as a nursing professional. There was no active or inactive license or certification found for Employee 3, in any state. During an interview, on 12/08/22 at 10:00 a.m., the Regional Clinical Nurse indicated Employee 3 was not enrolled in a Certified Nursing Assistant school/class. During an interview, on 12/08/22 at 11:20 a.m., the Business Office Manager (BOM) indicated she held a late orientation for new employees and Employee 3 came to the orientation. Employee 3 informed the BOM she was to be in orientation as a resident assistant (RA). The BOM spoke with the Director of Nursing about two (2) days later, informing the DON she did not have an offer for employment letter for Employee 3. The DON informed her he was not aware of the employee. She later found out Employee 3 was to shadow (follow another employee to get an informational look at the position of RA), but not for orientation. She did search for a CNA certification for Employee 3 and did not find one in Florida (where the employee had moved from) or Indiana.		licensed and/or certified. All residents have the potential to be affected; however, there was no actual harm to none. In-service will be completed with the business office manager regarding the practice of obtaining a valid copy from the Indiana Professional Licensing Agency. A complete employee audit has been conducted with no issues found. A Quality Assurance tool has been developed and implemented to monitor employee files to ensure that each nursing employee's personnel file contains a license/certificate. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for 5 months and taken to QA monthly for review.	

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	She did reach out to Employee 3 multiple times to let the employee know the facility was unable to find a certification, but the employee did not respond. A facility policy, titled "Resident Neglect, Abuse and Misappropriation of Property," dated as revised in February 2022 and provided by the Regional Clinical Nurse on 12/08/22 at 10:11 a.m., indicated "...Employment screening is done on all potential employees...To assure the nursing employee has current licensure or certification...."			
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 interview and record review, the facility failed to perform a health assessment screening or a two-step Mantoux test, a tuberculosis (TB) skin test, for 1 of 3 new employees reviewed for TB. (The Memory Care Director) Finding includes: The employee records were reviewed on 12/06/22 beginning at 4:00 p.m. The Memory Care Director was hired on 8/04/22. The facility was unable to provide the employee's initial 2-step Mantoux test for Tuberculosis. A document from the Indiana Department of Health, titled "Tuberculosis Prevention Requirement for Comprehensive Care Nursing Facilities," received as a facility policy by the Regional Clinical Nurse, on 12/05/22 at 12:15 p.m., did not address initial new hire employee testing for Tuberculosis. During an interview, on 12/07/22 at 11:22 a.m., the Regional Clinical Nurse indicated the facility did not have any other Mantoux/Tuberculosis	R 0121	The company is in the process of completing a policy for new hire Mantoux 2 step and annual health screening thereafter. All residents have the potential to be affected; however, there was no actual harm to none. In-service of the new policy will be completed with the Director of Nursing, Business Office Manager and Executive Director. A Quality Assurance tool has been developed and implemented to monitor employee files to ensure that each personnel file contains the Mantoux 2 step. The annual heath screen, if applicable. This tool will be completed by the Administrator and/or their designee weekly for four weeks, then monthly for 5 months and taken to QA monthly for review.	01/06/2023

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	policies addressing employee testing.			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility failed to place an open date on an injectable and an oral medication in 1 of 1 medication refrigerator reviewed for medication storage. (The Memory Care Unit) Finding includes: During an observation, on 12/05/22 at 2:50 p.m., with QMA 1 in attendance, an open 30 milliliter bottle of Ativan (an anti-anxiety medication) with 29.25 milliliters (ml) was found open in the refrigerator without an open date, and a bottle of injectable Ativan one milliliter bottle of 2 milligrams/milliliter was found open, half full and without an open date. During an interview, on 12/05/22 at 2:50 p.m., QMA 1 indicated the medications should have been labeled with an open date. During an interview, on 12/07/22 at 9:28 a.m., the Regional Clinical Nurse indicated her expectation was open dates were to be put on the Ativan bottles when they were opened. During an interview, on 12/08/22 at 9:56 a.m., the Regional Clinical Nurse indicated the facility did not have any additional policies addressing labeling medications with open dates.	R 0300	It is the practice of this facility to ensure that medications are labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. All residents have the potential to be affected; however, there was no actual harm to none. In-service labeling will be completed with nursing staff. A Quality Assurance tool has been developed and implemented to monitor whether medications are being labeled properly. This tool will be completed by the Director of nursing and/or their designee weekly for four weeks, then monthly for 5 months and taken to QA monthly for review.	01/06/2023

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	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT SOLANA	7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240

(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
	A facility policy, titled "Medication Storage & Labeling Procedure," dated as revised in August of 2022 and provided by the Regional Clinical Nurse on 12/07/22 at 9:36 a.m., did not address putting open dates on medications.			