STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION (X3)				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING				
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	ı		
NAME OF I	PROVIDER OR SUPPLIE	R		ESSLER BLVD E			
KESSLE	RWOOD PLACE			IAPOLIS, IN 46220			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	T	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
R 0000							
Bldg. 00							
			R 0000	Submission of this response a	and		
	This visit was for a	a State Residential Licensure		Plan of Correction is NOT a le			
	Survey. This visit	included the Investigation of		admission that a deficiency ex	=		
	Complaint IN0040	3549.		or, that this Statement of			
				Deficiencies was correctly cite	ed,		
	•	3549 - No deficiencies related to		and is also NOT to be constru	red		
	the allegations are	cited.		as an admission against intere	est		
				by the residence, or any			
	Survey dates: Apri	il 17, 18, and 19, 2023		employees, agents, or other			
				individuals who drafted or mag			
	Facility number: 0	10064		discussed in the response or Plan			
				of Correction. In addition,			
	Residential Census	s: 30		preparation and submission o	f this		
				Plan of Correction does NOT			
		ential Findings are cited in		constitute an admission or			
	accordance with 4	10 IAC 16.2-5.		agreement of any kind by the			
	0.10	1 . 1 . 4 . 121 2022		facility of the truth of any facts			
	Quality review cor	npleted on April 21, 2023		alleged or the correctness of a	any		
				conclusions set forth in this			
				allegation by the survey agen	cy.		
R 0092	410 IAC 16.2-5-1	3(i)(1_2)					
11.0002	Administration ar						
Bldg. 00	Noncompliance	ia managomone					
	•	st maintain a written fire and					
		dness plan to assure					
		of residents in cases of					
	emergency as fol						
		in facilities shall include the					
		fire alarm signal and					
		ergency fire conditions,					
		novement of nonambulatory					
		areas or to the exterior of					
	the building is no	t required. Drills shall be					
	conducted quarte	erly on each shift to					
	familiarize all faci	ility personnel with signals					
	and emergency a	action required under varied					
	<u> </u>						
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE		
Ashley Lay	/-Wolf		RN, RD0	cs	05/02/2023		

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 disclosed 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			LETED	
			B. WING 04/19/2023			/2023	
			STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER	t .	5011 KESSLER BLVD E				
KESSLEI	RWOOD PLACE		INDIANAPOLIS, IN 46220				
					, <b></b>		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DETGENCTI		DATE
		st twelve (12) drills shall be Vhen drills are conducted					
		nd 6 a.m., a coded					
		ay be used instead of					
	audible alarms.	dy be used instead of					
		six (6) months, a facility					
		old the fire and disaster drill					
	· ·	n the local fire department.					
		ning and drills shall be					1
		the names and signatures					
	of the personnel present.  Based on interview and record review, the facility						
			R 0	092	R 092 Administration and		05/02/2023
					Management - Noncomplianc	<u>e</u>	
		drills were conducted monthly					
		reviewed. This had the			1. What corrective action		
	-	ll 30 residents that reside at the			will be accomplished for tho		
	facility.				residents found to have been	n	
	Findings include:				affected by the deficient		
	Findings include:				practice?		
	The fire drills were	provided by the Administrator					
		a.m. The following fire drills					
	were conducted:	The folio mg Into dilino			Executive Director (ED) or		
					designee will conduct a fire dr	ill on	
	4/29/22 on 3rd shift	.,			or before 5/5/2023. Any conc		
	5/24/22 on 1st shift	,			identified will be corrected at t		
	8/25/22 on 1st shift	,			time.		
	9/21/22 on 3rd shift	., &					
	10/31/22 on 2nd shi	ift.					
		TRAINING SUMMARY", dated			2. How will the facility		
	· ·	ire drills and fire evacuation			identify other residents havi	-	
	were discussed with	all staff.			the potential to be affected by	_	
	A doormant titl- 1 "	Annual Training Calandar and			the same deficient practice a		
		Annual Training Calendar and Safety Drills", undated, was			what corrective action will be	е	
		ministrator on 4/18/23 at 2:28			taken?		
	-	indicated a fire drill listed to be					
	conducted monthly.						
	conducted monding.				An audit of 2022 and 2023 fir	e drill	
			1		7 311 GUGIL OF ZUZZ GITU ZUZO III	o um	I

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/19/2023	
	PROVIDER OR SUPPLIE	R	5011	T ADDRESS, CITY, STATE, ZIP COD KESSLER BLVD E ANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION DATE	
				logs was completed on 4/20 by ED with no additional fire omitted.		
				3. What measure will be into place or what systemi changes the facility will mate to ensure that the deficient practice does not reoccur?	c ake	
				The ED was re-trained by Regional Director of Clinical Services (RDCS) on 4/20/20 regarding fire drill regulation requirement (Attachment 1) maintenance technician (MT be trained by the ED on the drill regulation requirement hire. Until a MT is hired ar trained, ED will be responsil ensuring regulation is met.	D23 New ) will fire upon id	
				4. How the corrective action(s) will be monitored ensure the deficient practiwill not recur, i.e., what quassurance program will be into place?	ce ality	
				The ED is responsible for sustained compliance. The designee will audit the fire d monthly for 3 months, then		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		04/19/	2023
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ESSLER BLVD E		
KESSLEF	RWOOD PLACE				APOLIS, IN 46220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					bi-monthly for 2 months to ens fire drills are completed per	ure	
					regulatory requirement. The		
					audits will be discussed at		
					monthly QI meetings. The QI		
					Committee will determine if		
					continued auditing is necessar	-	
					based on 3 consecutive month		
					compliance. Monitoring will be	•	
					on-going.		
					![if !supportAnnotations]>		
R 0117	410 IAC 16.2-5-1.	4(b)					
	Personnel - Deficie	• •					
Bldg. 00		ufficient in number,					
ŭ	, ,	training in accordance with					
	-	ws and rules to meet the					
	twenty-four (24) ho	our scheduled and					
	unscheduled need	ls of the residents and					
	-	The number, qualifications,					
	_	ff shall depend on skills					
		e for the specific needs of					
		inimum of one (1) awake					
	-	current CPR and first aid					
		oe on site at all times. If esidents of the facility					
	- ' '	esidential nursing services					
		of medication, or both, at					
		ng staff person shall be on					
	, ,	esidential facilities with					
	over one hundred	(100) residents regularly					
		al nursing services or					
	administration of n	nedication, or both, shall					
		(1) additional nursing staff					
	•	l on duty at all times for					
	-	ty (50) residents. Personnel					
	_	only those duties for which					
	they are trained to	perform. Employee duties					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> C		COMPI	3) DATE SURVEY COMPLETED 04/19/2023	
	PROVIDER OR SUPPLIER			5011 K	ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF shall conform with Based on interview failed to ensure a st cardiopulmonary re certification was on days for CPR and 3	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION written job descriptions.  and record review, the facility aff member with suscitation (CPR) and first aid site during all shifts for 2 of 8 of 8 days for first aid. This had ct all 30 residents that reside at	R 01	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)  R 117 Personnel — Deficiency  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice?	<u>(</u> (s)	(X5) COMPLETION DATE  05/15/2023
	4/18/23. The facility binder with certificate The following date(in CPR and/or first 4/18/23- no first aid 4/17/23- no first aid 4/12/23- no CPR certificate A/11/23- no CPR certificate CPR c	reviewed from 4/11/23 to y staff were identified per the ations for first aid and CPR. (s) noted a lack of staff certified aid:  I certified staff on day shift, I certified staff on night shift.  I certified staff on night shift, I certified staff on night shift.  I ceted with the Regional Services, on 4/19/23 at 4:36 e wasn't first aid/CPR certified pon the schedules reviewed.			On or before 5/5/2023, the E and Care Services Manager (will review and update staffing schedule to ensure a minimulation one employee with current Cl and first aid certification will be present on each shift.  2. How will the facility identify other residents have the potential to be affected be the same deficient practices what corrective action will be taken?	CSM) g m of PR e	
					An audit of employee first aid certification was completed o 5/2/2023 by the ED. Employe without current first aid/CPR certification will obtain certific by 5/20/2023.  1.What measure will be pure into place or what systemic	n ees ation	

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/19/2023
	ROVIDER OR SUPPLIE	ER	5011 K	ADDRESS, CITY, STATE, ZIP COD ŒSSLER BLVD E NAPOLIS, IN 46220	•
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE (X5)  COMPLETION  DATE
				changes the facility will to ensure that the deficie practice does not reoccu	ent
				The ED was re-trained by on 4/20/2023 to ensure a member with cardiopulmo resuscitation (CPR) and fi certification is on site duri shifts per the regulatory requirement (Attachment	staff nary rst aid ng all
				1.How the corrective as will be monitored to ensideficient practice will no recur, i.e., what quality assurance program will linto place?	ure the t
				The ED is responsible for sustained compliance. The Services Manager (CSM) designee will audit the state schedule weekly for 4 weeks, their monthly for one month to first aid/CPR certified empalways on site. The audit discussed at monthly QI meetings. The QI Commit determine if continued audit necessary based on 3 cormonths of compliance. Minimulations will be on going.	ne Care or or offing eks, n ensure a bloyee is s will be ttee will diting is nsecutive

State Form Event ID: R2SB11 Facility ID: 010064 If continuation sheet Page 6 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  04/19/2023	
	PROVIDER OR SUPPLIER		5011 K	ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E NAPOLIS, IN 46220	
(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)	(X5) COMPLETION DATE
R 0240 Bldg. 00	activities of daily libased upon individed as a relevel of care and set to where a resident pulse and/or respirat for 1 of 3 closed record on 4/19/23 at 3:00 put were not limited depression, hyperteinsomnia, and musc was admitted to the A document titled "Scope of Treatment the physician regard code and to attempt A "Service Plan Suindicated Resident I one staff for bathrougrooming, bathing, was a high fall risk, "frequent checks".  A resident service mindicated the follow medication aide] came that resident wa entering resident's r	Deficiency and assistance with ving, shall be provided dual needs and preferences.  and record review, the facility sident was assisted per his rvice plan for frequent checks was later found without a tions for an unknown period cords reviewed. (Resident R32)  for Resident R32 was reviewed o.m. The diagnoses included, it to, atrial fibrillation, insion, Parkinson's disease, ele weakness. Resident R32 facility on 2/25/23.  Indiana Physician Orders for (POST)", signed 3/8/23, by ling Resident R32 being a full	R 0240	R 240 Health Services – Deficiency  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice?  Resident R32 was found deceased on 3/25/2023.  2. How will the facility identify other residents havi the potential to be affected by the same deficient practice awhat corrective action will be taken?  CSM completed an audit of a service plans for residents the require frequent checks on 4/29/2023. CSM completed a audit of resident task sheets the ensure residents who require frequent checks are identified the task sheet on 4/29/2023. findings from these audits we corrected immediately.	ing by and be all at an bo

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	ΈD
			B. W	ING _		04/19/2023	
		I		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R					
KESSI E	RWOOD PLACE			5011 KESSLER BLVD E INDIANAPOLIS, IN 46220			
NEGGLE				וואטואוו			
(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	<del> </del>	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for and] tactile stimulation, 0 [no] pulse, 0 [no] respirations noted. Attempted to turn resident						
	over to initiate CPF						
	_	n this writer noted resident's			1.What measure will be put	t	
		ainst leg of table and did not			into place or what systemic		
		5 a.mPer EMS [emergency			changes the facility will make	e	
	_	eath pronounced [symbol for			to ensure that the deficient		
	at] 8:32"				practice does not reoccur?		
	l	1 10/07/00					
		note, dated 3/25/23 at 11:40					
	a.m., indicated Resident R32's body was released				The CSM was re-trained by		
	to coroner's office at that time.				RDCS on 4/20/2023 to ensure		
					residents are assisted per the		
	-	atement, 3/25/23, from			level of care and service plan	for	
		onnel (RCP) 9 indicated she			frequent checks; also ensure		
		nt R32 on 3/25/23 at 2:30 a.m.,			resident's needs are appropria	ately	
	_	n., and 3/25/23 at 6:00 a.m. while			outlined on the task sheet	.	
		al walk through with day shift			(Attachment 2). CSM re-traine	I	
	RCP 10.				all clinical staff on 4/20/2023 to		
		4 1 4 1 2 /25 /22 C			ensure residents are assisted	· .	
	-	atement, dated 3/25/23, from			their level of care and service	· .	
		he following, "[Room number kes to sleep in so I go to him			for frequent checks (Attachme	ent	
	_				3).		
		lown and his head was laying vision] tray next to the bed. I					
	_	e was cold so I called for the					
		edication aide]He [Resident					
		rith all ADLs [activities of daily			1.How the corrective action	n(e)	
		as no indication that RCP 10			will be monitored to ensure t	` '	
		R32's room prior to 8:00 a.m.			deficient practice will not		
	chi mio resident	1.02 5 Toolii prior to 0.00 u.iii.			recur, i.e., what quality		
	An interview condi	acted with the Regional			assurance program will be p	ut	
		l Services (RDCS), on 4/19/23 at			into place?		
		d the RCP 9 commented on how					
	she went into Resident R32's room at 6:00 a.m. to						
		nat didn't align with the timeline			The CSM is responsible for		
	due to the extent of Resident R32 being deceased.				sustained compliance. The C	sm	
		rigid and seemed like a while			or designee will audit 5 reside		
		t shift nurse told us. The last			services plans and task sheet	I	
		omeone was in there was the			weekly for 4 weeks, bi-weekly	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
			B. W	NG		04/19/	/2023
				CTD FET	ADDRESS STEW STATE ZID SOD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E		
KE661 E	RWOOD PLACE				APOLIS, IN 46220		
KESSLEI	WOOD FLACE			INDIAN	AFOLI3, IN 40220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	night shift nurse on	3/25/23 at 3:45 a.m. for a			2 months, then monthly for 1		
	temperature check.				month to ensure residents are		
					assisted per their level of care		
		cted with RDCS, on 4/19/23 at			service plan for frequent check		
	-	since Resident R32 was an			The audits will be discussed a	t	
		for toileting he would need to			monthly QI meetings. The QI		
		every "couple of hours". The			Committee will determine if		
	•	the RCPs to check on the			continued auditing is necessar	-	
	-	uple of hours" depending on			based on 3 consecutive month		
	the level of assistance. She could believe that RCP				compliance. Monitoring will be	)	
9 went into Resident R32's room at 4:00 a.m. but she confirmed with the day shift RCP, (RCP 10),					on-going.		
that they didn't conduct a walk through nor go into Resident R32's room at 6:00 a.m.				1 551			
	into Resident R32's	room at 6:00 a.m.			![if !supportAnnotations]>		
R 0272	410 IAC 16.2-5-5.	1(a)					
1 0212		nal Services - Deficiency					
Bldg. 00		e served at a safe and					
Diag. 00	appropriate tempe						
	appropriate temperature.		R 0272		R 272 Food and Nutritional		05/15/2023
	Based on observation	on, interview, and record	10.	Services – Deficiency			03/13/2023
		failed to ensure cold food were					
	-	riate temperature for 17			1. What corrective action(	s)	
		re food from Servery 1 and			will be accomplished for thos	•	
	failed to ensure food	d temperatures were obtained			residents found to have beer		
	prior to serving food	d for 13 residents that receive			affected by the deficient		
	food from Servery 2	2. This had the potential to			practice?		
	affect all 30 residen	ts that reside in the facility.					
	Findings include:						
					The Dietary Manager (DM) wa	as	
		ducted with Chef 2, on 4/18/23			re-trained by ED and RDCS or	า	
	-	od temperatures for Servery 1.			5/2/2023 to ensure all food is		
	-	erature was obtained at 52			served at an appropriate		
	-	nmented "that seems warm"			temperature at point of service	;	
	-	rve the meal including the			(Attachment 4).		
		s on the first-floor dining					
	room.						
	A 1	1 4 1 60 2 3					
	An observation con-	ducted of Servery 2 on the			2. How will the facility		

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/19/2023	
	ROVIDER OR SUPPLIER		5011 k	ADDRESS, CITY, STATE, ZIP COD (ESSLER BLVD E NAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR third floor, on 4/18/ Care Personnel (RC pass food plates out floor. RCP 3 indicar	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 23 at 12:25 p.m., of Resident P) 3 proceeding to prepare and to the residents on the 3rd ted there were no logs for food	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)  identify other residents havi the potential to be affected if the same deficient practice a what corrective action will b	ng DATE  py and	
	third floor conducted Dietary Assistant 4 containing food for Licensed Practical 1 proceeded to start procee	Four Factors that Directly ome Unsafe", undated, was ministrator on 4/18/23 at 2:28 indicated the following, tratureBacteria can grow in mains in the "temperature in is between 41 F [Fahrenheit]		An audit of food temperature in the kitchen and serveries were completed on 5/2/2023 by the ED. Findings concluded that temperatures were regularly checked in the kitchen but no the serveries.  1. What measure will be purinto place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?  The ED was re-trained by RE on 4/20/2023 to ensure cold for was served at an appropriate temperature (Attachment 1). DM was re-trained on 5/2/202 ED and RDCS to ensure cold was served at an appropriate temperature at point of service (Attachment 4).	ras efood t in  t ce  OCS ood The e3 by food	
				1.How the corrective actio will be monitored to ensure deficient practice will not	* *	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/19/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5011 KESSLER BLVD E INDIANAPOLIS, IN 46220					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				recur, i.e., what quality assurance program will be p into place?	ut			
				The ED is responsible for sustained compliance. The D designee will audit temperature logs from serveries and the matchen weekly for 4 weeks, bi-weekly for 2 months, then monthly for 1 month to ensure food temperatures are compler routinely before serving. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessate based on 3 consecutive mont compliance. Monitoring will be on-going.	re ain  e eted  ry hs of			
				![if !supportAnnotations]>				
R 0273 Bldg. 00	(f) All food prepara (excluding areas i maintained in acc	nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and d safe food handling	D 0252		05/15/2022			
	review, the facility storage regarding us main kitchen, undat third-floor refrigera dishwasher, the use	on, interview, and record failed to ensure adequate food indated and expired food in the red and expired food in the tor, ensure functionality of of hairnets, and ensure a refrigerator and freezer located	R 0273	R 273 Food and Nutritional Services – Deficiency  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice?	se			

State Form Event ID: R2SB11 Facility ID: 010064 If continuation sheet Page 11 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED	
			B. W	B. WING		04/19/2023	
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E		
KEGGIFI							
VESSIEI	RWOOD PLACE			INDIAN	IAPOLIS, IN 46220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	on the third floor. T	This had the potential to affect					
	all 30 residents that	reside in the facility.					
	Findings include:				The lettuce, lemons, pastries,	,	
					salsa, Caesar salad dressing,	and	
	1. The main kitcher	n was observed on 4/17/23 at			vegetable base were discarde	d on	
	12:20 p.m. The mai	in refrigerator was observed			4/17/2023 by Dietary Assistan	ıt 4.	
	with the following:				Ecolab was called to service t	he	
					dish machines on the first floo	r	
		in a bag that was brown in			and third floor due low temper		
	color with liquid in	_			on 5/2/2023. RCP 3, RCP 8,		
	- A box of lemons,	dated 3/16/23, that had brown			Director of Memory Care were	<b>;</b>	
	spots,				retrained by the CSM on		
	- A box of pastries with no date that were covered				4/20/2023 on the kitchen and		
	with clear wrap,				servery dress code, including		
	- A container of sal				wearing hairnets in the kitcher	1	
		esar Salad dressing with a best			and servery (Attachment 3).		
	by date of 1/12/23,						
		d a container of vegetable					
	base with a best by	date of 11/19/22.			2. How will the facility		
					identify other residents havi	_	
		acted with Dietary Assistant 4,			the potential to be affected b	-	
		p.m., indicated she would go	the same deficient practice and				
		ow away the items listed		what corrective action will be			
	above.				taken?	ļ	
	2 The first flear S-	umiomi (Comiomi 1) was absorbed					
		ervery (Servery 1) was observed e on 4/18/23 at 12:10 p.m. The					
		sticker that indicated it was a			An audit of kitchen was done	on	
		er with a recommended			4/30/2023 by the CSM to ensu		
		degrees for wash and rinse			no outdated food present. Issu		
	_	ppm (parts per million) on the			identified during this audit wer		
		mum. The temperature was			addressed at that time and an		
		s and went up to 113 degrees			outdated or unlabeled food wa	-	
	after another cycle.				discarded at that time.	10	
	arter another cycle.				Giscarded at trial tille.	ļ	
	An observation con	ducted on 4/18/23 at 1:30 p.m.					
		ted the dish machine was on					
	-	of cleaning dishes. The			1.What measure will be put	<u> </u>	
	I ma m me process c				intriat incusure will be put	• !	l

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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	A. BUILDING <u>00</u> CO			ETED
			B. Wl	NG		04/19/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ESSLER BLVD E		
KESSLE	RWOOD PLACE				IAPOLIS, IN 46220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF C			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ON TAG DEFICIENCY)		DATE		
	temperature was no	oted at 107 degrees.			into place or what systemic		
	There were no logs located in Servery 1 for the				changes the facility will mak	е	
					to ensure that the deficient		
	dish machine.				practice does not reoccur?		
	2 The thind H	om tom; (Som tom; 2)					
		ervery (Servery 2) was			The ED was to trained by DD	.00	
	observed on 4/18/23 at 12:25 p.m. Resident Care Personnel (RCP) 3, RCP 8, and the Director of				The ED was re-trained by RD		
	Memory Care were present and preparing the				on 4/20/2023 to ensure adequal food storage regarding undate		
	cooked food onto plates. All three of them were				and expired food in the main	u	
	not wearing a hairnet. The Director of Nursing				kitchen and serveries, to ensu	ro	
	(DON) came shortly after and directed the three				functionality of the dishwashe		
	staff members to obtain a hairnet while serving				use of hairnets, and to ensure		
	food. RCP 3 obtained a hairnet, but RCP 8 and the				thermometer is in all refrigerate		
		y Care proceeded to prepare			and freezers (Attachment 1).		
	food without the us				DM was re-trained by the ED		
					RDCS on 5/2/2023 to ensure		
	There was a dish m	achine located in Servery 2.			adequate food storage regard	ing	
		nad a sticker that indicated it			undated and expired food in the	-	
	was a chemical dis	hwasher with a recommended			main kitchen and serveries, to		
	temperature of 120	degrees for wash and rinse			ensure functionality of the		
	cycle along with 50	ppm (parts per million) on the			dishwasher, the use of hairne	ts,	
		mum. The dish machine was		and to ensure a thermometer is in			
	reading "Lo" on the	e gauge regarding temperature.			all refrigerators and freezers		
					(Attachment 4).		
		acted with RCP 3, on 4/18/23 at					
	_	ed "we don't take temperatures					
		n asked about the dish					
		machine was run through a					
		th the following temperature(s)			1.How the corrective action		
	noted:				will be monitored to ensure t	:he	
	E	1 0			deficient practice will not		
	- First cycle at 102				recur, i.e., what quality		
	1	08 degrees after rinse, &			assurance program will be p	ut	
	- Third cycle at 112	2 degrees after rinse.			into place?		
	The refrigerator/fre	ezer combo was observed in					
	Servery 2 with 2 containers of what appeared to						
	be orange juice wit	h no date or label. There was a			The ED is responsible for		
	container of watern	nelon chunks with a sell by			sustained compliance. The E	D or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  04/19/2023	
NAME OF PROVIDER OR SUPPLIEF	2	5011 K	ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E IAPOLIS, IN 46220		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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	
date of 4/10/23. The refrigerator or freeze what appeared to be counter being server. Care Unit with no large unit with unit and unit with unit and unit with unit and unit with unit	ere wasn't a thermometer in the ser. There were 3 containers of a lemonade noted on the d to residents on the Memory abel or date noted.  erature logbook located in the dish machine and/or the serious the dish machine and/or the serious the following, "1. Dating & items must be labeled usingDelivered food items must be d datePrepared food items the common name, prepared date uidelines to hold food3 days for prepared foods7 days end items like pudding, fruits, days - opened condiments like up, mustard, pickled foods, nato products"	TAG	designee will conduct observational audits of the kitt and serveries 3 times per were 4 weeks, then 2 times per were for 4 weeks, then weekly for 4 weeks to ensure safe food handling is maintained, include food be discarded by the manufacturers use by date; as well as the proper use of hairs. The ED or designee will cond observational audits of all dist machines, refrigerators, and freezers temp logs 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then we for 4 weeks to ensure proper temperature readings and functionality. Results of the as will be discussed in the month QI meetings. The QI Committ will determine if continued audits necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	chen ek for ek ing s nets. uct n es eekly udits nly ee	

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>00</u>			COMPLETED	
			B. WIN	G		04/19/	/2023	
			<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	L			ESSLER BLVD E			
KESSLEF	RWOOD PLACE				APOLIS, IN 46220			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		door allowing warmer						
	•	er the spaceDishwasher						
		ffer for low temperature						
	(chemical) or high temperature machines. It is							
	_	appropriate form based on						
		in the communityReport						
	improper temperatu	res immediately"						
	A document titled "Four Factors that Directly							
		ome Unsafe", undated, was						
	provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "Poor Personal HygieneThis is the largest risk for developing foodborne illnesses. The best							
	personal hygiene pr	actices include hand washing,						
	covering cuts or sor	res and covering hair (this						
	includes beards)"							
R 0274	410 IAC 16.2-5-5.	1(a)(1-3)						
	Food and Nutrition	1-71						
Bldg. 00	Noncompliance							
ŭ	-	an organized food service						
		ed by a supervisor						
	•	service management and						
	·	sanitation standards, food						
	-	paration, and meal service.						
	(1) The supervisor	must be one (1) of the						
	following:	, ,						
	(A) A dietitian.							
	(B) A graduate or	student enrolled in and						
	within one (1) year	r from completing a division						
	approved, minimu	m ninety (90) hour						
	classroom instruct	tion course that provides						
	classroom instruct	tion in food service						
	supervision who h	as a minimum of one (1)						
		e in some aspect of						
		ervice management.						
	, , -	a dietetic technician						
		by the American Dietetic						
	Association.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  04/19/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5011 KESSLER BLVD E INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
IAU	(D) A graduate of university or within from an accredited degree in foods an administration with of experience in somanagement. (E) An individual vin food service support (2) If the supervised dietitian shall provide the premises at pear regularly schedu (3) Food service sensure proper food sanitation.  Based on observation review, the facility knowledgeable regard food handling, means a dish machine, morninge/freezer, and the service. This had the residents that resides.	an accredited college or on one (1) year of graduating discollege or university with a and nutrition or food on a minimum of one (1) year ome aspect of food service with training and experience pervision and management. For is not a dietitian, a cide consultant services on eak periods of operation on alled basis. It taff shall be on duty to did preparation, serving, and failed to ensure staff were urding sanitation standards of a service, monitoring the use of initoring of temperatures for a the use of hairnets during meal e potential to affect all 30	R 0274	R 274 Food and Nutritional Services – Noncompliance  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice?  The lettuce, lemons, pastries salsa, Caesar salad dressing	05/15/2023 (s) ose n		
		n refrigerator was observed		vegetable base were discarde 4/17/2023 by Dietary Assistan Ecolab was called to service	ed on nt 4.		
	color with liquid in  - A box of lemons, spots,  - A box of pastries with clear wrap,  - A container of sale	dated 3/16/23, that had brown with no date that were covered		dish machines on the first floor and third floor due low tempe on 5/2/2023. RCP 3, RCP 8, Director of Memory Care were retrained by the ED on 4/20/2 on the kitchen and servery dr code, including wearing hairn the kitchen and servery	rature and e 2023 ess		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			TED	
			B. W	ING		04/19/2	023
		l .		STPEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ESSLER BLVD E		
KEGGI EI	RWOOD PLACE				IAPOLIS, IN 46220		
NESSLEI	RWOOD PLACE			INDIAN	APOLIS, IN 40220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	by date of 1/12/23,				(Attachment 3).		
	A holding fridge had a container of vegetable						
	base with a best by	date of 11/19/22.					
					2. How will the facility		
		cted with Dietary Assistant 4,			identify other residents havi	-	
		p.m., indicated she would go			the potential to be affected b	-	
		ow away the items listed			the same deficient practice a		
	above. She commented on how corporate was in				what corrective action will be	e	
	the facility a "few weeks ago" and looked through				taken?		
	the kitchen. She couldn't answer the question						
	regarding auditing the fridge for labels and/or						
	dates.						
		(5 4)			An observational audit of kitch	hen	
		rvery (Servery 1) was observed			and servery were done on		
		e on 4/18/23 at 12:10 p.m. The			4/30/2023 by the CSM to ensu		
		sticker that indicated it was a			no outdated food present. Issu		
		er with a recommended			identified during this audit wer	e	
	_	degrees for wash and rinse ppm (parts per million) on the			addressed at that time. Any outdated or unlabeled food wa		
		num. The temperature was			discarded at that time.	48	
		s and went up to 113 degrees			discarded at that time.		
	after another cycle.						
	and another cycle.						
	An observation con	ducted on 4/18/23 at 1:30 p.m.			1.What measure will be put	,	
		ted the dish machine was on			into place or what systemic	١	
	-	of cleaning dishes. The			changes the facility will mak	_	
	temperature was no	_			to ensure that the deficient	·	
	permane was no				practice does not reoccur?		
	There were no logs	located in Servery 1 for the			p. Lottor dood not rooddin.		
	dish machine.	<b></b>					
					The ED was re-trained by RD	ocs	
	3. The third floor So	ervery (Servery 2) was			on 4/20/2023 to ensure adequ		
		3 at 12:25 p.m. Resident Care			food storage regarding undate		
		RCP 8, and the Director of			and expired food in the main		
	, , ,	present and preparing the			kitchen and serveries, to ensu	ıre l	
	cooked food onto plates. All three of them were				functionality of the dishwashe		
	not wearing a hairnet. The Director of Nursing				use of hairnets, and to ensure		
	-	y after and directed the three			thermometer is in all refrigerat		
		otain a hairnet while serving			and freezers (Attachment 1).		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. W	B. WING			04/19/2023	
				CTREET	ADDRESS OF A TE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
KEOOLE			5011 KESSLER BLVD E					
KESSLE	RWOOD PLACE			INDIAN	APOLIS, IN 46220			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
	food. RCP 3 obtain	ed a hairnet, but RCP 8 and the			DM was re-trained by the ED a	and		
	Director of Memory Care proceeded to prepare				RDCS on 5/2/2023 to ensure			
	food without the us	e of a hairnet.			adequate food storage regardi	ng		
					undated and expired food in th	ie		
	There was a dish machine located in Servery 2.				main kitchen and serveries, to			
	The dish machine h	and a sticker that indicated it			ensure functionality of the			
	was a chemical disl	hwasher with a recommended			dishwasher, the use of hairnet	s,		
	temperature of 120 degrees for wash and rinse				and to ensure a thermometer i			
	cycle along with 50 ppm (parts per million) on the				all refrigerators and freezers			
	sanitation at a minimum. The dish machine was				(Attachment 4). The dietary a	nd		
	reading "Lo" on the gauge regarding temperature.				clinical staff were re-trained by	the		
					CSM on 4/20/2023 to ensure t	he		
	An interview conducted with RCP 3, on 4/18/23 at				use of hairnets, ensure the pro	per		
	12:19 p.m., indicated "we don't take temperatures				temperature of the dish machi	ne,		
	or have a log" when asked about the dish				refrigerator and freezer, and			
	machine. The dish	machine was run through a			sanitation standards of food			
	couple of cycles wi	th the following temperature(s)		handling during meal service				
	noted:				(Attachment 3).			
	- First cycle at 102	_						
	_	08 degrees after rinse, &						
	- Third cycle at 112	2 degrees after rinse.						
					1.How the corrective action	ı(s)		
	_	combo was observed in Servery		will be monitored to ensure the				
		of what appeared to be orange			deficient practice will not			
	-	or label. There was a container			recur, i.e., what quality			
		nks with a sell by date of			assurance program will be p	ut		
		n't a thermometer in the			into place?			
	_	zer. There were 3 containers of						
		e lemonade noted on the						
		ed to residents on the Memory						
	Care Unit with no l	abel or date noted.			The ED is responsible for			
					sustained compliance. The El	O or		
		erature logbook located in			designee will conduct			
		g the dish machine and/or the			observational audits of the kito			
	fridge/freezer.				and serveries 3 times per wee			
					4 weeks, then 2 times per wee	k		
	A document titled '				for 4 weeks, then weekly for 4			
		ndated, was provided by the			weeks to ensure safe food			
	Administrator on 4/18/23 at 11:25 a.m. The				handling is maintained, includi	ng		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  04/19/2023	
	PROVIDER OR SUPPLIER		5011 K	ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E IAPOLIS, IN 46220	
(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
IAU	document indicated LabelingAll food food storage labels. labeled and received must be labeled with and use by dateGu - from preparation of from opening canner and vegetables30 mayonnaise, ketchu salad dressings, tom A document titled "Temperature Logs". Administrator on 4/document indicated temperatures must be recorded on the Kita Log. Each appliance thermometed document the temperatures should external thermometed document the temperature should external thermometers should each unit, as this is due to opening the other temperatures to enter the temperature logs did (chemical) or high to important to use the the type of machine improper temperature. A document titled "Cause Food to Becoprovided by the Adep.m. The document	the following, "1. Dating & items must be labeled usingDelivered food items must be datePrepared food items h common name, prepared date nidelines to hold food3 days for prepared foods7 days - d items like pudding, fruits, days - opened condiments like p, mustard, pickled foods, nato products"  Kitchen Appliance , undated, was provided by the 18/23 at 2:28 p.m. The the following, "Appliance be monitored daily and chen Appliance Temperature es should have an internal eter. Freezer and cooler and every the taken from the erRead the thermometer and every the taken from the erRead the thermometer and every the placed at the front of considered the warmest part the spaceDishwasher effer for low temperature emperature emperature machines. It is appropriate form based on in the communityReport	IAU	food be discarded by the manufacturers use by date; as well as the proper use of hairr The ED or designee will conditude observational audits of all distinguishments, refrigerators, and freezers temp logs 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then we for 4 weeks to ensure proper temperature readings and functionality. Results of the a will be discussed in the month QI meetings. The QI Committed will determine if continued audits necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	s nets. uct r s eekly udits uly ee

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PRINTED: 05/10/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 00  B. WING		COMPLETED 04/19/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5011 KESSLER BLVD E INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	personal hygiene pra	borne illnesses. The best actices include hand washing, es and covering hair (this					
R 0349 Bldg. 00	on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on interview	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that records must be as  umented. sible. organized. and record review, the facility	R 03	49	R 349 Clinical Records – Noncompliance		05/15/2023
	a wound treatment t staff without a phys records reviewed. (I Findings include:				1. What corrective action(s will be accomplished for thos residents found to have been affected by the deficient practice?	se	
	on 4/18/23 at 11:45 but were not limited dementia, and anxie	ote, dated 3/14/23 at 9:00 a.m.,			A physician order was obtaine by CSM for Resident R30 wou treatment on 4/20/2023.		
	dark area 2.5 cm [co touch"  A resident service n a.m., indicated a nur company came to as	ing, "Noted R [right] heel entimeters] x 2.5 cm, tender to ote, dated 3/15/23 at 10:00 rse with a home health ssess the wound to Resident e wound was a blister that was			2. How will the facility identify other residents havin the potential to be affected by the same deficient practice a what corrective action will be taken?	y nd	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 04/19/2023			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5011 KESSLER BLVD E				
KESSLE	RWOOD PLACE			IAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR then open. Home he	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION alth will be doing the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	implemented for ho following forms we  - 3/15/23- indicated heel and new orders - 3/17/23- indicated - 3/20/23- indicated - 3/23/23- indicated - 3/27/23- indicated There were no phys clinical record regar heel.	ver charting form was me health services. The re noted: wound care provided to right		CSM completed an audit on 4/29/2023 of all resident recording ensure physician orders are in place for all wound treatments that documentation is comple No other findings during this at 1. What measure will be pure into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?	n s and te. audit.		
	indicated Resident I changed by the facil no indication of what with or what was ap heel.  An interview condu Nursing (DON), on Resident R30's wou health, and they (ho supposed to change orders for the facility	R30's right heel dressing was ity's nursing staff. There was at the dressing was changed plied to Resident R30's right cted with the Director of 4/18/23 at 2:13 p.m., indicated and was managed by home me health) were the ones the dressing. If there were no y staff to change it, then we eft up to home health.		The CSM was re-trained by RDCS on 4/20/2023 to ensure community has a physician or for all wound treatments and ensure the documentation regarding the wound treatment complete (Attachment 2). The licensed staff were re-trained CSM on 4/20/2023 to ensure community has a physician or for all wound treatments and ensure the documentation regarding the wound treatment complete (Attachment 3).  1.How the corrective action will be monitored to ensure deficient practice will not	rder to  nt is e by rder to  nt is		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/19/2023			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ESSLER BLVD E			
KESSLEI	RWOOD PLACE		INDIANAPOLIS, IN 46220				
(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)	(X5) COMPLETION DATE		
				recur, i.e., what quality assurance program will be p into place?	ut		
				The CSM is responsible for sustained compliance. The C or designee will audit 5 resident treatment orders and documentation for treatments weekly for 4 weeks, bi-weekly 2 months, then monthly for 1 month to ensure community h physician order for all wound treatments and to ensure the documentation regarding the wound treatment is complete. audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessal based on 3 consecutive monticompliance. Monitoring will b on-going.	for as a The		
D 0444	440 140 40 0 5 40			![if !supportAnnotations]>			
R 0414 Bldg. 00	hands after each	Deficiency st require staff to wash their direct resident contact for ng is indicated by accepted					
	Based on observation review, the facility	on, interview, and record failed to ensure infection ere maintained during meal	R 0414	R 414 Infection Control – Deficiency  1. What corrective action(s) w	05/15/2023 ill be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 04/19/2023			/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
KECCI E			5011 KESSLER BLVD E INDIANAPOLIS, IN 46220				
KESSLEI	RWOOD PLACE			INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	service for 2 of 3 re	esidents observed for meal			accomplished for those reside	nts	
	service. (Resident R20 and Resident R27)				found to have been affected b	y the	
					deficient practice?	,	
Findings include:				·			
					LPN 5 was re-trained by CSM	on	
	An observation was	s conducted of meal service on			4/20/2023 to ensure infection		
		Jnit, on 4/18/23 at 12:25 p.m.			control practices were maintai	ned	
		d Practical Nurse (LPN) 5			during meal service (Attachme		
		th Residents R27, R24, and			3).		
		ded to assist Resident R27 with			- '		
	eating by utilizing utensils and then assisted				2. How will the facility identify		
Resident R20 with cutting up her food without					other residents having the		
	performing hand hygiene between resident				potential to be affected by the		
	contact. Resident R27 dropped some pieces of				same deficient practice and w		
		ad LPN 5 picked up the food			corrective action will be taken		
		d to assist Resident R27 with			Serresare delien viii pe taken	•	
		ging Resident R20 to eat her			An observational audit of infec	rtion	
	food and touched h				control practices during meal	7.11011	
	encouraging her to				service, by current staff was		
					conducted on 4/20/2023 by CS	SM	
	A document titled "	'Hand Washing", undated,			Findings were corrected at this		
		e Administrator on 4/18/23 at			time.	5	
		ment indicated the following,			unio.		
		wrists up to forearms,			3. What measure will be put in	nto	
		gernails, vigorously and with			place or what systemic change		
		for a minimum of 20 seconds			the facility will make to ensure		
		Immediately before			that the deficient practice does		
	1 -	andling equipmentBefore			reoccur?	3 1101	
		and after taking gloves offAs			1000001:		
		whenever contamination			The CSM was re-trained by R	DCS	
		ning face, hair, or any body			on 4/20/2023 to ensure infection		
	partBetween each				control practices are maintaine		
	partDetween each	t task performed			during meal service (Attachme		
					,		
					2). All clinical staff were re-tra on 4/20/2023 by CSM to ensu		
					· · · · · · · · · · · · · · · · · · ·		
					infection control practices are		
					maintained during meal service	Æ	
					(Attachment 3).		
					4 How the corrective setime (-)	\iII	
					4. How the corrective action(s	) WIII	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
			B. WI	NG		04/19/2023	
AND PLAN (	OF CORRECTION  ROVIDER OR SUPPLIE  RWOOD PLACE  SUMMARY  (EACH DEFICIEN	IDENTIFICATION NUMBER	A. BU B. WI	STREET A	DDDRESS, CITY, STATE, ZIP COD ESSLER BLVD E APOLIS, IN 46220  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place  The CSM is responsible for sustained compliance. The C or designee will complete observational audits of infectic control practices during meal service 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, then weekly for 4 weeks	COMPL 04/19/	ETED
					ensure infection control practi are maintained during meal service. The audits will be discussed at monthly QI meetings. The QI Committee		
					determine if continued auditin necessary based on 3 consec months of compliance. Monit will be on-going.	g is cutive	

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