STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00303796. Complaint IN00303796 - Substantiated. State Residential Findings are cited at R0052. Survey dates: September 18, 19, and 20, 2019 Facility number: 013328 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state regulation.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from neglect for 1 of 1 residents reviewed for neglect. (Resident C) A record review for Resident C was done from 9/18/19 to 9/20/19. Resident C's diagnosis include, but were not limited to, hypertension, chronic kidney disease, atrial fibrillation, dementia, and cerebral vascular accidents. The resident's cognition was moderately impaired.	R 0052	It is the intent of Crown Senior Living to ensure all residents are kept safe and free from the potential for neglect. Resident C remains a resident of Crown Senior Living and had no additional incidents. All residents have the potential to be affected by this alleged deficient practice. The facility's policies and procedures regarding	11/04/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The Level of Service Assessment/Evaluation, completed on 10/2/17, indicated the following: "....Receptive Communication, 2. Understands information conveyed. May miss some part or intent of the message...Orientation, 2. Disoriented to the point of no longer ale to function independently 3 or more days a week or part of every day for a 7-day period...Memory, has difficulty remembering and using information. Requires at least daily cueing from others. Cannot read written direction...Mobility, 2. Can get around inside without assistance but needs assistance of another person outside. Endurance limited to immediate vicinity of facility/ Requires constant presence of staff for safety outside." A progress note, dated 5/29/18 at 10:53 p.m., indicated, " Writer received call from the local MD [medical doctor, sic] office located near the parking lot of the facility. Employee at the office states that the resident is in the office confused and does not know where she lives, and states that she had driven to the location. Employee noticed the lanyard the resident was wearing and called the facility to locate her home. Writer took the facility bus and picked up the resident without incident. [family member]...was notified of the incident and MD called. Resident has outside PCP [primary care provider] and office called for appointment to be seen. [family member] to arrange the appointment time so that she can transport and assist resident to the appt [appointment]. Resident placed on 15 minute checks for at least next 24 hours. Resident knows her [family member...name and phone number and her apartment number once inside the facility.". The incident report received from ED (Executive Director) on 9/20/18 at 10:48 a.m., dated 5/29/18, indicated the predisposing Physiological Factors		Leave of Absences, signing in and out procedures and staff responsibilities for regular accounting of each resident and general elopement policies were reviewed by the leadership team and current practices updated considering this incident. All Staff will be retrained on the facility's LOA policies and staff's responsibilities for regular verification of each resident's whereabouts. The Executive Director and Director of Nursing met with resident council and reviewed with them the facility's LOA policies and signing in and out procedures. Elopement policy and search procedures were reviewed with staff including when a resident shall be considered to have eloped and process to follow in searching for and reporting missing resident. Leadership team will also confirm at each Morning Meeting what residents are out of the building and the reason for, location of them and date of expected return. Resident chart notes will reflect this information. Compliance will be monitored via regular walking rounds and observations by the Executive Director and other leadership team members, interviewing up to 5 residents each time regarding resident rights and dignity.	

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	as: confused and impaired memory. The immediate action taken was: Resident escorted into the facility bus and taken back to the facility without incident. The resident was not taken to the hospital. Under the Predisposing Situation Factors, the word "none" was checked. A service plan created on 5/29/18, indicated the resident has a history of leaving the facility. The intervention noted on the service plan was to notify family/POA of behavioral changes. Resident C was not moved to the Dementia unit at this time and remained on the unit which, allowed her to move freely about the facility. The clinical record on 5/29/18, did not indicate that the resident was checked by a nurse upon returning to the facility. A progress note, dated 7/3/19 at 10:03 p.m., indicated the resident was found by two persons staying at (hotel's name). The resident was confused and wandering in the parking lot. The resident had told the two hotel patrons that she was with a friend but no one was with her at the time. The two patrons of the hotel noticed the resident's lanyard and escorted her back to the facility where she was identified by another resident of the facility and taken to her room. The progress note fails to state that a nurse performed an assessment on the resident upon returning the facility. An interview with DON (Director of Nursing) on 9/20/19 at 11:14 a.m., indicated the exact amount of time the resident was missing from the facility could not be established. Resident counts are done at midnight and since the resident was free to move about the facility, she would not have been noticed to be missing until midnight.		Concerns will be addressed. Observations will continue weekly for 4 weeks, then monthly for 3 months. Findings will be reported to the QAPI Committee for review and recommendations.	

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	A sign out/in log provided by the DON on 9/20/19 at 11:21 a.m., indicated the resident did not sign out or in of the facility on 7/3/19. During an interview on 9/20/19 at 11:21 a.m., the DON indicated no incident report had been filed regarding Resident C's incident on 7/3/19 nor the resident's clinical record provide proof that the resident was assessed by a nurse following being found at 10:03 p.m. on 7/3/19. A Wandering Risk Assessment provided by the DON on 9/20/19 at 11:09 a.m. and dated 7/1/19 at 3:50 p.m., states, "....Orientation, 3. Forgetful/short attention span....Medications, 1. Taking antipyschotics. 2. Taking antidepressants...". The Wandering Risk Assessment was not completed at that time and no further Wandering Risk Assessments could be located by the DON. An interview with the ED on 9/20/19 at 11:14 a.m., indicated an incident report should have been filed following the incident on 7/3/19. After they had looked into the resident's history, the resident should have been moved to the Dementia unit prior to the 7/3/19 incident. A Elder Abuse Information & Policy provided by the ED on 9/20/19 at 10:48 a.m., stated, "Signs and symptom of specific types of elder abuse....Neglect by caregivers or self-neglect...Unsafe living conditions...Procedure: 1. The Administrator, Director of Nursing Services and/or designee will report all allegations that a resident has been subjected to abuse, neglect, or financial exploitation with 24 hours to:...2. Community Reporting and Investigations Instructions a.) The community will thoroughly			

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	investigate all allegations of abuse, neglect or exploitation and maintain on-site written documentation of the investigation. b.) The community will take appropriate action to prevent further incidents of abuse, neglect or exploitation while the investigation is in progress. c.) Investigations will be sent to all appropriate state and local agencies...". The Sign-Out/Sign-In policy provided by the ED (Executive Director) on 9/20/19 at 10:35 a.m., states, "....2. When away from the facility, all residents are asked to sign-out when they leave the building, give an anticipated time of return and sign-in when they return... 4. Residents are asked to notify staff when they may be gone. Alternate plans and documentation may be necessary if resident/tenant has medications administered by the residence...". There was no documentation in Resident C's chart indicating she would be out of the building on 7/3/19. A Missing Resident Policy provided by ED on 9/20/19 at 10:35 a.m., states, "A resident is considered missing after staff has been unable to find then in their normal area of residence. When a resident is missing, staff should:... 5. Once 90 minutes have passed, family should be notified and the police should be contacted. 6. Once the resident is found, the resident should be checked by a nurse. Contact the Nurse on call. If needed, EMS [emergency medical service] should be called. 7. Complete an incident report. 8. Follow state specific guidelines for reporting to regulatory agencies." This State residential finding relates to complaint IN00303796.			

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R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in			

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	effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to ensure the most recent annual survey results were available for examination in the facility in a place readily accessible to residents. This deficient practice had the potential to affected 70 of 70 residents that reside in the facility. Findings include: An interview was conducted with Resident 44 on 9/19/19 at 2:26 p.m. She indicated "They won't let us see the survey book." An observation of a sign located between the first floor elevator and the front desk was made on 9/18/19 at 11:20 a.m. The sign read, "A Copy of the Indiana State Department of Health Surveys are available at the Front Desk." An interview was conducted with Receptionist 4, who was standing behind the front desk, on 9/18/19 at 11:21 a.m. She indicated she was unaware of the location of the surveys referenced in the sign posted between the front desk and elevator. She'd been working at the facility since June, 2019 and had never seen a copy of the survey at the front desk. Receptionist 4 asked the BOM (Business Office Manager), who was also standing behind the front desk. The BOM	R 0090	· All current residents will be informed via a letter written by the Administrator reviewing their resident rights as a member of a residential care facility. This review will include a reminder of how to report any concerns or violations and the purpose and location of the State Survey Binder in the front lobby of the community. · All residents have the potential of being affected by this alleged deficiency. · All Current Staff will be in serviced regarding resident rights and where to locate the current state survey result book. The Administrator will meet with the Resident Council to review the annual survey results, and location of the binder that contains the facility's state survey results reports. The binder will be kept in the front lobby and labeled with a "do not remove" tag to prevent future incidents of the binder disappearing. · Compliance will be via regular walking rounds and	11/04/2019

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	indicated she didn't know where the survey was, but would look in the ED's (Executive Director's) office. The BOM went into the ED's office and came out with a survey binder. The binder was reviewed at this time, then handed back to Receptionist 4. Receptionist 4 gave the binder to the BOM who returned it to the ED's office. The ED was out of town at a conference at this time. An observation of the front desk area was made on 9/18/19 at 12:01 p.m. There was no survey binder available. An interview was conducted with Receptionist 4 on 9/18/19 at 12:01 p.m. She indicated the survey binder was currently in the ED's office. An interview was conducted with the ED in her office on 9/18/19 at 2:10 p.m., after her return from the conference. She indicated she'd been at the conference since 9/17/19 and was scheduled to come back on 9/19/19. She put something into the survey binder, prior to leaving for the conference, and did not get the binder back out to the front desk. The survey binder was observed sitting on a desk behind the ED at this time. An interview was conducted with the ED on 9/18/19 at 3:00 p.m. She indicated the facility had no policy on survey availability, but the survey binder should have been accessible to residents.		observations by the Executive Director and other leadership team members, interviewing 5 or more residents each time regarding their rights, and whether they know location of state survey results binder. This check will be done a minimum of once a week for three months. Findings will be reported to the QAPI Committee for review and recommendations.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the			

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	transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on interview and record review, the facility failed to conduct fire drills quarterly on each shift. This deficient practice had the potential to affected 70 of 70 residents in the facility. Findings include: The Fire Drill Attendance Records, from October, 2018 through September, 2019, were provided by the DON (Director of Nursing) on 9/18/19 at 1:40 p.m. There were no fire drills document on the second and third shifts for the first quarter of 2019 and no second shift drill in the second quarter of 2019. An interview was conducted with the ED (Executive Director) on 9/19/19 at 2:49 p.m. She indicated, perhaps, not all the fire drill records were provided. On 9/19/19 at 3:15 p.m., the ED provided copies of	R 0092	· It is Crown Senior Living's intention to conduct scheduled fire and disaster drills per ISDH guidelines. · All residents and staff have the potential to be affected by this alleged deficient practice. · The Regional Nurse/Operations Director have in-serviced the Executive Director and Maintenance Director on the regulations pertaining to fire and disaster drills. As an initial intervention the community will conduct a fire drill on each shift to ensure understanding and compliance by all. Drills will then be conducted according to the established quarterly schedule. The Maintenance Director will be responsible for completion of the	11/04/2019

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	the same fire drill records provided by the DON. There were no additional drills provided. The Fire policy was provided by the Memory Care Director on 9/20/19 at 8:55 a.m. It indicated "Fire drills will occur on a monthly basis. They will be rotated on each shift so there are 4 drills per year on each shift."		safety drills, maintaining records of drills and completing a drill report to the Executive Director. The Executive Director will be responsible for confirming that these drills take place per schedule and any concerns are addressed and resolved. · The Executive Director/designee will review the fire and disaster drill logs monthly for four months. Findings will be reviewed at regularly scheduled QAPI meetings. The Executive Director may also request increased drills or monitoring as needed at any time.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The			

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	director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to assure the Director of the dementia unit had 12 hours of dementia training within 3 months of employment for 1 of 5 employee records reviewed (Memory Care Director) Findings include: The employee record for the MCD (Memory Care Director) was reviewed on 9/19/2019 at 10:30 a.m. The date of hire for the MCD was 2/22/2019. The employee record for the MCD did not contain documentation to verify that 12 hours of dementia care training had been completed. During an interview on 9/19/2019 at 12:07 p.m., the Executive Director indicated that the MCD had not received 12 hours of dementia training.	R 0095	· The Memory Care Director (MCD) will obtain the required 12 hrs. of Dementia specific training by 11/04/19 and provide completion certificates for placement in the employee's personnel file. · All residents residing on the Memory Care Unit have the potential to be affected by this alleged deficiency. · The Regional Director of Operations reviewed with the Executive Director and Business Office Manager state requirements for the Memory Care Director to ensure ongoing compliance Yearly training will be obtained as required and recorded in the staff members personnel file. · The Executive Director/designee will confirm required dementia specific training and monitor ongoing training completion & report such compliance at regularly scheduled QAPI meetings for review and recommendations.	11/04/2019

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight			

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(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
	loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility did not assure a 2 step tuberculin skin test was completed for 1 of 5 employee records reviewed. (Dietary Aide 5) Findings include: The employee record for DA (Dietary Aide) 5 was reviewed on 9/19/2019 at 10:05 a.m. The date of hire for DA 5 was 3/6/2019. The employee record for DA 5 did not contain documentation of a 2 step tuberculin skin test. During an interview on 9/19/2019 at 12:07 p.m., the Executive Director indicated that DA 5 had not received a 2 step tuberculin skin test upon hire. On 9/19/019 at 9:34 a.m., the Executive Director provided the Mantoux Testing Policy. The policy reads as follows: "... All new employees will have a two-step mantoux test for tuberculosis..."	R 0121	· All residents have the potential to be affected by this alleged deficient practice. · All new employees will have 1st step administered on initial employment or prior. HR/designee to monitor & issue reminders to new hires to ensure 2nd step of TB testing is administered within 14 days of hire. · All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 11/04/19. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and Nursing Managers on the TB requirements. The Director of Nursing audited all current employee health records to ensure compliance. Any concerns were promptly addressed. · The Business Office Manager, as coordinator of employee hiring & training processes, will ensure all new hires and current employees remain compliant with this regulation. · The Business Office Manager/designee will audit/review all new hire personnel files and 10% of current long-term employees, monthly, times 3 months. Any items of concern will be promptly resolved. BOM/designee will report	11/04/2019

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			compliance at regularly scheduled Quality Assurance meetings. Monitoring will be ongoing.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure kitchen appliances, walls and floor were clean, and a dishwasher was reaching 50 ppm (parts per million) per mfg recommendation of sanitization of the dishes for 2 of 2 kitchen observations. Findings include: 1. An observation was made of the kitchen with the Dietary Manager (DM) and Dietary Aide (DA) 5 on 9/18/19 at 2:12 p.m. The DM ran the dishwasher during that time. The dishwasher's data plate on the dishwasher indicated the temperature of wash, rinse, and sanitation. It read the wash and rinse was to reach 120 degrees Fahrenheit and 50 ppm to reach sanitation. DA 5 using the white strips measured the sanitation of the dishwasher water. The strip was dipped in the water of the dishwasher, and the strip turned a light purple in color. DA 5 then placed the strip to the color coded legend on the container of the strips. DA 5 indicated the water was not reaching 50 ppm, because the strip should be turning a medium color purple. It was a light purple. DA 5 indicated at that time the dishwasher sanitation should be checked after each meal service. The dishwasher sanitization had not been checked	R 0154	It is Crown Senior Living's intention to maintain a clean kitchen that meets ISDH sanitary guidelines. The concerns noted by the survey team were addressed via a "deep clean" of the kitchen area and servicing of the dish machine by a qualified service technician. All residents have the potential to be affected by this alleged deficiency. The Executive Director and Dietary Director reviewed and revised cleaning schedules and assigned duties of kitchen staff to ensure better cleaning practices. Dietary staff were retrained on these changes and generally accepted cleaning routines. Dietary staff were also refreshed on the importance of testing and recording dishwasher ppd levels and immediately reporting any concerns to their supervisor for resolution.	11/04/2019

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	that day. The sanitation was not documented on the temperature logs only the wash and rinse temperatures. DA 5 could not determine the last time the sanitation was obtained. The sanitation strips were out, so it was possible the day before. The DM reported the dishwasher had been used that day to clean and disinfect the breakfast and lunch meal dishes. The dishwasher temperature logs were provided. There were no sanitation documented on the dishwasher temperature logs. An interview was conducted with the DM on 9/19/19 at 11:47 a.m. The service man had been out, and the dishwasher had been repaired. 2a. During an observation of the kitchen with the DM on 9/18/19 at 2:12 p.m. The kitchen floor had food and dirt debris scattered along the walls and food prep floor area of the kitchen. There was a black tar substance on the floor under the ice machine, dishwasher, and around the legs of the appliances in the kitchen. The server bottom shelf had a brown splattered substance on the shelf. The back wall of the stove and oven was observed to have had brown yellow substance dripped down the wall and on stove and oven. 2b. An observation was made of the kitchen with the DM on 9/19/19 at 11:47 a.m. The bottom shelf of the server had a brown substance splatter on the shelf. The back wall and on the stove and oven had a yellow brown substance dripped down them. The kitchen floor was observed to have a black tar substance around the legs of the appliances, dishwasher area and under the ice machine. The floor also had food and dirt debris scattered along the back walls and under the server. The DM indicated the kitchen floor needed to be scrubbed.		Compliance will be monitored by use of an audit process and observation to evaluate kitchen cleanliness and proper daily recordkeeping of sanitation tests. The Dietary Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee for review and recommendations.	

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	An interview was conducted with DA 5 on 9/19/19 at 12:10 p.m. She indicated the kitchen does get deep cleaned monthly, but the kitchen staff does not document. A cleaning policy was provided by the Memory Care Director on 9/19/19 at 9:36 a.m. "...Cleaning..1. All equipment, food contact surfaces and utensils shall be cleaned...6. The floor of the kitchen must be cleaned daily and after each spill or contamination...8. Wall surfaces that become splattered during the food preparation process must be cleaned daily...11. Documentation of cleaning must be maintained..." The "Food Code Temperatures" document was provided by the Memory Care Director on 9/19/91 at 9:36 a.m. It indicated "..Dish machine...To ensure food safety, always refer to the data plate on your dish machine.. Chlorine concentration..50 ppm..120 degrees Fahrenheit..."			
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview, the facility failed to ensure trash was contained within the dumpster. This deficient practice had the potential to affected 70 of 70 residents in the facility. Findings include: An observation of the dumpster area was made on 9/18/19 at 12:05 p.m. There were 4 blue, 2 white,	R 0155	It is Crown Senior Living's intention to maintain a clean and organized garbage dumpster area. The area is fenced in and access is limited as such. All residents have the potential to be affected by this alleged deficient practice.	11/04/2019

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	and 1 pink latex gloves on the ground, 3 plastic cups, a cigarette butt, 2 plastic hangers, and other various debris. An observation of the dumpster area was made on 9/19/19 at 10:00 a.m. The 4 blue latex gloves, 2 white latex gloves, 1 pink latex glove, 3 plastic cups, cigarette butt, 2 plastic hangers, and other various debris from the previous day remained on the ground. An observation of the dumpster area was made with the ED (Executive Director) on 9/19/19 at 2:55 p.m. The 4 blue, 2 white, and 1 pink latex gloves on the ground, along with 3 plastic cups, a cigarette butt, 2 plastic hangers, and other various debris from the 9/19/19, 10:00 a.m. observation remained. There were an additional 2 blue latex gloves on the ground as well as a blue latex glove hanging off the middle of the dumpster lid. One blue glove and one white glove were on the ground just outside of the dumpster gate. An interview was conducted with the ED on 9/19/19 at 2:55 p.m. She indicated the trash should be contained in the dumpster. The Trash Pick-up and Recycling policy was provided by the Memory Care Director on 9/20/19 at 8:55 a.m. It did not reference ensuring trash was contained in the dumpster.		The Regional Director of Operations inserviced the Administrator, Maintenance staff and Dietary Director regarding the importance of maintaining an effective waste disposal program. All other staff were retrained by the Executive Director/designee regarding importance of properly disposing of garbage and other waste products appropriately and ensuring all items are placed in the dumpster. The community also placed signage by the dumpster reminding people not to place things outside of the dumpster. Compliance will be monitored and verified as part of daily walking rounds of maintenance staff and/or weekend manager. Any concerns will be promptly addressed and corrected at time of discovery. Findings will be reported to the QAPI Committee for review and recommendations.	
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty			

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	(120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to maintain water temperatures between 100 and 120 degrees Fahrenheit for 3 of 5 residents whose room water temperatures were retrieved. (Residents F, V, and X) Findings include: An environmental tour of the facility was conducted with the Environmental Director on 9/20/19 at 10:20 a.m. The Environmental Director retrieved the water temperature from Resident X's kitchen sink at 121.3 degrees Fahrenheit and restroom sink at 121.6 degrees Fahrenheit. The water temperature from Resident F's restroom sink was at 121.3 degrees Fahrenheit. The water temperature from Resident V's restroom sink was at 122.7 degrees Fahrenheit. An interview was conducted with the Environmental Director on 9/20/19 at 10:45 a.m. He indicated he checked water temperatures once a week, one on each floor, in order to obtain all room water temperatures. He documented the temperatures in a binder, but the binder had been missing for 2 weeks, and since the binder was missing, he' had been documenting the water temperatures on paper, but threw them away. The temperatures he retrieved in Residents V, F, and X's rooms were typical, and would reach as high as 125 degrees Fahrenheit. He thought the water temperatures on the water heaters were set to 127 degrees Fahrenheit, so the water would be hot by the time it reached the 4th floor. He tried to keep water temperatures at 118 degrees Fahrenheit and had not had any complaints about water temperatures.	R 0187	It is Crown Senior Living's intention to maintain hot water temperatures that serve resident areas within the 100 to 120-degree Fahrenheit range. Concerns identified by survey team were promptly addressed via adjustments in mixing values by maintenance staff. All residents have the potential to be affected by this alleged deficient practice. At no time should hot water temperatures in resident areas exceed 120 degrees F. The Regional Director of Operations in-serviced the Administrator, Leadership Team and Maintenance Staff on the hot water temperature guidelines and use of tracking form. Facility Tracking Form was updated to allow for recording of resident room hot water temperatures five days a week, at a minimum of five points of reference, to be varied by day. Maintenance staff reviewed how to adjust mixing values and method for obtaining service from authorized plumber, as needed, to ensure compliance and safe water temperatures. Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this	11/04/2019

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	An observation of the water heater room on the 1st floor of the facility was made on 10/20/19 at 10:58 a.m. There were 3 large water heaters with digital displays on the front of the heaters. The first heater was set to 118 degrees Fahrenheit with an actual water temperature of 121 degrees Fahrenheit. The second heater was set to 122 degrees Fahrenheit with an actual water temperature of 124 degrees Fahrenheit. The third heater was set to 125 degrees Fahrenheit with an actual water temperature of 125 degrees Fahrenheit. An interview was conducted with the Environmental Director on 9/20/19 at 11:43 a.m. He indicated the facility had no policy on water temperatures. They used the regulations to maintain them between 100 and 120 degrees Fahrenheit.		audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe hot water temperatures. Findings will be reported to the QAPI Committee for review and recommendations.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to obtain an admission weight for 1 of 5 residents whose clinical records were reviewed.	R 0216	· ·It is Crown Senior Living's intention to provide every resident	11/04/2019

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	(Resident Y) Findings include: The clinical record for Resident Y was reviewed on 9/19/19 at 9:45 a.m. The diagnoses for the resident included, but were not limited to, Parkinson's disease and hypertension. He was admitted to the facility on 11/9/18. The Weights and Vitals Summary for Resident Y indicated the earliest weight obtained was on 12/11/18. There was no weight upon admission located in the rest of the clinical record. An interview was conducted with the DON (Director of Nursing) on 9/19/19 at 2:15 p.m. She indicated she was unable to locate an admission weight for Resident Y. The Weight Monitoring policy was provided by the Memory Care Director on 9/19/19 at 9:34 a.m. It read, "A routine cycle will be established in the assistance/service plan for weight monitoring for each resident..."		with an evaluation upon admission including a weight. Resident Y's missing admission weight could not be corrected but they were weighed now and found to have no weight loss concern. ·All residents have the potential to be affected by this alleged deficient practice. An audit of all resident's charts was performed to identify any missing or incomplete evaluations including weights. Identified concerns were addressed and new evaluations performed, as appropriate. ·Upon review of this alleged noncompliance Crown Senior Living updated their procedure and assignments to ensure weights are obtained as specified. Going forth, all residents will have weights done upon admission, monthly and with each service plan review. To enhance the effort of this change, under the direction of the Executive Director and the Director of Nursing any staff member responsible with assisting with an admission will be reeducated on all needed items to be completed upon an admission. ·Each Resident admitted will be reviewed by the Director of Nursing to ensure compliance. All admission needs will be reviewed, documented and monitored by the Director of Nursing and Executive Director, weekly for three months, then monthly thereafter. Any deficiencies found in the audits will	

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			be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe hot water temperatures. Findings will be reported to the QAPI Committee for review and recommendations.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be			

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	involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to have a service plan for 5 of 5 residents whose clinical records were reviewed. (Resident C, F, G, Q and Z) Findings include: 1. The clinical record for Resident Z was reviewed on 9/18/19 at 2:00 p.m. The diagnoses for the resident included, but were not limited to, schizophrenia and bipolar disorder. She was admitted to the facility on 11/17/18. No service plan was located in Resident Z's clinical record. An interview was conducted with the MCD (Memory Care Director) and DON (Director of Nursing) on 9/18/19 at 3:05 p.m. The MCD reviewed Resident Z's clinical record and indicated she was unable to locate a service plan for her. The DON indicated they were working on service plans, and had 35 unsigned service plans in the system. The Assistance/Service Plan policy was provided by the MCD on 9/19/19 at 9:34 a.m. It read, "1. An assistance/service plan will be completed by the Resident Services Coordinator prior to move-in. 2. The Resident Services Coordinator and Resident Assistant will visit with the resident and family to complete the plan. 3. The Resident Services Coordinator will establish a schedule for services based on the assistance/service plan and inform the Resident Assistants of assistance needs. 4. All components of the assistance/service plan form must be competed."	R 0217	·It is Crown Senior Living's intention to provide every resident with a current service plan detailing plan of care and individual needs of the resident. The service plans of resident's C, F, G, Q and Z were updated. ·All residents have the potential to be affected by this alleged deficiency. The Director of Nursing audited all resident charts for a current service plan and updated all those missing such or in need of an update. Service plan meetings will be scheduled with residents and family members to develop everyone service plan if found to need review, updated or if they have a missing signature. Crown Senior Living will accommodate any resident with the need of conference calls, to accommodate family that may not be able to be physically present and if the resident choses to have family involved in the development of this service plan. The resident will sign if able to and 2 staff will be present with and conference calls for service plans. Both staff will sign off and verify that the call took place and indicate who the call was with. ·Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct an audit of 10% of the current	11/04/2019

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	2. The clinical record for Resident Q was reviewed on 9/18/19 at 3:00 p.m. The diagnoses for the resident included, but was not limited to, vascular dementia. A service plan, dated 7/21/19, for Resident Q was provided by the Memory Care Director on 9/19/19 at 1:57 p.m. It did not include Resident Q's signature. An interview was conducted with the Director of Nursing (DON) on 9/19/19 at 2:55 p.m. She indicated they are working on the service plans. Resident Q had not signed her service plan. 3. The clinical record for Resident F was reviewed on 9/18/2019 at 2:30 p.m. The diagnoses for the resident included, but were not limited to, dementia and chronic kidney disease. During an interview on 9/18/2019 at 11:20 a.m., QMA (Qualified Medication Aide) 4 indicated Resident F was not interviewable due to her diagnosis of dementia. The clinical record for Resident F contained a services plan, dated 9/3/2019. There was no documentation in the clinical record indicating that the service plan had been signed or reviewed by Resident F's legal representative. During an interview on 9/20/2019 at 10:50 a.m., the Memory Care Director indicated that there was no signed service plan for Resident F. 4. The clinical record for Resident G was reviewed on 9/19/2019 at 3:10 p.m. The diagnoses for the resident included, but were not limited to, diabetes, hypothyroidism, and pain in joints. During an interview on 9/19/2019 at 2:15 p.m.,		resident's charts as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Committee for review and recommendations	

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	Resident G indicated he had never had his service plan reviewed with him. The clinical record contained a service plan, with a revision date of 9/12/2019, which was not signed by Resident G. There was no documentation in the clinical record that the service plan had been reviewed with him. During an interview on 9/20/2019 at 10:50 a.m., the Memory Care Director indicated there was no signed service plan for Resident G. On 9/19/2019 at 9:34 a.m., the Memory Care Director provided the Assistance/ Service Plan Policy which reads as follows: "...2. The Resident Services Coordinator and Resident Assistant will visit with the resident and family to complete the plan..." 5. The record for Resident C was reviewed on 9/17/19 at 10:15 a.m. Diagnoses included, but were not limited to, dementia, hypertension, chronic kidney disease, atrial fibrillation, and cerebral vascular accident. The Clinical Record for Resident C indicated the last service plan was created on 5/29/18 and was to be reviewed by 8/29/18. An interview with MCD on 9/19/19 at 9:24 a.m. indicated, Resident C's service plan had not been updated since 5/29/18. Resident C's service plan was on a list of 'to be completed' service plans.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling			

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	standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure kitchen staff were monitoring food temperatures with an easily assessable food temperature measuring device for 2 of 2 kitchen servers observed and to ensure safe food handling standards for the residents dining on the Dementia unit during the dining observation for 23 of 23 residents eating on the Dementia unit. Findings include: 1. A kitchen observation was made with the Dietary Manager and Dietary Aide (DA) 5 on 9/19/19 at 11:47 p.m. The kitchen food server was observed with metal pans of food sitting inside the server. DA 5 indicated she did not have a thermometer for food temperatures. She had been missing a thermometer for 3 to 4 weeks. DA 5 had been using the oven to obtain food temperatures. At that time, DA 5 placed oven mittens on and went to the oven. The oven door was pulled down and she indicated at that time a black wire string device attached inside the oven wall would be used to measure food temperatures. The black wire device was tangled inside the oven, so DA 5 placed her oven mitten hands and worked the wire device free from where it was caught in the oven. She then returned to the server and remove a metal pan of food and placed the pan inside the oven. DA 5 was observed placing the black wire device into the food and then closing the oven door. She then pushed buttons on the oven to obtain the food temperature. After, DA 5 removed the pan and returned it back to the server. She repeated that procedure with each metal pans of food on the server. The September 2019 food temperature logs were	R 0273	· It is the intention of Crown Senior Living to follow established safe food handing guidelines including recording of food temperatures prior to service. · All residents have the potential to be affected by this alleged deficiency. · Food temperatures at point of service will be recorded by dietary servers using the established tracking form. Any variances will be addressed to ensure safe serving of food. All dietary staff will be re-educated no later than 11/02/2019 at mandatory dietary staff meeting on appropriate food temps & procedures for recording such and how to address any variances to resolve temperature concern. · Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Committee for review and recommendations.	11/04/2019

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	provided by the Dietary Manager. It indicated the following days and meal service food temperatures were not obtained by the dietary staff: -9/4/19 - breakfast, lunch, and dinner, -9/7/19 - dinner, -9/12/19 - lunch and dinner, -9/14/19 - lunch and dinner, -9/15/19 - dinner, and -9/17/19 - breakfast, lunch, and dinner 2. An observation was made of the Memory Care kitchen server with Qualified Medication Aide (QMA) 20 and Certified Nursing Assistant (CNA) 13 on 9/19/19 at 2:24 p.m. QMA 20 and CNA 13 indicated metal pans of food are brought up from the downstairs kitchen and placed in the food server. CNA 13 and QMA 20 did have food temperature logs and thermometer, but they do not obtain food temperatures. QMA 20 reported she turned up the knobs on the server to keep the food warm. The temperature food logs were provided at that time. The September 2019 daily food logs were all blank. There were no food temperatures logged. The Retail Food Establishment Sanitation Requirement, dated 11/13/04, indicated "...410 IAC 7-24-253 Durability and strength of food temperature measuring devices Sec. 253. (a) Food temperature measuring devices may not have sensors or stems constructed of glass, except that thermometers with glass sensors or stems that are encased in a shatterproof coating, such as candy thermometers, may be used. Function of temperature measuring devices Sec. 256. (a) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature in		***R299- Pharmaceutical Services- Noncompliance***	

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	the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.Food temperature measuring devices shall be provided and readily accessible for use in ensuring attainment and maintenance of food temperatures as specified under section 139 through 160, 162 through 167, 169 through 183, 185 through 191, 193 through 200, 203, 234, 236, 245 through 247, or 249 of this rule.(b) A temperature measuring device with a suitable small diameter probe that is designed to measure the temperature of thin masses shall be provided and readily accessible to accurately measure the temperature in thin foods, such as meat patties and fish filets..." 3. An observation was made of the Dementia unit dining room on 9/18/19 at 12:15 p.m. At that time, CNA 4 was plating food from the steam table for the residents on the unit. CNA 4 had on gloves when she wiped her brow with her left, gloved, hand. CNA 4 then grabbed an empty plate with the same hand, plated food for a resident and that plate was served to the resident. An interview with CNA 4 on 9/18/19 at 12:31 p.m., indicated she should not have touched her face and continued to plate food with the same gloved hand when serving residents food. The Retail Food Manual states,"....Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms...			

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	(b) For purposes of this section, a violation of subsection (a) is a critical item.;".			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review, the facility failed to document a resident's pharmacy review in accordance with a facility policy for 1 of 5 residents whose clinical records were reviewed. (Resident Y) Findings include: The clinical record for Resident Y was reviewed on 9/19/19 at 9:45 a.m. He was admitted to the facility on 11/9/18. The Diagnoses Report for the resident indicated the following diagnoses with onset dates of 11/9/18: diabetes mellitus, constipation, essential hypertension, insomnia, and Parkinson's disease. Acute bronchitis was listed with an onset date of 12/18/18. These were the only diagnoses listed. The physician's order for Resident Y indicated Olanzapine 10 mg to be given at bedtime related to essential hypertension, with a start date of 11/9/18. The 7/26/19 pharmacy recommendation read, "Please provide/clarify diagnosis for: Olanzapine. (essential hypertension not approved.)" There was no response to this recommendation or any information in the clinical record to indicate the recommendation was addressed. An interview was conducted with the DON	R 0299	·It is Crown Senior Living's intention to have a Pharmacy review for every resident every 60 days. Crown currently contracts for these services with PCA Pharmacy. This Pharmacy review will include a Pharmacist drug regimen review for every resident, with recommendations provided to the attending physician for review and response. ·All residents have the potential to be affected by this alleged deficiency. The Director of Nursing audited all current resident charts to confirm that they had received a recent pharmacy review and found no other deficiency. ·Crown Senior Living has reviewed and affirmed our current process of how Pharmacy recommendations are completed. We have added the step that if after 15 days the resident's physician has not responded the DON/designee will reach out to the physician for clarification of their response to the pharmacy recommendation. Such notification will be documented in	11/04/2019

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	(Director of Nursing) on 9/19/19 at 10:45 a.m. She reviewed Resident Y's diagnoses in his clinical record and indicated she was unsure about the diagnosis for the resident's Olanzapine use. The facility's process to address pharmacy recommendations was for the nurse practitioner or physician, who's in the facility twice weekly, to respond to the recommendation and for the response to be documented in the clinical record. She expected the 7/26/19 pharmacy recommendation to have been addressed by now. An interview was conducted with the DON and ED (Executive Director) on 9/19/19 at 2:15 p.m. The DON indicated she spoke with the nurse practitioner about the 7/26/19 pharmacy recommendation, and she was going to address it. The DON was unsure why the recommendation was not previously addressed, as it must have been missed. The ED stated, "I searched high and low, and can't find a policy on pharmacy reviews." An interview was conducted with the MCD on 9/20/19 at 9:33 a.m. She stated, "I know we gave the recommendation to the NP yesterday, but I don't see how the recommendation was addressed in his record." On 9/20/19 at 9:06 a.m., the ED provided a pink sticky note that read, "[Symbol for "no"] policy for pharmacy recommendations." An interview was conducted with the ED and MCD (Memory Care Director) on 9/20/19 at 9:20 a.m. The ED stated, "...we don't have a policy regarding pharmacy recommendations."		the resident's clinical record. ·Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct an audit of 10% of the current resident's charts as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Committee for review and recommendations.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records			

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	on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to have complete and accurate clinical records for 2 of 2 closed resident records reviewed. (Resident 55 and 83) Findings include: 1. The clinical record for Resident 55 was reviewed on 9/19/19 at 10:00 a.m. The diagnoses for Resident 60 included, but was not limited to dementia without behavioral disturbances. A nursing progress note, dated 9/9/19, indicated the resident had been sent to the emergency room. 2. The clinical record for Resident 83 was reviewed on 9/19/19 at 9:00 a.m. The diagnosis for Resident 83 included, but was not limited to, dementia with lewy bodies. A nursing progress note, dated 7/10/19, indicated the resident had been sent to the emergency room. The transfer discharge reports for Resident 55 and Resident 83 were provided by the Director of Nursing on 9/19/19 at 4:00 p.m. Resident 55 and Resident 83's transfer reports did not include the level of functioning, physical limitations, and	R 0349	·All residents have the potential to be affected by this alleged deficiency. ·Going forth all residents will need to have a completed discharge packet sent with them at time of transfer. The nurse/QMA will document in the chart the resident's discharge including reason and place of discharge. Copy of packet will be maintained, if possible, in the resident's clinical record. The DON will audit for completion within three business days of discharge. ·All nursing staff will be in-serviced on revised procedures including necessary documentations on transfer form, need for note in clinical record and placing a copy of the transfer form in the Medical record. ·DON/designee to review discharge packet monitoring weekly. If any discrepancy is noted, it will be addressed at the time found and the Executive Director will then re- evaluate if more frequent monitoring is in need. Our facility, as always, has the intent to be 100% in	11/04/2019

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	personal belongings sent with the residents. An interview was conducted with the Memory Care Director (MCD) and Director of Nursing (DON) on 9/19/19 at 4:11 p.m. The MCD indicated the level of functioning, physical limitations and personal belongings all are filled out manually after the reports are printed prior to leaving. The staff send all paperwork with the resident. They do not keep a completed copy of the transfer reports in the clinical record.		compliance. DON/designee will report compliance at the QA meeting Monthly to ensure compliance with ISDH.	
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on interview and record review, the facility failed to develop a comprehensive care plan within 30 days of admission for a resident with a major mental illness for 1 of 5 residents whose clinical records were reviewed. (Resident Z) Findings include: The clinical record for Resident Z was reviewed on 9/18/19 at 2:00 p.m. She was admitted to the facility on 11/17/18. The 11/19/18 Admission Record for Resident Z indicated a diagnosis of schizophrenia with an onset date of 11/17/18 and a diagnosis of schizoaffective disorder, bipolar type with an onset date of 11/17/18. No service plan or comprehensive care plan were located in Resident Z's clinical record. An interview was conducted with the MCD (Memory Care Director) and DON (Director of	R 0382	***(f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility.*** ***(g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive care plan for the resident that includes the following:*** ***(1) Psychosocial rehabilitation services that are to be provided within the community.*** ***(2) A comprehensive range of activities to meet multiple levels of need, including the following:*** ***(A) Recreational and socialization activities.*** ***(B) Social skills.***	11/04/2019

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	Nursing) on 9/18/19 at 3:05 p.m. The MCD reviewed Resident Z's clinical record and indicated she was unable to locate a service plan for her. An interview was conducted with the MCD (Memory Care Director) on 9/19/19 at 10:50 a.m. She indicated the facility began utilizing a mental health provider at the facility in June, 2019, and Resident Z did not have a comprehensive care plan developed within 30 days of her admission. On 9/19/19 at 10:50 a.m., the MCD provided mental health notes for Resident Z, including the 6/18/19 Psychiatry Initial Consult. The consult included an assessment and plan for her schizoaffective disorder, bipolar type." The Health Counseling policy was provided by the MCD on 9/19/19 at 12:20 p.m. It read, "Health counseling should occur when the resident has a concern or the staff has identified a concern."		***(C) Training, occupational, and work programs.*** ***(D) Opportunities for progression into less restrictive and more independent living arrangements.*** · The identified concern with Resident Z's missing plan of care was resolved, her care plan was updated and placed in her clinical record including a mental health screen. · All residents have the potential to be affected by this alleged deficiency. The Director of Nursing/designee will complete an audit of every current resident's chart to verify that they have a current service plan including a mental health screen, as appropriate. Missing or incomplete plans of care will be created or revised and placed into their clinical record. Service plan meetings with the resident/POA will be scheduled, either in person or by conference call and involve the resident, their POA or any other invited guests of their choosing. The meeting will be documented in the resident's clinical record and the resident or their representative will sign the service plan. · To enhance the effort of this change, under the direction of the Executive Director and the Director of Nursing any staff member responsible with the	

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			responsibility of assisting with the creation of an ISP will be re-educated on including Mental Illness Diagnosis being added to the ISP. This reeducation will be in the form of written and verbal in-servicing. Reeducation will include that each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Crown Senior Living, in cooperation with the mental health service providers, shall develop the comprehensive care plan for the resident that includes the following, Psychosocial rehabilitation services that are to be provided within the community. A comprehensive range of activities to meet multiple levels of need, including the following: Recreational and socialization activities, Social skills, Training, occupational, work programs and opportunities for progression into less restrictive and more independent living arrangements. · Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided	

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			to staff or additional monitoring conducted, as necessary, to ensure service plans are complete and timely. Findings will be reported to the QAPI Committee for review and recommendations	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a resident had an annual health assessment, including history of significant past or present infectious diseases, and a statement that the resident shows no evidence of tuberculosis in an infectious stage for 1 of 5 residents reviewed (Resident C) Finding includes: The record for Resident C was reviewed on 9/17/19 at 10:15 a.m. Diagnoses included, but were not limited to, dementia, hypertension, chronic kidney disease, atrial fibrillation, and cerebral vascular accident. The clinical record for the resident was reviewed on 9/17/19. The record indicated there was no physician signed annual health statement stating the resident was free from tuberculosis in an infectious stage.	R 0409	· It is Crown Senior Living's intention to ensure every resident receives an annual health assessment including history of infectious diseases. Crown Senior Living nurses will complete an annual Health Assessment including TB screen for each resident. Resident C's annual health assessment was updated and placed in their clinical record. · All residents have the potential to be affected by this alleged deficiency. The Director of Nursing/designee audited all current resident records to ensure that each resident had the required health assessment fully completed including TB screen, in accordance with state regulations. Any resident not current had an updated health	11/04/2019

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	Interview with the Memory Care Director (MCD) on 9/18/19 at 10:00 a.m., indicated there was no annual health statement.		assessment completed and placed in their clinical record. · Going forth, every new admission will have an annual TB Health assessment completed upon admission. Thereafter, this assessment will be completed annually with the community's schedule for residents' TB administration. · Compliance will be monitored by use of an Audit Process and Tracking Form. The Administrator/designee will audit the records of all new admission records to ensure proper documentation including evidence of a tuberculin skin test within three months prior to admission. Compliance audits conducted per the following schedule: 2 times a week for four weeks; weekly for four weeks; then monthly thereafter. Any identified areas of concern will be promptly addressed. Audit results will be regularly reported to the QAPI Committee for review and recommendations.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a			

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	documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to have tuberculin (TB) skin testing upon admission to the facility for 4 of 5 residents whose clinical records were reviewed. (Residents F, Q, Y and Z) Findings include: 1. The clinical record for Resident Y was reviewed on 9/19/19 at 9:45 a.m. The diagnoses for the resident included, but were not limited to, Parkinson's disease and hypertension. He was admitted to the facility on 11/9/18. The Immunization Report for Resident Y indicated he had a TB 1 Step Mantoux administered on 3/15/19. There was no information in the clinical record to indicate a TB test upon admission. An interview was conducted with the DON (Director of Nursing) on 9/19/19 at 2:15 p.m. She indicated she was unable to locate verification of a TB test upon admission. 2. The clinical record for Resident Z was reviewed on 9/18/19 at 2:00 p.m. The diagnoses for the	R 0410	R410 – Infection Control – (Missing 2 Step) · It is Crown Senior Living's intention to provide every resident with a safe, sanitary and comfortable environment and help prevent the development and transmission of diseases and infection. The Director of Nursing obtained orders to have a new tuberculin skin test completed on Residents F, Q, Y and Z to ensure they were free of tuberculosis. · All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing/designee audited all resident records to ensure that each resident had the required tuberculin skin test in accordance with state regulations. Any resident not current was offered a new TB skin test to ensure they are free of tuberculosis and their record updated.	11/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	resident included, but were not limited to, schizophrenia and bipolar disorder. She was admitted to the facility on 11/17/18. The Immunization Report for Resident Z indicated she had a TB 1 Step Mantoux administered on 3/15/19. There was no information in the clinical record to indicate a TB test upon admission. An interview was conducted with the MCD (Memory Care Director) and DON (Director of Nursing) on 9/18/19 at 3:05 p.m. The MCD reviewed Resident Z's clinical record and indicated she was unable to locate verification of a TB test upon admission. 3. The clinical record for Resident Q was reviewed on 9/18/19 at 3:00 p.m. The diagnosis for the resident included, but was not limited to, vascular dementia. The "Immunization/Mantoux (Tuberculosis) Record" for Resident Q indicated the 2nd step PPD was obtained on 8/21/18 and read on 8/24/18. It did not include an annual PPD. An interview was conducted with the Director of Nursing (DON) on 9/19/19 at 2:55 p.m. She indicated an annual PPD had not been completed in August 2019 for Resident Q. The Mantoux Testing Policy was provided by the Memory Care Director on 9/19/19 9:34 a.m. It indicated "..Tuberculosis is on the rise as a communicable disease. To be in compliance with state laws....All staff and residents will be retested per state and county guidelines, annually..." 4. The clinical record for Resident F was reviewed on 9/18/2019 at 2:30 p.m. The diagnoses for the resident included, but were not limited to, dementia and chronic kidney disease.		· Prior to or at the time of admission, all new admissions will have their 1st step administered if they had not already had done. If admitting from home, facility will administer the 1st step within 72 hrs. The 2nd step will be administered within 14-21 days of admission. Director of Nursing/designee will verify TB screening and its inclusion into the medical record. No resident shall be admitted without that information on file and in their medical record. Current residents will be monitored for yearly screen and tuberculin skin test by use of a reminder on the eMAR and a report reminder to the Director of Nursing. The Regional Clinical Nurse inserviced nurses and QMA's on the facility Infection Control policies pertaining to tuberculosis. · Compliance will be monitored by use of an Audit Process and Tracking Form. The Administrator/designee will audit 10% of current resident clinical records to verify proper documentation of health assessment including yearly TB screening. Compliance audits conducted per the following schedule: 2 times a week for four weeks; weekly for four weeks; then monthly thereafter. Any identified areas of concern will be addressed. Audit results will be regularly reported to the QAPI	

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	The clinical record indicated the resident was admitted to the facility on 4/27/2019. The record lacked a 2 step tuberculin skin test. During an interview on 9/20/2019 at 12:32 p.m., the Director of Nursing indicated Resident F did not have a 2 step tuberculin test documented as completed upon admission. On 9/19/019 at 9:34 a.m., the Executive Director provided the mantoux Testing Policy. The policy reads as follows: "... All assisted living residents will has a two-step mantoux test within 3 days of admission..."		Committee for review and recommendation.	