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	12/30/2022

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00387049. Complaint IN00387049- Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 28, 29, and 30, 2022. Facility number: 012007 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 2, 2022.	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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rich Pedersen	Executive Director	12/16/2022

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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	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 as required once per quarter on each shift. This deficient practice had the potential to affect 81 of 81 residents living in the facility. Findings include: The review on 11/29/22 at 10:30 a.m., of the monthly Fire Drill reports lacked documentation of any fire drills conducted from December 2021 through May of 2022. During an interview on 11/29/22 at 1:53 p.m., the Executive Director indicated he was having trouble finding the fire drill reports from the previous maintenance director. He indicated he could attest for 80% (percent) of the drills but did not have copies of the reports to show what days, times, or shifts they were conducted on. The previous maintenance director from the time period of December of 2021 thru May of 2022 had left and he could not locate the documentation. During an interview on 11/30/22 at 10:51 a.m., the Executive Director indicated the facility did not have a policy fire drills, however they were to be done on alternating shifts once a month.	R 0092	1. Documentation for fire drills completed December 2021- May 2022 missing 2. All residents are potentially at risk of same alleged deficient practice. 3. ED to audit fire drills to verify missing documentation. 4. Management Staff in-serviced on fire drill requirements on 12/15/2022 5. ED will audit Fire-drills for completeness Monthly to ensure documentation is safely filed in binder in ED office. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable	01/02/2023
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice			

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	education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure employees received 6 hours of dementia training as required for new hire employees for 4 of 5 personnel files (Housekeeper	R 0120	1. Employees reviewed during survey completed dementia training, abuse and neglect training.	01/15/2023

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	5, RN 8, Dietary Server 6, and LPN 7) reviewed and abuse inservicing for 1 of 5 personal files (Housekeeper 5) reviewed. Findings include: The review of the Personnel files on 11/29/22 at 10:00 a.m., indicated the following: -Housekeeper 5's personnel file lacked documentation of abuse inservicing since her hire date of 9/13/22. - RN 8's personnel file lacked documentation of 6 hours of dementia training since her hire date of 5/13/22. - Dietary Server 6's personnel file lacked documentation of 6 hours of dementia training since her hire date of 1/5/22. - LPN 7's personnel file lacked documentation of 6 hours of dementia training since her hire date of 4/11/22. During an interview on 11/30/22 at 9:00 a.m., the DON (Director of Nursing) indicated Housekeeper 5 had worked 53 days since her hire date of 9/13/22, Dietary Server 6 had worked 251 days since her hire date of 1/5/22, LPN 7 had worked 39 days since her hire date of 4/11/22, and RN 8 had worked 23 days since her hire date of 5/13/22. During an interview on 11/30/22 at 11:56 a.m., both the Executive Director and the Director of Nursing indicated they did not have documentation of 6 hours of dementia training for any of the requested employees. They completed a phone inservice with a few of the employees, but it was not anywhere near a 6 hour curriculum and at that		2. All residents are potentially at risk of same alleged deficient practice. 3. Bom or designee to audit all current personnel files for documentation of dementia training and abuse and neglect training by 12/20/2022. 4. Management Staff in-serviced on Dementia training requirements on 12/15/2022. 5. All employees will receive 6 hours of dementia training by 1/15/2022 to satisfy the requirement for training during orientation. 3 hours of annual training will be provided thereafter. 6. All new hires will receive 6 hours of Dementia training during first 90 days of employment effective 1/2/2022 and 3 hours of annual training thereafter. 7. All staff were in-serviced on Abuse & and Neglect on 12/20/2022 In-servicing will be provided quarterly, and PRN. 8. Abuse & Neglect training will be provided to all new hires during orientation effective 12/15/2022with continued training quarterly, and PRN. 9. BOM or designee will audit new employee personnel files for completeness utilizing the state audit tool per following schedule: all new hires 4 weeks, 50% of new hires for 4 weeks, 25% of hires for 4 months. Any missing documents discovered will be completed with employee.	

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	time they did not have a 6 hour dementia curriculum for new employees. They also could not locate any abuse inservicing for Housekeeper 5.		ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure documentation of general orientation, specific orientation, job description for 3 of 4 personnel files reviewed. (Housekeeper 5, Dietary Server 6, and LPN 7)	R 0123	1. 1. Employees reviewed during survey completed general orientation, job specific orientation and signed job descriptions. 2. All residents are potentially at risk of same alleged deficient	01/03/2023

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	Findings include: The review of the Personnel files on 11/29/22 at 10:00 a.m., indicated the following: - Housekeeper 5's personnel file lacked documentation of both general and specific orientation and a job description. - Dietary Server 6's personnel file contained a specific orientation form, however the form was not completed or signed by an orienting staff member. The file also lacked documentation of general orientation. - Licensed Practical Nurse (LPN) 7's personnel file lacked documentation of general orientation. During an interview on 11/30/22 at 9:00 a.m., the Directory of Nursing (DON) indicated Housekeeper 5 had worked 53 days since her hire date of 9/13/22, Dietary Server 6 had worked 251 days since her hire date of 1/5/22, and RN 7 had worked 39 days since her hire date of 4/11/22. During an interview on 11/29/22 at 1:53 p.m., the Executive Director (ED) indicated he did not have copies of staff general orientation. They were not doing the checklist it appeared. He could not locate Dietary Server 6's specific orientation or Housekeeper 5's job description. During an interview on 11/30/22 at 10:51 a.m., the ED indicated for orientation they did not have a specific policy but they had an orientation guide book that was to be filled out for new employees. They did not have a general orientation checklist. They did not have a specific policy on personnel files and they would follow the state guidelines.		practice. 3. Bom or designee to audit all current personnel files audited for signed job descriptions, and general orientation job specific orientation by 12/20/2022 4. Office Staff and Management Staff in-serviced on personnel file requirements ON 12/15/2022 5. Signed job descriptions along with job specific general orientation will be provided to all new hires effective 12/21/2022 6. BOM or designee will audit new employee personnel files for completeness utilizing the state audit tool per following schedule: all new hires 4 weeks, 50% of new hires for 4 weeks, 25% of hires for 4 months. Any missing documents discovered will be completed with employee. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

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	The form the state agency used to audit is the information they should maintain in the personnel files or training binder for the training.			
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 and interview, the facility failed to ensure the kitchen and equipment were clean and in good repair during 3 of 3 kitchen observations. This deficient practice had the potential to affect 81 of 81 residents who received meals from the kitchen. Findings include: 1. During the initial kitchen tour on at a.m., while accompanied by the acting Dietary Manager, the following observations were made: - There was a heavy accumulation of grime buildup on the floor under and behind the dishwasher. - The dishwasher, which the Dietary Manager indicated was currently non-functioning, was filled with standing water which had heavy calcium buildup, orange and white scum observed on top surface of of the stagnant water. - There was a heavy accumulation of grease and grime on the floor and wall behind and under the stove and wall oven. - There was a heavy accumulation of brown. fuzzy dust to the oven vent hood. - There was a moderate accumulation of grease to the outside of the deep fryer and brown grease splatters on the wall behind the deep fryer.	R 0273	Kitchen vents have been cleaned; floor cleaned under dishwasher; wall and floor under and behind stove and oven cleaned; vent hood cleaned; outside of fryer cleaned; and wall behind fryer cleaned. Dishwasher has been ordered and will be replaced. Light fixtures with missing covers will be replaced . 2. All residents are potentially at risk of same alleged deficient practice. 3. Executive Director and Dietary Manager will complete sanitary Inspection by 12/15/2022 to ensure that all areas of kitchen are properly maintained. 4. Dietary manager and dietary Staff to be in-serviced on cleaning procedures and reporting of malfunctioning equipment by 12/13/2022. Cleaning schedules to posted and monitored by Dietary Manager. 5. Kitchen Sanitation will be audited for cleanliness 3/week for 4 weeks, 2/week for 4 weeks, 1/week for 2 months, then monthly	01/15/2023

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	During an interview on 11/28/22 at 10:35 a.m., the Dietary Manager indicated the dishwasher was not functioning. They had ordered a new one but the old broken washer had not been removed and was building up stagnant water and holding mold. They would drain it and pour bleach in it, but it would just re-accumulate. She had asked the ED (Executive Director) to take it out but he had not. 2. During the meal service observation on 11/28/22 at 11:27 a.m., the same issued remained as previously identified. 3. During a follow-up kitchen observation on 11/29/22 at 1:34 p.m., the same areas of concerns previously identified continued, also identified were the following concerns: - The dishwasher, which still remained with stagnant dirty water in it, now had a very strong musty, spoiled odor. The odor could be observed all the way on the opposite side of the kitchen. - There was a coating of brown, fuzzy dust to the light fixtures, ceiling, and all ceiling vents. - There were black, fuzzy spots, described as "mold" by the Dietary Manager, on the ceiling vents by the drink fridge, above the serving window, in the dry storage, and above the dishwashing station. - The vent above the deep fryer had a very heavy accumulation of dust and brown stains. - The light fixtures above the prep area and by the back door did not have covers and had exposed fluorescent bulbs. During an interview on 11/29/22 at 1:40 p.m., the Dietary Manager indicated the water in the dishwasher looked like "chunky, moldy soup" to her. She thought the vent hood was supposed to		ongoing by Dietary Director. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable. Kitchen sanitation audit must score 85% or better to reduce to monthly.	

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	be cleaned monthly but was not certain, as an outside company was contracted to do it. Maintenance was supposed to dust the vents and clean them but it had been spotty recently. The brown staining on the vent above the deep fryer was from the grease from the deep fryer she believed. She could observe the strong odor from the dish washer across the kitchen. The light fixture cover above the prep area had not been replaced when it had been removed over the summer for a leak, and the light fixture cover by the back door had been missing since before she was hired in October of 2021. During an interview on 11/29/22 at 1:45 p.m., Dietary Cook 4 indicated she could observe the odor of the dishwasher over on the opposite side of the kitchen, it was very strong to her. During an interview on 11/29/22 at 1:53 p.m., the ED (Executive Director) indicated he was not aware of the issues with the dishwasher or the concerns observed in the kitchen. A company was supposed to come in every six months and clean the vent hoods. The daily cleaning tasks schedule, provided on 11/30/22 at 10:00 a.m., by the ED indicated staff were to drain the dishwasher and remove debris each shift, clean the stove and back splash as needed, and sweep and mop the kitchen floor nightly The most current Cleaning Procedures, provided on 11/30/22 at 10:00 a.m. by the ED, included but was not limited to, "... Procedure... 1. Items cleaned daily... Stove top... Grill... Kitchen and dining room floors... Exterior of large appliances..." The most current Kitchen Sanitation policy,			

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	provided on 11/30/22 at 10:00 a.m., by the ED, included but was not limited to, "... Procedure... 1. The Food Service Manager will monitor food safety and sanitation of the Dietary Department on a daily basis..." The most current Dish Machine Operation police, provided on 11/30/22 at 10:00 a.m., by the ED, included but was not limited to, "... 5. Check the dishwashing machine for cleanliness before the start of each meal. Drain cover as necessary during dishwashing to ensure food debris does not build up... Remove any built up debris, lime or scale as necessary or generally complete a thorough de-liming per cleaning schedule or one time weekly..."			