STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155616		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/19/2019	
	ROVIDER OR SUPPLIER BANY NURSING AI	ND REHABILITATION CENTER		201 E E	ADDRESS, CITY, STATE, ZIP COD ELM ST LBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		:	IID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDE ACTION SHOULD THE APPROVIDE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDE ACTION SHOULD TO THE APPROVIDE ACTION SHOULD TO THE		ΙΤΕ	(X5) COMPLETION DATE
F 0000							
Bldg. 00	IN00301128.  This visit resulted in Substandard Quality	ne Investigation of Complaint n a Partially Extended Survey - y of Care - Immediate	F 00	00			
	_	128 - Substantiated. encies related to the l at F689.					
	Unrelated deficienc	ies cited					
	Survey dates: July	17, 18, and 19, 2019					
	Facility number: 00 Provider number: 1 AIM number: 2001	55616					
	Census Bed Type: SNF/NF: 86 Residential: 9 Total: 95						
	Census Payor Type Medicare: 1 Medicaid: 73 Other: 12 Total: 86						
	These deficiencies raccordance with 410	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review com	pleted on July 21, 2019					
F 0689 SS=J	483.25(d)(1)(2) Free of Accident						'

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

TITLE

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.

Event ID: QMRP11 Facility ID: 001145

(X6) DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/19/2019		
	PROVIDER OR SUPPLIER BANY NURSING AI	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 201 E ELM ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ίΤΕ	(X5) COMPLETION DATE
Bldg. 00	Hazards/Supervis §483.25(d) Accided The facility must be §483.25(d)(1) The remains as free of possible; and  §483.25(d)(2)Each adequate supervisito prevent accider Based on interview failed to ensure ade was in place when a dementia and a wan building at 5:25 p.m. the side door betwee room and hall 4 and from the facility between the facility between the facility the between the assisted 4. The resident them from the facility and from the facility and from the wastewate store. The Health Fa Director of Nursing Jeopardy on 7/17/19  Findings include:  The incident report, indicated Resident Manother resident was	ion/Devices ints. Insure that - In resident environment In accident hazards as is In resident receives Ision and assistance devices Ints. In and record review, the facility Interested (Resident B) with Interested (Resid	F 00		Resident B was returned to fa by staff person and immediate assessed by Director of Nursi with no injuries or signs and symptoms of physical distress noted. Resident's physician notified and order received to to hospital for assessment. Resident admitted to hospital inpatient psychiatric treatment Resident returned to facility or 7-23-19 and was assessed by physician for continued stay of the facility's memory care unit Family notified. Order for Was Guard was obtained and place resident. Resident referred to in-house psychiatric services follow up.  The elopement risk assessment and care plans for all resident were reviewed and updated a needed. Inservice education regarding resident elopement identification and prevention initiated immediately after the incident for all staff.  To prevent reoccurrence of the deficient practice, the following systemic procedural changes,	ely ng s send for t. n n nder ed on for ents s	07/29/2019

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155616	B. WI	NG _		07/19/	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t					
NEW AL	BANY NURSING AI	ND REHABILITATION CENTER		201 E ELM ST NEW ALBANY, IN 47150			
	Г		ı				T
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	the activity director and brought back to the building. The resident had a wanderguard in				staff and resident education, a		
		ent had a wanderguard in			heightened surveillance include		
	place.				Quarterly Elopement Dr		
	The eliminal manual	for Decident Decree accious d			have been increased to weekl	-	
		for Resident B was reviewed			6 weeks and then monthly for	12	
		a.m. Diagnoses included, but			months;		
	were not limited to, dementia without behavior disturbance and schizophrenia.				2. Elopement identification		
	distuibance and SCII	nzopinema.			and prevention training on 7/1 7/15, 7/16, 7/17, 7/18, 7/23, 7/		
	The care plan dated	1 3/16/17 indicated the			7/15, 7/16, 7/17, 7/16, 7/25, 7/ 7/29 and ongoing for 12 montl		
	The care plan, dated 3/16/17, indicated the resident was a risk for elopement due to pacing,				3. Residents with exit-seel		
		exit seeking, and decreased			behavior will be assessed	a	
		tions were to ensure basic			immediately and a Wander Gu	ıard	
	_	ovide activities of choice, and a			bracelet applied if deemed		
	wanderguard to the				appropriate and with physiciar	ı's	
					order;	•	
	The nurse's note, da	ated 7/11/19 at 1:10 p.m.,			4. Exit-seeking behavior w	ill	
		nt had been pacing up and			be documented on a Behavior		
	down the hallway.				Form and will be reviewed by		
					during morning QA meeting.		
	The re-admission el	opement assessment, dated			plan and CNA assignment she		
		he resident was cognitively			will be updated;		
	_	gnoses of dementia and			<ol><li>Nurses and QMAs will</li></ol>		
		ulated independently;			check for placement and		
		; verbally expressed a desire to			functioning of the Wander Gua		
		ory of elopement at home or			each shift (Wander Guard test		
	1	ad been observed standing at			were obtained and are availab		
	the exit door waitin	g for someone to let her out.			staff use) and document resul	ts in	
		1-444000			the treatment administration		
		ited 7/14/19 at 5:30 p.m.,			record (TAR);		
		y was made aware by an off			6. Unit Managers will audit		
	I -	hat the resident was out of the			TAR's daily 5 times a week for		
	facility.				months than weekly for 4 mon		
	The numeric sector 1.	stad 7/14/10 at 6:55			to ensure appropriate Wander		
		ated 7/14/19 at 6:55 p.m.,			Guard placement and function	IS	
		nt was found by the Activities			documented. Any areas of		
	Director.				concern will be addressed		
	During an interview	on 7/17/19 at 9:35 a.m., the			immediately.	vazill	
		indicated the resident was in			7. Medical records person	WIII	
	Director of Mursing	mulcated the resident was in	1		keep an inventory of Wander		l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 07/19/2019 155616 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 201 E ELM ST NEW ALBANY NURSING AND REHABILITATION CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the AL (assisted living) dining room (located by Guards and will check placement the kitchen and laundry). The resident exited the and function and expiration weekly facility when another resident was coming back and record on the Wander Guard into the building. Another resident's family inventory form. The wander Guard member alerted staff in the parking lot that the inventory form will be reviewed and resident was out of the building and they initialed by the DON weekly to immediately began to look for her. An off duty ensure compliance; staff member, LPN (Licensed Practical Nurse) 4, Door alarm range and also saw the resident and called the facility to volume have been adjusted at notify staff. She was found by the activity each door; director who brought her back to the building. The Maintenance director or During the weekend only the kitchen and laundry designee will check all door staff were present with no staff in the front lobby. alarms for appropriate function and When they are working they cannot hear the volume daily and record results alarm. If the side door opens for too long and then ongoing; someone with a wanderguard walks through the 10. All residents will have an alarming door, it does not make a different sound Elopement Risk assessment to alert staff. No one can really hear the alarm from completed on admission, the side door. It flashes at the nurse's station. " readmission from a hospital stay, but you can't hear it". If the nurse was not at the quarterly, annually and with any nurse's station then they would not see the light change in condition; flashing. 11. No deliveries or outside venders to go to secured unit The written statement from the off duty staff without Department head or member LPN (Licensed Practical Nurse) 4, dated designee supervision; 7/14/19 and untimed, indicated LPN 4 was driving 12. Drills are being conducted to work for his shift and was 2 blocks away by the weekly for two months and high rise apartment. LPN 4 was in heavy traffic monthly ongoing at various times and thought he saw a resident walking. LPN 4 did of the day with sound being not get a full view due to the traffic, and there was monitored in the furthest locations no place to pull over or park. LPN 4 came into the on the units with various activities facility at approximately 5:40 p.m., went straight to going on. Logs are being kept with the nurse on the 123 hall where the resident time and date. Any response resided, and inquired if Resident B was in the times greater than 1 minute will building. Resident B was not found. LPN 4 and require employee education and another staff member went back to the area where possible disciplinary action. the resident was first seen. However, they could 13. All residents who are not locate the resident. assessed as independent smokers have been educated by

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During an interview on 7/17/19 at 9:56 a.m., the

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the Administrator regarding use of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155616		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  07/19/2019	
	PROVIDER OR SUPPLIER BANY NURSING AI	ND REHABILITATION CENTER	201 E	ADDRESS, CITY, STATE, ZIP COD ELM ST ALBANY, IN 47150	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	Activity Director in resident about a mil wastewater treatmee 6:53 p.m. and broug The resident was we shirt, long pants, and The written statemen Nursing, dated 7/14 upon Resident B's rewearing a black jack. The temperature ou 91 degrees on 7/14/  During an interview (Certified Nursing worked the 4 hall of care at the time of the side door alarm hall where she was the current policy to Identification, Previdated 1/6/16 include "PurposeIt is the purposeIt is the purpose authorizationEloper leaves the premises authorizationand/or other medical being struck by a murch of the side door located to a mile of the side door located to a mile of the side of	nt from the Director of /19 and untimed, indicated eturn to the facility she was ket and appeared to be flushed.  tside ranged between 90 and 19 from 4:56 p.m. and 6:56 p.m.  on 7/17/19 at 12:31 p.m., CNA Assistant) 4 indicated she n 7/14/19 but was providing the incident. It was hard to hear at the opposite end of the 4 working.  itled "Elopement ention and Management" and ed, but was not limited to, policy of this facility to ensure exceives adequate ment occurs when a resident or a safe area without or any necessary supervision who leaves a safe area may r cold exposure, dehydration all complications, drowning, or	TAG	court yard door only to enter a exit the designated smoking at 14. The number of employed scheduled daily will vary base census and will be consistent applied seven days a week. Managers will be on duty for reless than four hours per week day. Staffing schedules as worked are posted daily and available for review.  Each element of this plan will enumerated on an audit form the elements of the plan in its entirety will be reviewed week the interdisciplinary team with completion and progress documented for each element. This weekly audit will be conducted for six months. The audits will be reviewed month the QAPI committee and review by corporate risk management threshold of 100% is not achieve a resolution action plan will be developed to ensure compliant.  Completion date 7-29-19	be and dly by t. le ely by ewed at. If eved e

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PRINTED: 08/12/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155616 B. WING 07/19/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 201 E ELM ST

NEW ALBANY NURSING AND REHABILITATION CENTER    201 E ELM S1   NEW ALBANY, IN 47150						
(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		
F 0921 SS=F Bldg. 00	Administrator and Director of Nursing were notified of the Immediate Jeopardy on 7/17/19 at 2:50 p.m. The Immediate Jeopardy was not removed by exit date of the survey.  This Federal tag relates to Complaint IN00301128  3.1-45(a)(2)  483.90(i)  Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  Based on observation and interview, the facility failed to ensure the sanitary condition of the kitchen was in place related to peeling plaster and paint, gnats, drain flies, and flies for residents and staff during 2 of 2 kitchen observations. This deficient practice had the potential to affect 86 out of 86 residents who reside in the facility.  Findings include:  On 7/8/19 at 3:36 p.m, the following was observed in the kitchen:  - A three inch by three inch hole in the floor next to the floor drain with 16 floor tiles missing around the hole.  -An area on the floor that measured 1 foot by 1 foot located in front of the dishwasher when stepped on had a clear liquid bubble up and gnats and drain flies flew out from under the tiles.	F 0921	The following Corrections to the deficient practice affecting all residents are as follows: 1) The 3" x 3" hole in the floor next to the floor drain with 16 missing floor tiles was repaired and tiles replaced; 2) The area on the floor measuring 1' x 1' located in front of the dish machine was repaired; 3) The hole in the ceiling to the right of the floor drain measuring 8" x 4" and a 3' long area of plaster will be repaired; 4) the peeling plaster above the dish machine will be repaired; 5) The peeling paint on the ceiling to the right of the food serving table will be repaired; 6) The water stains on the ceiling directly behind the peeling paint to the right of the food serving table will be repaired; 7) The missing drywall and peeling	08/18/2019		
	-The ceiling to the right of the floor drain had a hole which measured 8 inches by 4 inches and a 3 foot long area of plaster hanging from the ceiling.		paint above the reach-in refrigerator will be repaired; 8) The 1" x 1" hole in the ceiling above			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  07/19/2019		
NAME OF F	PROVIDER OR SUPPLIER			STREET A 201 E E	ADDRESS, CITY, STATE, ZIP COD	•	
NEW AL	BANY NURSING AI	ND REHABILITATION CENTER			LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION (X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	- An area above the feet by 2 feet had please of peeli inches long.  - The ceiling to the read an area of peeli inches long.  - The ceiling to the read directly behind had two large water inches by 12 inches observed with an in 4 feet by 2 feet, with entire left side and a ceiling above observed with a one where the vent brace ceiling.  During an interview Dietary Manager in	dishwasher which measured 2 laster peeling off the ceiling.  right of the food serving table mg paint which measured 16  right of the food serving table the area with the peeling paint stains which measured 16 and 18 inches by 24 inches.  the reach in refrigerator 1 was serted panel, which measured the missing drywall down the a 6 inch area of peeling paint.  the air conditioning unit was einch by one inch hole next to ket was attached to the			the air conditioning unit will be repaired.  All residents are potentially affected by the deficient pract See corrections above.  The facility will maintain the kitchen floor, walls and ceiling good repair. The maintenanc staff and Dietary staff were in-serviced on 8/2/2019 regar identifying, reporting and performing repair needs in a t manner. The kitchen floors, v and ceilings are a part of the kitchen preventative maintenance program and will be inspected scheduled but no less than monthly. Needed repairs and replacements will be reported the administrator and perform a timely manner.	ice. g in e ding imely valls ance d as	
		ole but had increased in size asked on multiple occasions to			maintenance person will mon the condition of the kitchen flo		
	get it fixed.				walls and ceilings and docum findings on the PM audit tool		
	Maintenance Direct	on 7/18/19 at 3:45 p.m., the or indicated the hole in the			weekly for two months and monthly for four months and		
		of the floor drain was from a d floor. The water stains and			ongoing. If inspection requirements are not met, rep	vaire	
		a result of the roof leaking.			or replacements will be made		
		-			Results of the monitoring will	be	
	3.1-19(a)(4)(f)				reviewed during the facility's (		
					Committee meeting overseen the administrator and reviewe	-	
					corporate risk management.	-	
					compliance threshold of 95%		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155616		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/19/2019	
NAME OF I	PROVIDER OR SUPPLIER	 \			ADDRESS, CITY, STATE, ZIP COD		
NEW AL	BANY NURSING AI	ND REHABILITATION CENTER			ELM ST LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	not achieved an action plan w	ill bo	DATE
					developed.	ill be	
					Completion date 8-18-19		
F 0925	483.90(i)(4)						
SS=D		e Pest Control Program					
Bldg. 00		ntain an effective pest					
	control program so	o that the facility is free of					
	Based on observation	on and interview, the facility	F 092	5	Fly strips have been removed	l; the	08/18/2019
	failed to ensure an e	effective pest control was in			bug light has been cleaned a	nd a	
	place in the kitchen	related to flies, gnats, and			fresh strip replaced; the hole	in the	
	drain flies for 2 of 2	2 kitchen observations.			floor from the kitchen to the		
					basement has been sealed; the	ne	
	Findings include:				kitchen has been deep cleane		
					basement has been thorough	ly	
		p.m., the following was			cleaned; and, the drains		
	observed in the kitc	hen:			throughout the kitchen were treated.		
		y strips hanging from the					
	_	ashing area. The fly traps were			All residents are potentially		
	full of flies, drain fl	ies, and gnats.			affected by the deficient pract See corrections above.	ice.	
	- The bug light on the	he food prep side of the					
	kitchen was observe	ed to be full of flies and gnats.			The facility will maintain an		
					effective pest control program		
	· · · · · · · · · · · · · · · · · · ·	der the kitchen, was observed			the kitchen including the use		
	_	t of dead and live drain flies			outside professional vendor.	The	
	and gnats on the sta	irs, floor, walls, and ceilings.			pest control company was		
	F1: 4 1.1				consulted on remediation		
		rain flies were observed flying			recommendations. The	-4-ff	
	throughout the kitch	ien.			maintenance staff and dietary	start	
	During an interview	y on 7/17/10 at 2:30 n m , tha			were in-serviced on 8/2/2019	tativa	
	_	on 7/17/19 at 2:30 p.m., the dicated the drain fly's and			regarding pest control preven		
		up through the hole in the			measures and reporting. Pes control measures were	ot.	
	floor by the dishwar	-			incorporated into the kitchen		
	lioor by the dishwa				sanitation and preventative		
	On 7/18/19 at 3:36	p.m., the following was			maintenance schedule.		

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

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	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155616	A. BUILDING  B. WING	<u>00</u>	COMPLETED 07/19/2019
OVIDER OR SUPPLIER	ID REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COI 201 E ELM ST NEW ALBANY, IN 47150		
(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
- The area on the flo foot, in front of the construction was observed to have drain flies flew out of floor drain.  - Five flies and seven throughout the kitch.  During an interview Dietary Manager incomplete the food they contined the food they contined the theorem in that was prepared to the dietary Maintenance Director.	dishwasher, when stepped on e clear liquid bubble up and of the hole in the floor by the ral gnats were observed flying en  on 7/18/19 at 3:40 p.m., the dicated when the staff prepped uously swatted at the flies. Instructed to cover the food keep the flies off the food.  on 7/18/19 at 3:50 p.m., the or indicated pest control had		To ensure compliance, the Die supervisor or designee will ins the kitchen daily for one month and weekly for five months wit findings and remedial action documented on a QAPI audit to Results of the monitoring will be reviewed during the facility's Committee meeting overseen the administrator and reviewed corporate risk management. It compliance threshold of 95% in not achieved an action plan will developed.  Completion date 8-18-19	pect  h  cool.  pe  QAPI  by d by f a  s
IN00301128.  This visit resulted in Substandard Quality Jeopardy.  Unrelated deficienci Survey date: July 1	a Partially Extended Survey - of Care - Immediate es cited 7, 18, and 19, 2019	R 0000		
	OVIDER OR SUPPLIER ANY NURSING AN SUMMARY S (EACH DEFICIENCE REGULATORY OR Observed:  - The area on the flot foot, in front of the co was observed to have drain flies flew out of floor drain.  - Five flies and seventhroughout the kitch During an interview Dietary Manager ince the food they contine The staff had been in that was prepared to During an interview Maintenance Directo been in to spray frequenties been in to spray frequenties effective.  3.1-19(f)(4)  This visit was for the IN00301128.  This visit resulted in Substandard Quality Jeopardy.  Unrelated deficienci Survey date: July 17	OVIDER OR SUPPLIER  ANY NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION observed:  - The area on the floor that measured 1 foot by 1 foot, in front of the dishwasher, when stepped on was observed to have clear liquid bubble up and drain flies flew out of the hole in the floor by the floor drain.  - Five flies and several gnats were observed flying throughout the kitchen  During an interview on 7/18/19 at 3:40 p.m., the Dietary Manager indicated when the staff prepped the food they continuously swatted at the flies. The staff had been instructed to cover the food that was prepared to keep the flies off the food.  During an interview on 7/18/19 at 3:50 p.m., the Maintenance Director indicated pest control had been in to spray frequently but it had not been effective.  3.1-19(f)(4)  This visit was for the Investigation of Complaint IN00301128.  This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate	OVIDER OR SUPPLIER ANY NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION observed:  - The area on the floor that measured 1 foot by 1 foot, in front of the dishwasher, when stepped on was observed to have clear liquid bubble up and drain flies flew out of the hole in the floor by the floor drain.  - Five flies and several gnats were observed flying throughout the kitchen  During an interview on 7/18/19 at 3:40 p.m., the Dietary Manager indicated when the staff prepped the food they continuously swatted at the flies. The staff had been instructed to cover the food that was prepared to keep the flies off the food.  During an interview on 7/18/19 at 3:50 p.m., the Maintenance Director indicated pest control had been in to spray frequently but it had not been effective.  3.1-19(f)(4)  This visit was for the Investigation of Complaint IN00301128.  This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy.  Unrelated deficiencies cited  Survey date: July 17, 18, and 19, 2019	OVIDER OR SUPPLIER  ANY NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MOST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION observed:  The area on the floor that measured 1 foot by 1 foot, in front of the dishwasher, when stepped on was observed to have clear liquid bubble up and drain flies flew out of the hole in the floor by the floor drain.  Five flies and several gnats were observed flying throughout the kitchen  During an interview on 7/18/19 at 3:40 p.m., the Dietary Manager indicated when the staff prepped the food they continuously swatted at the flies. The staff had been instructed to cover the food that was prepared to keep the flies off the food.  During an interview on 7/18/19 at 3:50 p.m., the Maintenance Director indicated pest control had been in to spray frequently but it had not been effective.  3.1-19(f)(4)  This visit was for the Investigation of Complaint IN00301128.  This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy.  Unrelated deficiencies cited  Survey date: July 17, 18, and 19, 2019

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

PRINTED: 08/12/2019 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155616	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/19/2019
	PROVIDER OR SUPPLIEF	ND REHABILITATION CENTER	201 E I	ADDRESS, CITY, STATE, ZIP COD ELM ST ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	Residential Census	: 9			
	These State Resider accordance with 41	ntial Findings are cited in 0 IAC 16.2-5.			
R 0148	410 IAC 16.2-5-1.				
Bldg. 00	(e) The facility sha grounds, and equ in good repair, an adversely affect the residents or the period (1) Each facility shadened a written to ensure the condition (2) The electrical appliances, cords sources, fire alarm shall be maintained functioning and confident electrical codes.  (3) All plumbing somply with state	nall establish and en program for maintenance tinued upkeep of the facility. system, including , switches, alternate power n and detection systems, ed to guarantee safe ompliance with state hall function properly and plumbing codes. , heating and ventilating			
	Based on observation failed to ensure the kitchen was in place paint, gnats, drain for staff during 2 of 2 kitchen the deficient practice has of 9 residents who staff durings include:	on and interview, the facility sanitary condition of the e related to peeling plaster and lies, and flies for residents and citchen observations. This ad the potential to affect 9 out reside in the facility.  .m, the following was	R 0148	The following Corrections to the deficient practice affecting all residents are as follows: 1) The x 3" hole in the floor next to the floor drain with 16 missing floor tiles was repaired and tiles replaced; 2) The area on the find measuring 1' x 1' located in from the dish machine was repaired; 3) The hole in the ceiling to the right of the floor drain measuring x 4" and a 3' long area of plass will be repaired; 4) the peeling	e 3" e or loor ont red; e ng 8" ter
	- A three inch by th	ree inch hole in the floor next		plaster above the dish machin	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
		155616	B. W	ING		07/19/	2019
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		201 E E			
NΕ\// ΔΙ Ι	BAND NI IDSING A	ND REHABILITATION CENTER			LBANY, IN 47150		
INL VV ALI		ND REHABILITATION CENTER		INLVVA	LDAN1, IN 47 130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to the floor drain with 16 floor tiles missing around				will be repaired; 5) The peeling	-	
	the hole.				paint on the ceiling to the right	of	
					the food serving table will be		
		or that measured 1 foot by 1			repaired; 6) The water stains of	on	
		t of the dishwasher when			the ceiling directly behind the		
	stepped on had a clear liquid bubble up and gnats				peeling paint to the right of the		
	and drain flies flew out from under the tiles.				food serving table will be repa		
					7) The missing drywall and pe	eling	
	-The ceiling to the right of the floor drain had a				paint above the reach-in		
	hole which measured 8 inches by 4 inches and a 3				refrigerator will be repaired; 8)		
	foot long area of plaster hanging from the ceiling.				1" x 1" hole in the ceiling abov		
					the air conditioning unit will be		
	- An area above the dishwasher which measured 2				repaired.		
	feet by 2 feet had plaster peeling off the ceiling.				l <b>.</b>		
	TT1				All residents are potentially		
	_	right of the food serving table			affected by the deficient practi	ce.	
	1	ing paint which measured 16			See corrections above.		
	inches long.				The facility will maintain the		
	The eailing to the	right of the food serving table			The facility will maintain the	in	
	_	the area with the peeling paint			kitchen floor, walls and ceiling good repair. The maintenance		
		r stains which measured 16			staff and Dietary staff were	=	
	_	s and 18 inches by 24 inches.			in-serviced on 8/2/2019 regard	lina	
	menes by 12 menes	s and 16 menes by 24 menes.			identifying, reporting and	inig	
	- The ceiling above	the reach in refrigerator 1 was			performing repair needs in a ti	melv	
		nserted panel, which measured			manner. The kitchen floors, w	-	
		th missing drywall down the			and ceilings are a part of the	uno	
		a 6 inch area of peeling paint.			kitchen preventative maintena	nce	
		u o men ureu or peering punio.			program and will be inspected		
	- The ceiling above	the air conditioning unit was			scheduled but no less than		
		e inch by one inch hole next to			monthly. Needed repairs and	or	
		cket was attached to the			replacements will be reported		
	ceiling.				the administrator and performe		
					a timely manner.		
	During an interview	v on 7/18/19 at 3:36 p.m., the					
		ndicated the hole in the floor			To ensure compliance, the		
		ole but had increased in size			maintenance person will monit	tor	
		asked on multiple occasions to			the condition of the kitchen flo		
	get it fixed.	-			walls and ceilings and docume		
	-				findings on the PM audit tool		
	1		1		i -		

State Form Event ID: QMRP11 Facility ID: 001145 If continuation sheet Page 11 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/19/2019	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	201 E E	ADDRESS, CITY, STATE, ZIP COD ELM ST ILBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
R 0149	Maintenance Direct ceiling to the right of leak from the secon	or on 7/18/19 at 3:45 p.m., the or indicated the hole in the of the floor drain was from a d floor. The water stains and a result of the roof leaking.		weekly for two months and monthly for four months and ongoing. If inspection requirements are not met, rep or replacements will be made. Results of the monitoring will I reviewed during the facility's Committee meeting overseen the administrator and reviewe corporate risk management. I compliance threshold of 95% not achieved an action plan w developed.  Completion date 8-18-19	be QAPI by d by If a is
Bldg. 00	Sanitation and Sa (f) The facility shall program in operation operation (failed to ensure an explace in the kitchen drain flies for 2 of 2 (failed to ensure an explace in the kitchen drain flies for 2 of 2 (failed to ensure an explace in the kitchen drain flies for 2 of 2 (failed to ensure an explace in the kitchen drain flies for 2 of 2 (failed to ensure an explanation of failed to ensure an expla	fety Standards - Deficiency Il have a pest control ion in compliance with 410 on and interview, the facility effective pest control was in related to flies, gnats, and extichen observations.  p.m., the following was hen:  y strips hanging from the ashing area. The fly traps were	R 0149	Fly strips have been removed bug light has been cleaned ar fresh strip replaced; the hole i floor from the kitchen to the basement has been sealed; the kitchen has been deep cleaned basement has been thoroughl cleaned; and, the drains throughout the kitchen were treated.  All residents are potentially affected by the deficient practices see corrections above.  The facility will maintain an effective pest control program	nd a n the ne ed; ly ice.
		der the kitchen, was observed of dead and live drain flies		the kitchen including the use of outside professional vendor.	of

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

PRINTED: 08/12/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155616	B. W	ING		07/19/2019		
AND PLAN	PROVIDER OR SUPPLIED BANY NURSING A  SUMMARY (EACH DEFICIEN REGULATORY OF and gnats on the state of throughout the kite of the sum o	ND REHABILITATION CENTER  STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION LITS, floor, walls, and ceilings.  Irain flies were observed flying hen.  Iv on 7/17/19 at 2:30 p.m., the dicated the drain fly's and up through the hole in the sher.  p.m., the following was  Foot that measured 1 foot by 1 dishwasher, when stepped on the ve clear liquid bubble up and of the hole in the floor by the  For all gnats were observed flying hen  For all gnats were observed flying hen	A. BU	JILDING ING STREET A 201 E E	ADDRESS, CITY, STATE, ZIP COD ELM ST LBANY, IN 47150  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  pest control company was consulted on remediation recommendations. The maintenance staff and dietary were in-serviced on 8/2/2019 regarding pest control prever measures and reporting. Per control measures were incorporated into the kitchen sanitation and preventative maintenance schedule.  To ensure compliance, the D supervisor or designee will in the kitchen daily for one mon and weekly for five months w findings and remedial action documented on a QAPI audit Results of the monitoring will reviewed during the facility's Committee meeting overseer the administrator and reviewed corporate risk management. compliance threshold of 95%	ietary spect th iith tool. be QAPI by by ed by If a is	LETED	
	· ·	nuously swatted at the flies.			not achieved an action plan v	vill be		
		instructed to cover the food			developed.			
	that was prepared to	o keep the flies off the food.			Completion date 8-18-19			
	Maintenance Direc	ov on 7/18/19 at 3:50 p.m., the tor indicated pest control had quently but it had not been			Completion date o-10-19			

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