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	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00399970, IN00395543, IN00393659 and IN00395113. Complaint IN00399970 - State deficiencies related to the allegations are cited at R0241 Complaint IN00395113 - State deficiencies related to the allegations are cited at R0048 Complaint IN00395543 - State deficiencies related to the allegations are cited at R0036 and R0048 Complaint IN00393659 - State deficiencies related to the allegations are cited at R0036, R0217, and R0240 Survey dates: April 3, 4, 5, and 6, 2023 Facility number: 013328 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 12, 2023	R 0000	The Plan of Correction is neither an agreement with nor an admission of wrong doing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 31, 2023.	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility	R 0029	This citation is being submitted for the informal dispute resolution	05/31/2023

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

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	04/06/2023

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

(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
	failed to ensure a resident's dignity was protected, when a staff member spoke in an intimidating way to a resident, causing her emotional distress and ongoing fear of further incidents for 1 of 3 residents reviewed for dignity (Resident N). Findings include: The clinical record for Resident N was reviewed on 4/4/23 at 1:31 p.m. The Resident's diagnosis included, but were not limited to, major depressive disorder, anxiety disorder, and multiple sclerosis. A service plan, last revised on 8/4/22, indicated she had a psychosocial well-being problem related to anxiety and depression. The goal was for her to effectively cope with her feelings of depression and anxiety. The interventions included, but were not limited to, encourage, assist and support to set realistic goals and follow community policies and house rules, last revised 8/4/22, engage in conversations with team members and other residents daily, last revised 8/4/22, engage in discussions about care and living environment: discuss all procedures, treatments, medication, and changes in condition, initiated 8/4/22, and to continue psych services, initiated 8/4/22. A service plan, last revised on 8/4/22, indicated she had psychological services for depression and anxiety. The goal was for her not to act out with behaviors, in a way that was harmful to herself or others. The interventions, initiated 8/4/22, were that she would make choices that did not comply with physicians' orders. She was aware of the risks of not following physicians' orders and staff would document refusals. The physician would be notified on noncompliance or refusals, and continued psychological services.		process. In January of 2023, a new management company assumed responsibility for the operations of the community. An interim administrator was put in place until the permanent administrator could be hired. During the first few weeks of her leadership, the interim administrator experienced several complaints related to this resident, describing her as a bully, having a temper to the point other residents are fearful of her and intimidating others into getting her way. Because new leadership is often an opportunity for residents or staff to be air long standing grievances or even an attempt to taint the new leadership's perspective, the interim administrator waited to observe behaviors and validate the concerns before taking any action. The interim administrator also reviewed the resident handbook and its contents with residents in a meeting before taking any action. The interim administrator and department managers attempted to intervene in resident's behaviors, particularly in cases in which other residents were obviously upset by her actions. The resident did not alter her behaviors. Based upon her previous assessments, the team agreed, in conjunction with her case manager, to move forward with a structured meeting to clearly list her inappropriate	

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	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Level of Care Assessment, dated 12/14/22, indicated Resident N was able to communicate information, she understands information conveyed, may miss some parts of the intent of the message. She was oriented to person, place, and time. She needed reassurance 3 or more days a week and may refuse to make decisions. Her decisions were poor, requiring cueing and supervision. She is not have a memory impairment. She attitudes, disturbances, and emotional created daily difficulties and can only be modified in a special setting or with a special plan. A Behavior Note, dated 3/14/23 at 10:29 a.m., read "...When speaking with another resident [Resident N] interrupted and asked if I was scared of her, if she intimidated me, and if I had any problems with her. She had asked multiple times in a row. This is in regard to her last service plan meeting. I had told her no, and that this is something we should not be discussing..." During an interview on 4/4/23 at 1:31 p.m., Resident N indicated that she had received a certified letter at the end of February inviting her to attend a mandatory discharge meeting being held March 10, 2023. Resident N had asked the ADM (Interim Administrator) what the meeting was about and was not given any information or specifics about the upcoming meeting from the ADM. Resident N had asked about the meeting several times after receiving the mandatory discharge meeting invitation and had received no information about what the meeting would include. During the time between receiving the letter and the meeting occurring, Resident N had felt afraid that she was going to be kicked out and was scared that if she "breathed wrong" she would be in trouble. Resident N had invited		behaviors in a manner that prevents her from denying the behaviors and to share with her that continuing such behaviors would result in termination of her residency agreement. The CICOA case manager indicated that the resident had reached out to her an indicated that we were abusing her prior to the meeting because we had requested a meeting. The CICOA case manager indicated that it was a pattern for this resident to attempt to discredited staff members of the community by alleging some form of abuse when she is confronted with inappropriate behaviors. The CICOA case manager indicated to the resident that this did not merit abuse and that the resident could report this if necessary. Prior to the meeting, the resident approached the interim administrator once, not three times as alleged, the day prior to the scheduled meeting at a time when the interim ED had multiple meetings schedule. The interim administrator explained that she was booked for the remainder of the day, but that we would discuss the concerns with everyone present during the meeting. The meeting provided her a listing of behaviors, specific examples from witnesses and recommendations for modification of her behavior to continue her residency at this community. This	

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	04/06/2023

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

(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
	several people to attend the meeting with her including Resident P, Resident Z, the Ombudsman, and Family Member 18. During that meeting the ADM had accused Resident N of using excessive speed on her electric scooter, and of giving guidance to other residents about their medications. The ADM had asked Resident N not to discuss any medical issues with other residents. During the meeting the ADM had accused Resident N of bullying the staff and other residents and told Resident N that no one liked her and that they were all afraid of her. The ADM had told her she was gaslighting (to psychologically manipulate [a person] usually over an extended period of time the that the victim questions the validity of their own thoughts, perceptions of reality, or memories), and when Resident N attempted to defend herself, she was cut off by the ADM, accused of not telling the truth, and not allowed to say anything. Resident N felt that she was treated very disrespectfully during the meeting and felt attacked by the ADM and the other management staff who were present at the meeting. Resident N had not filed a grievance about the meeting because the ADM was also the new owner of the facility and Resident N did not want to make things worse for herself. The clinical record did not contain a progress note about the mandatory discharge planning meeting. During an interview on 4/5/23 at 11:38 a.m., Resident P indicated he has been present at the mandatory discharge planning meeting for Resident N on March 10, 2023. Resident P has spoken with Resident N several times prior to the meeting being held to offer reassurance because Resident N was scared about what would happen at the meeting. During the meeting, Resident P		approach was taken to comply with her service plan recommendations in place at the time of the non-compliance. During the meeting, she interacted frequently, denied each of the items brought to her attention despite witnesses explaining the scenario and spoke freely without intimidation. She, at no time, indicated that she was uncomfortable, stopped speaking or gave any indication that she felt intimidated or abused. Under the advice of the resident council president, this resident did advise the Ombudsman that he could not speak with us regarding any feelings that she had about the meeting. Contrary to the documentation in the survey, notes from the meeting could be found under the “Documents” tab in the EMAR. Staff was not asked for these notes and were not aware that surveyors were seeking this information. Staff and CICOA case manager were not aware of any allegation of abuse until the resident reported it to the surveyors during the state survey, nearly one month later. Following notification by the surveyors, an investigation was done of all staff members present during the discharge planning meeting, no verbal abuse or disrespect was validated as noted by the residents present and the CICOA case manager, with whom the	

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	04/06/2023

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

(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
	had been surprised when the ADM had a "laundry list" of things that Resident N was doing wrong. During the meeting Resident P had noticed that when Resident N tried to defend herself, she had not been allowed to speak and that ADM and the MC (Memory Care Coordinator) had accused Resident N of not telling the truth and gaslighting. Resident P felt that the ADM had been trying to intimidate Resident N during the meeting and could see that Resident N felt attacked. During an interview on 4/5/23 at 2:37 p.m., the Psych NP (Psychiatric Nurse Practitioner) indicated she had been seeing Resident N for quite a while. The Psych NP had worked with Resident N on developing coping skills to deal her PTSD relating to dealing with another resident in the facility who reminded Resident N of a person who had cause Resident N trauma in the past. The Psych NP was also working with Resident N of developing coping skills to deal with her anxiety and depression and that Resident N regularly saw a councilor to assist her with developing coping skills. The Psych NP had noticed an improvement in Resident N's overall mental health through the course of her treatment. The Psych NP had not been aware there had been a mandatory discharge meeting for Resident N and had not been invited to the meeting. The Psych NP would have liked to have attended the meeting so that she could have been more aware of issues Resident N needed to continue to improve upon. On 4/5/23 at 4:13 p.m., the ADM provided a copy of the invitation to the mandatory discharge planning meeting sent to Resident N on 2/23/23 which read "... This letter is to request your attendance at a mandatory discharge planning meeting on March 10th at 10:30 am in the		surveyors did not speak. As with all allegations of abuse, this community required that all involved parties to be immediately removed from the community and potential exposure of the resident to the parties. The community then completed an investigation and reported this allegation to the Indiana Department of Health. Based upon interviews of residents within the community as well as the case manager, the community found no abuse or disrespect to have occurred for the resident identified in this case. The new Administrator for the community will lead all discharge planning for this resident going forward. During the investigation completed for the review of allegation of abuse by staff members, this community interviewed residents and was not able to found additional persons who have alleged abuse or disrespect of a resident by a staff member. Therefore, no additional interventions were put in place. The new Administrator, for the community will lead any discharge planning meetings going forward in coordination with the residents' case managers in lieu of the management company representative. As part of the onboarding process for the new management company, each permanent employee is asked to	

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	04/06/2023

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

(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
	conference room at .... The meeting is to discuss your ongoing violations of the health and safety standards of the community which place not only us but also our other residents and staff at risk. We have taken the liberty of inviting your case manager from CICOA [sic], our leadership and .... Therapies. As you are your own responsible party, we have not invited any other parties. We would be happy to have other persons who you feel might assist you during this meeting. You may invite them, or you may ask us to do so. Unless you notify us that you are unable to attend, we will plan our meeting for March 10th at 10:30 am.... We appreciate your participation...." During an interview on 4/6/23 at 11:43 a.m., the SO (State Ombudsman) indicated that he had attended the mandatory discharge meeting for Resident N on March 10, 2023. The SO felt that the ADM had been very direct during the meeting and not "fluffed" her words. The SO could not recall if the ADM had accused Resident N of lying directly, but the sentiment was conveyed. During the meeting the ADM had accused Resident N of gaslighting and of engaging with the staff. The SO felt that the meeting was a negative assessment of Resident N character. The OS felt the meeting was a "warning" meeting about creating change in Resident N's behavior going forward and if change did not occur then the facility may attempt an involuntary discharge. Resident N had been hurt by the meeting and the SO would have felt hurt as well if he had been the "subject" of the meeting. After the meeting, the SO had asked Resident N if she needed to talk about the meeting or if she wanted some time alone. Resident N was not obviously crying but appeared very upset and shaken.		complete general orientation, including resident rights and reportable occurrences, to provide education to all employees. Following each discharge planning meeting, the case manager and resident or responsible party will be asked if they feel that the resident was treated fairly and appropriately, or if the resident feels that they were disrespected or abused in any way. The community will take and incorporate any feedback from the case manager and resident to provide support for that person. This will take place with each discharge planning meeting for a period of one year.	

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	04/06/2023

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

(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
	During an interview on 4/6/23 at 1:42 p.m., FM (Family Member) 18 indicated she had attended the mandatory discharge meeting for Resident N on 3/10/23. FM 18 felt that the ADM had conducted the meeting in a firm and business-like manner. FM 18 could see that Resident N felt attacked and FM 18 had assisted Resident N by trying to be the go between for the ADM and Resident N during the meeting. FM 18 was trying to "soften" what was said so that Resident N could understand it. Resident N had gone into "Defense Mode" during the meeting and attempted to defend herself. During an interview on 4/6/23 at 3:40 p.m., the ADM indicated that a care plan meeting had been held to discuss Resident N's behaviors. The ADM had gone through specific examples of Resident N's behaviors and the Resident N had denied anything that was brought up. After the meeting, Resident N went to each person, confronting them. The ADM had told Resident N that she was gaslighting during the meeting and that it was not appropriate for Resident N to confront the staff about her care. The ADM had invited the Psych NP, but the Psych NP had been unable to attend. On 4/6/23 at 10:23 a.m.., the Director of Nursing provided the Resident Rights policy, dated January 2023, which read "...This community seeks to provide each of our residents an environment in which he or she can feel valued and fulfill his or her purpose...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality..."			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the			

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	04/06/2023

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

(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
	resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to ensure notification of a resident's representative with a change of condition for 1 of 2 residents reviewed for discharge, and to timely communicate a resident's significant weight loss to the resident's Power of Attorney for 1 of 1 resident reviewed for weight loss. (Resident K and Resident L) Findings include: A clinical record review for Resident K was reviewed on 4/3/23 at 2:21 p.m. Resident K's diagnosis included, but was not limited to, stage 5 kidney disease. The resident was discharged on 10/18/22. During a Confidential Interview 7, she indicated staff had not notified Family Member 22, Resident K had been transferred to the hospital in September. An incident noted dated 9/21/22 indicated "...Notified by nrsg [nursing] staff that res [resident] on floor in apartment. Res unable to state nature of fall. Res with confusion at that time. Alert to self and place only. Res request evaluation via ER [emergency room] services. 911 called and res transported to [name of hospital] for eval [evaluation] and treatment. Attempted to contact [Family Member 22], unable to leave	R 0036	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. No additional staff members were present or involved in the discharge planning for the resident named in this occurrence. Existing staff members were not present nor are aware of the details involved in Resident K's discharge or M's notifications that were made or attempted to be made. This community is unable to retroactively correct the alleged failure to provide notifications. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, each of the residents is at risk for failure to provide notifications under the prior	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	voicemail d/t [due to] mailbox full....Res transported to [name of hospital] for eval and treat. Resident K's emergency file indicated Family Member 22 - emergency contact 1, Family Member 23 - emergency contact 2, Family Member 24 - emergency contact 3, Case Worker Representative - contact 4. The resident's clinical record did not include any documentation staff had made more attempts to contact Family Member 22 nor any other emergency contact in the resident's file at the time Resident K was discharge to hospital. An interview was conducted with the Administrator Interim on 4/3/23 at 10:00 a.m. She indicated the current management company had taken over on 1/1/23. The former management company had destroyed files. Some documentation might not be available to be provided due to under the care of another management prior to 1/1/23. A documented form regarding Resident K was provided by the Administrator Interim on 4/5/23 at 4:13 p.m. It indicated resident had been discharged from the facility in 2022, and was under the care of the former management company. The clinical record for Resident L was reviewed on 4/3/23 at 11:41 a.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and protein calorie malnutrition. A physician's order, dated 10/14/22, indicated a full set of vitals and weight were to be done monthly.		leadership. After assessing performance and implementing policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing had failed to complete assessments and service plans timely and had failed to hold service plan meetings with residents, responsible parties, case managers and other relevant parties. In addition, the Director of Nursing restricted the access to documentation by Qualified Medication Aides in the electronic medical records, preventing their ability to document any of their actions or those of the residents. The Director of Nursing failed to implement necessary changes, including training the Qualified Medication Aides on documentation and documentation requirements, completing assessments timely, completing service plans timely, holding interdisciplinary service plan meetings with vested parties or providing timely notification for required change of conditions. In February, after becoming aware of the inability of the QMAs to document, the interim administrator provided access to document to the QMAs in the EMAR. The interim administrator terminated the Director of Nursing for failure to follow policies,	

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	04/06/2023

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

(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
	Resident L's weight was recorded on 12/1/22 as 144.0 Lbs. (Pounds). There were no weights recorded in the clinical record for January 2023 or February 2023. Resident L's weight was recorded on 3/11/23 as 128.0 Lbs., showing an 11.1% weight loss from 12/1/22. During an interview on 4/3/23 at 5:08 p.m., Family Member 19 indicated that she had been invited to one service plan meeting in the three years Resident L had resided at the facility. The facility did not communicate with her when there were changes. She had not been made aware of Resident L' s weight loss but thought she had looked thinner the last time she saw her. On 4/4/23 at 12:42 p.m., the ADM (Interim Administrator) provided the Resident Change of Condition policy, dated January 2023, which read "...It is the policy of this community that all changes in resident condition will be communicated to the physician, resident, family/ responsible party, case manager and other parties as directed by the resident and ensure that appropriated, timely, and effective intervention occurs..." This Residential tag relates to Complaints IN00393659 and IN00395543. .		procedures and regulations, and hired a new Director of Nursing, who's first day after general orientation was that of the start of the state survey. The Director of Nursing has initiated every other week meetings for nurses, QMAs and CNAs. Nursing Staff members are being educated on all regulations, operations of the EMAR for which they were previously not trained or had access as well as policies and procedures of the new management company to include notice of change of condition. The Director of Nursing and/or her designee will audit 10% of charts weekly to identify change of condition for the first 30 days and 5% of charts weeks for an additional 60 days following in-service training on the topic of change of condition.	
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the			

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	04/06/2023

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

(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
	movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D).			

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	04/06/2023

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

(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
	Based on interview and record review, the facility failed to ensure a resident's continuity of care when the facility proposed to transfer and/or discharge a resident without ensuring the resident's physician had documented in the clinical record the necessity of the transfer and/or discharge from the facility for 1 of 5 residents reviewed for transfers/discharge rights. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/4/23 at 11:19 a.m. Resident D's diagnoses included, but not limited to, bipolar disorder, hypertension, and diabetes type II. Resident D's Level of Care assessment dated 12/5/22 indicated, Resident D's abilities in the following areas were as such: - Cognition/behavior: understood information conveyed without difficulty, communicated information and was understood, oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings, was adaptive to change and made plans, handles crisis well, was confident, adjusted to major changes or needs reassurance only at time of major decisions, decisions were made in an organized manner, daily routine, and decisions were consistent, reasonable and organized, reflecting lifestyle, culture and values, understood needs that must be met for self-maintenance, and their attitudes, habits and emotional states do not limit the individual. - Eating, Transfers, Dressing and Personal Hygiene: did not require night needs, able to feed, chew, and swallow foods without difficulty, able to get into and out of bed, get into and out of the tub or roll over in bed without any assistance from	R 0044	This citation is being submitted for the informal dispute resolution process. As part of the discharge planning process, the community first holds a discharge planning meeting, in which the concerns of the community are shared with the resident and, in the case of Medicaid Waiver, the case manager. With this particular resident, he was non-complaint with ADL care and incontinent, creating an infection control issue. Purpose Home Health was to provide ADL care at the time and day of the resident's request. Unfortunately, the resident demonstrated behaviors with the caregiver, calling him names and refusing services. The caregiver had been very engaged in attempting to get the resident to participate but was unable to do so. The resident was observed cussing at this person in the bistro during donuts and coffee. He then referred to the caregiver as a "wet back camel jockey." The interim administrator attempted to redirect the resident but was unable to do so as was the pattern with other employees. Other residents were offended by the resident's behaviors. The interim administrator pulled the caregiver aside and apologized profusely for the behaviors. Therefore, the interim administrator reached out to the CICOA case manager for this resident related to potential	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	anyone, can dress and undress self without assistance or supervision, was highly involved in the activity of bathing but required assistance with minimal parts of bathing but may require standby assistance and/or bathing equipment, and able to manage personal hygiene regularly without reminders, assistance or supervision. - Mobility: 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 or safety outside.. - Toileting: marked as "Not Applicable", bladder control maybe continent or incontinent and manages own care; bowel control may be continent or incontinent and manages own care. A copy of a certified letter sent to Resident D from the Facility was received on 4/4/23 at 3:08 p.m. from ADM (Administrator). The letter was dated 1/27/23. The letter indicated, "This letter is to request your attendance at a mandatory discharge planning meeting on February 7 at 10:30 am [sic] in the conference room at Crown Senior Living. The meeting is to discuss you ongoing violations of the health and safety standards of the community with place not only us but also out other residents and staff at risk. We have taken the liberty of inviting the ombudsman, your case manager from [sic, outside agency name], our leadership team, your physician or nurse practitioner, [sic, name of home health agency] and [sic, name of therapy company]." This letter did not indicate a copy of the letter was sent to Resident D's physicians. Resident D's clinical record did not contain a Level of Care Assessment dated after the December 2022 assessment nor prior to the Discharge/Transfer meeting to indicate a need for		discharge planning for this resident due to non-compliance. The case manager attended the discharge planning meeting but the resident failed to do so. The interim administrator asked for feedback regarding the resident's behaviors and the community's infection control concerns. The case manager and interim administrator discussed that resident was exhibiting some signs of dementia and felt that he would likely benefit from the structure and additional support of a skilled nursing community. The case manager indicated that she wanted to speak with the resident to understand his thoughts or to identify a discharge location. No community staff members were present during this meeting but the case manager informed the interim administrator that the resident preferred to return to the skilled nursing community from which he came. The interim administrator referred resident to the psychiatric NP for review and possible intervention following the initial meeting. With additional medical support from the psychiatric NP and the resident's desire to improve his behaviors, there was no need for discharge documentation, an additional discharge, 30-day Notice of Transfer/Discharge or other documentation. Had the pattern behavior continued despite	

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	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a higher level of care. A typewritten statement from the facility regarding Resident D's discharge planning meeting was received on 4/4/23 at 3:08 p.m. from ADM. The statement indicated, " Due to his non-compliance with sanitation and his behaviors, a Discharge Planning Meeting was held for [sic, Resident D's name] to discuss the reasons he was being considered for discharge...We took the liberty of inviting the Ombudsman but he informed us that he could only come if [sic, Resident D's first name] invited him. His case manager [sic, case manager's name], was invited and did attend...On February 7, 2023, [sic, Resident D's first name] did not come to the meeting as scheduled. The case manager, Executive Director and Culinary Services Director were in attendance. After discussion with his case manager, the case manager recommended that she speak with him in his apartment to attempt to address this with him...Resident asked if he could remain here if his behavior had improved. ED informed him that...he needed to refrain from verbal outburst of profanity, using racist or derogatory terms with staff or agency members and perform hygiene daily. Resident has agreed to this and we have postponed further discharge planning at this time." Resident D's clinical record did not contain a progress note to indicate when and/or which physicians were invited to the discharge planning meeting, nor had his physician(s) indicated, in the clinical record, that he required a higher level of care such that he needed to be discharged/transferred. An interview with Resident D's Psychosocial Nurse Practitioner (Psych NP) was conducted on		intervention, the community would have requested documentation of lack of success of the medical intervention and sanitation issue by an NP present for the resident's case as well as providing a 30-day notice of transfer/discharge, appeals information and bed hold policy with a discharge location identified by the resident. The NP noted in the surveyor's documentation left around January 17 and was not present during the initiation of the discharge planning process. At this time, the resident identified modified his behavior and is in good standing with the residency agreement and handbook. If the behaviors resume, the community will ask the medical provider to provide documentation prior to the first discharge planning meeting, rather than waiting to the meeting in which a discharge location is determined. For all residents identified as non-compliant with the residency agreement, the resident handbook, state rules and regulations or those who appear to meet the criteria for discharge, an initial discharge planning meeting will be held. The resident, responsible party when relevant, guests invited by the resident, staff members, case manager, physicians, therapists and other involved parties are invited. During this meeting, the concerns for that	

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	04/06/2023

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

(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
	4/5/23 at 2:37 p.m. Psych NP indicated, she was unaware of Resident D's mandatory discharge planning meeting that was held on 2/7/23 and stated she would have liked to be part of that discussion. An interview with Medical Provider 2 (MP 2) was conducted on 4/6/23 at 1:31 p.m. MP 2 indicated, Resident D was previously her resident since his admission into the facility until approximately the middle of January 2023. She stated, she became aware of Resident D being "put out" from the facility when DON (Director of Nursing) 1 had mentioned they were going to discharge him because he could not take care of himself. When asked if she was consulted about the decision to move Resident D to a higher level of care, she indicated, she hadn't been consulted and from the tone of the conversation, she felt as though the decision had already been made. A Scope of Services policy was received on 4/4/23 at 11:24 a.m. from DON 2. The policy indicated, "The resident should not be admitted to the community [sic] must be discharged from the community under the following conditions: a. The resident is a danger to self or others' health, safety or wellbeing; b. The resident requires 24 hour per day comprehensive nursing care or nursing care oversight for a chronic condition; c. The resident requires 24 hour per day comprehensive nursing care, nursing care oversight or rehabilitation therapies and has not entered into a contract with an appropriately licensed provider of the resident's choice to provide those services. d. The resident is not medically stable in the management of chronic conditions requiring multiple hospitalizations or physician visits or		have lead to the discharge planning meeting will be reviewed. The resident should leave with an understanding of these issues that have led to the meeting, the opportunities to correct these issues if possible or interventions that might be beneficial in correcting these issues. The resident will also be given the opportunity to share a preferred discharge location if the situation warrants moving forward with discharge. If the resident discontinues relevant behaviors or starts mutually agreed upon steps to correct behavior, the community would then discontinue the discharge planning process. If the resident does not, documentation from a relevant MP would be sought for cases related to medical or behavioral issues prior to issuing the Notice of Transfer Discharge and related paperwork with a designated discharge location. All leadership team members and visiting NPs will be educated on this process. The administrator will review all medical records for all persons for whom a Notice of Transfer Discharge is being issued to ensure 100% of cases related to clinical needs have MP documentation of the need for discharge.	

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	04/06/2023

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

(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
	comprehensive nursing management. e. The resident meets at least 2 of the 3 criteria unless the resident is medically stable and the community can meet their needs through community staff or contracted providers: i. Requires total assistance with eating; ii. Requires total assistance with toileting; iii. Requires total assistance with transferring."			
R 0048 Bldg. 00	410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency (18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident. (19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs. (20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan. (21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the			

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	04/06/2023

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

(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
	meeting shall be to discuss possible alternatives to the proposed relocation plan. (23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by: (A) the administrator or his or her designee; (B) the resident; (C) the resident ' s legal representative; and (D) an interested family member, if known; each of whom may make written comments on the report. (24) The written report of the meeting shall be included in the resident ' s permanent record. Based on record review and interview, the facility failed to ensure a resident was able to return to the facility as planned after a hospitalization and skilled nursing facility rehabilitation stay for 1 of 2 residents reviewed for discharge (Resident K)." Findings include: A clinical record review for Resident K was reviewed on 4/3/23 at 2:21 p.m. Resident K's diagnosis included, but was not limited to, stage 5 kidney disease. The resident was discharged on 10/18/22. During a Confidential Interview 7, She indicated the facility would not allow Resident K to return to the facility after a hospitalization and rehabilitation stay that was in September. During a Confidential Interview 8, She indicated Resident K had fallen in the facility in September and was sent to the hospital. After hospitalization, Resident K had been discharged to a skilled facility for rehab for 20 days. Resident K's belongings had been left in the apartment, because she had planned to return after rehab. The skilled facility contacted the assisted living	R 0048	This citation is being submitted for the informal dispute resolution process. On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. No additional staff members were present or involved in the discharge planning for the resident named in this occurrence. Existing staff members were not present nor are aware of the details involved in Resident M’s discharge notifications that were made or attempted to be made. Resident M was discharged to a hospital and did not return. As per the communication provided to the state surveyors, Resident M’s	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	after completion of rehab to discharge Resident K back. The facility refused to accept the resident. The facility had not provided any notification to Resident K or Resident K's representatives she was not allowed to return. An incident noted dated 9/21/22 indicated "...Notified by nrsg [nursing] staff that res [resident] on floor in apartment. Res unable to state nature of fall. Res with confusion at that time. Alert to self and place only. Res request evaluation via ER [emergency room] services. 911 called and res transported to [name of hospital] for eval [evaluation] and treatment. Attempted to contact [name of family member], unable to leave voicemail d/t [due to] mailbox full....Res transported to [name of hospital] for eval and treat. A nursing note dated 9/22/22 indicated Resident K was admitted to the hospital for elevated potassium. A nursing note for Resident K dated 9/25/22 indicated staff was made aware resident was being discharged from the hospital and would be going to a skilled facility for rehab. An administration note dated 10/18/22 indicated Resident K was in rehab. The resident's clinical record did not include any documentation resident had discharged from the facility. A Notice of Transfer or Discharge form was provided by the Administrator Interim on 4/5/23 at 4:13 p.m. It indicated Resident K had discharged on 9/21/22 to a skilled nursing facility, because the residents needs were unable to be met.		family spoke with the interim administrator on January 4, 2023. They were upset because the resident had appeared in the community per the former DON without communication, orders or an assessment after discharging AMA from another community. The interim Administrator notified the family that we would be more than happy to accept the resident back if we have the opportunity to assess the resident's needs and obtain orders. The family member yelled at the interim administrator and stated that the resident had readmitted to another community and they were calling to notify the interim administrator that they would be cleaning out the apartment. The family cleaned out the apartment without notice. The interim administrator requested that the resident be discharged from the EMAR system because the prior company had not shared with staff members how to put a resident on a leave of absence. The resident was then discharged from the system for paperwork compliance. After assessing performance and implementing policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing had failed to distribute Notices of Transfer/Discharge. The Director of Nursing was asked to train staff	

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	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A documented statement was provided by the Administrator Interim on 4/3/23 at 3:15 p.m. It indicated "...ED noted that nursing staff were not providing Notice of transfer and Discharge, The Appeal form and the Bed hold policy to all discharges. DON [Director of Nursing 1] stated that she was unaware of this requirement..." A documented statement regarding Resident K was provided by the Administrator Interim on 4/5/23 at 4:13 p.m. It indicated the staff were unable to provide documented reason Resident K had discharged from the facility. The resident had discharged from the facility in 2022, and was under the care of another management company. The new current management company took over the facility on 1/1/23. On 4/5/23 at 4:13 p.m., the ADM provided the current Non-Emergency Discharge Process policy, which read "... When a transfer or discharge of a resident is proposed, provision for continuity of care shall be provided by this community. This state residential finding relates to Compliants IN00395543 and IN00395113.		members and was asked to ensure copies were available for staff. These items were completed by the Memory Care Coordinator by April 3, 2023. The Director of Nursing was terminated in March of 2023. In the instance of Resident N, this resident was not issued a Notice of Transfer/Discharge during her Discharge Planning meeting because the meeting was in fact a Discharge Planning Meeting that precedes the distribution of a Notice of Transfer/Discharge. The Notice of Transfer/Discharge must contain a discharge location, which cannot be provided unless the resident has been asked and provides a discharge location or the resident fails to provide a discharge location after a reasonable time. Contrary to the documentation provided in the survey, a summary of this meeting is contained under Documents in the resident's EMAR. Staff, including the interim admin, were not asked to provide this documentation. This community is unable to retroactively issue a Notice of Transfer Discharge for Resident M as she left the community in December of 2022. This community will issue a Notice of Transfer Discharge to Resident N when we are prepared to discharge the resident and after the resident has had the	

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	04/06/2023

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

(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
			opportunity to provide a discharge location. An audit of all current residents for whom discharge is planned was completed. Residents who identified a discharge location and for whom the community had reached the point of discharge were issued a Notice of Transfer Discharge. Moving forward, all residents who areas identified meeting the criteria for discharge, an initial discharge planning meeting will be held. The resident, responsible party when relevant, guests invited by the resident, staff members, case manager, physicians, therapists and other involved parties are invited. During this meeting, the concerns that have led to the discharge planning meeting will be reviewed. The resident should leave with an understanding of these issues that have led to the meeting, the opportunities to correct these issues if possible or interventions that might be beneficial in correcting these issues. The resident will also be given the opportunity to share a preferred discharge location if the situation warrants moving forward with discharge. If the resident discontinues relevant behaviors or starts mutually agreed upon steps to correct behavior, the community would then discontinue the discharge planning process. If	

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	04/06/2023

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

(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
			discharge is appropriate or agreed upon, the Notice of Transfer Discharge and related paperwork with a designated discharge location would be provided to the resident and or relevant parties. The administrator will review all discharges to ensure a Notice of Transfer Discharge is being issued to ensure in 100% of cases where the initial discharge planning meeting has been held, a discharge continues to be necessary and a discharge location has been identified for a period of one year.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded 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			

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	04/06/2023

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

(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
	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 quarterly fire drills. This had a potential to affect 54 of 54 residents that reside in the facility. Findings include: During an entrance conference interview with the Administrator Interim on 4/3/23, a request to review a year of quarterly fire drills that had been conducted in the facility. A document form was provided by the Administrator Interim on 4/3/23 at 3:15 p.m. It indicated the facility had currently a new management company that had taken over on 1/1/23. Prior to 1/1/23, the Administrator Interim was unaware if she was able to provide documentation from the previous management company. The Director of Maintenance had left his position on 1/31/23, and had removed his maintenance records from the facility. She was aware of one fire drill that was conducted in January 2023, but she was unable to provide documentation. A fire policy was provided by the Administrator Interim on 4/6/23 at 2:53 p.m. It indicated "...Policy: In the event of a fire, every person in the community must be prepared to act quickly and rationally. Safety of every staff member and resident is the first priority. The fire procedures must be memorized and practiced in order to make certain that everyone will react to a fire appropriately. The community will hold routine fire drills no less than once every quarter on all	R 0092	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. When assuming responsibility for the building, the interim administrator asked the Maintenance Director to provide his compliance binder for her review. The Maintenance Director quit without notice shortly thereafter. A review of the Maintenance Director's office by the new Environmental Services Director and a corporate consultant was only able to find a binder from which all documentation had been removed. All residents had the potential to be negatively impacted by the failure to complete documented fire drills, but this community experienced no fire activity within the first quarter of 2023. This community has provided orientation to the newly hired Environmental Services Director regarding the regulation as well as	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	three shifts as a means of ensuring that all staff and residents are prepared in the event of a fire..."		the policy and procedures for fire drills. The Environmental Services Director or his designee will provide education to residents and staff on all three shifts regarding fire drills and procedures. The Environmental Services Director will hold fire drills on all three shifts. The Executive Director and/or his designee will be responsible for monitoring the completion of 1 fire drill per shift per quarter by reviewing the Environmental Services Director's documentation binder monthly for 6 months following education	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall			

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	04/06/2023

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

(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
	have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to assure that at least 1 awake staff person with CPR (Cardiopulmonary Resuscitation) and First Aid Training were present in the facility each shift, for all shifts reviewed in a 7-day period with the potential to affect 54 of 54 residents residing at the facility. Findings include: On 4/3/23 at 1:52 p.m., the ADM (Interim Administrator) provided the schedules as worked for the week of March 25, 2023, through March 31, 2023. During an interview on 4/6/23 at 3:50 p.m., the ADM indicated the facility did not have any information on what staff members were certified in CPR and First Aid Training. The previous management company had removed the binder which contained the staff members cpr and first aid certification. The facility had not recollect this information as of yet.	R 0117	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. When assuming responsibility for the building, the interim administrator discussed documentation for nursing employee certifications and licenses with the Director of Nursing. The Director of Nursing showed the interim administrator a binder labeled CPR/First Aid. The Director of Nursing stated that the Business Office Manager was responsible for licensure for nursing staff. The Director of Nursing was terminated in March. A review of the Director of Nursing's office by the new Director of Nursing and a corporate consultant was only able to find a binder from which all documentation had been removed. All residents had the potential to be negatively impacted by the	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
			failure to complete documented CPR and First Aid certification on all three shifts, but this community did not provide CPR services or services outside of the scope of practice for CNAs, QMAs or LPNs . This community has requested that each staff member provide a copy of their CPR/First Aid card as evidence of their certification. This community will document CPR/First Aid certified employees on the schedules, both planned and as worked, to ensure that CPR/First Aid certified employees are available on each shift. The Executive Director and/or his designee will audit schedules weekly to ensure that at least one staff member per shift has a CPR/First Aid certified employee working for 90 days.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and			

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	04/06/2023

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

(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
	applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to assure staff received resident rights and dementia training prior to working independently in the facility for 2 of 5 employee's records reviewed (QMA 22 and CNA 24) Findings include: The employee record for QMA (Qualified Medication Aide) 22 was reviewed on 4/5/23 at 3:22 p.m. The employee record indicated that QMA 22 had started employment with the facility on 12/22/22. The employee record did not contain information that he had received dementia or resident rights training during the orientation process. The employee record for CNA (Certified Nursing Assistant) 24 was reviewed on 4/5/23 at 3:30 p.m. The employee record indicated that CNA 24 had	R 0119	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. When assuming responsibility for the building, the interim administrator discussed the documentation for personnel files with the Business Office Manager. The interim administrator also provided an audit tool for the Business Office Manager to identify any missing documentation from personnel	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	started employment with the facility on 1/1/23. The employee record did not contain information that she had received dementia or resident rights training during the orientation process. During an interview on 4/6/23 at 3:50 p.m., the Interim Administrator indicated there was no documentation that resident rights and dementia training had been provided during orientation for QMA 22 and CNA 24.		files. The Business Office Manager indicated that there was no documentation of orientation in the employee files for persons hired by the former management company. All residents have the potential to be negatively impacted by lack of orientation for all new employees. The interim administrator provided education to all hiring managers and the business office manager on January 26, 2023 regarding the hiring process to include orientation. The Business Office Manager was asked to maintain her audit tool to ensure orientation is completed and documented prior to beginning job specific orientation. The community had assigned all employees to complete 100% of orientation and dementia training due to this management company's lack of access to the prior company's documentation by April 30, 2023 after the in-service training on January 26, 2023. All employees failing to complete the mandatory training will be removed from the schedule until this is completed. The Executive Director and/or his designee will audit the Business Office Manager's documentation of completion of orientation with each new hire for 90 days to ensure compliance.	

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	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 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 keep all kitchen equipment maintained in good repair by the walk-in freezer condenser leaking water onto boxes of food stacked below, having ice build-up on pipes, and frozen water droplets on the ceiling and from the condenser fans affecting 54 of 54 residents residing in the facility. (Facility) Findings include: A kitchen tour was conducted on 4/3/23 at 11:06 a.m. with Dietary Manager (DM). During the tour, the walk-in freezer was observed and these items were found: - Frozen water droplets were stuck to the ceiling - Freezer condenser fans had frozen water drips hanging off the fan covers - The pipes for the freezer condenser were coated in white, frozen water - Several boxes of stacked frozen food items which were under the condenser were found to have a coating of ice on the boxes. Some of these boxes were previously opened. An interview with DM was conducted at the same time as the kitchen tour. DM indicated, she wasn't aware of the condition of the walk-in freezer's condenser and indicated, it needed repaired based on the findings. A Culinary Services Infection Control policy was received on 4/4/23 at 2:15 p.m. from ADM	R 0154	The walk-in freezer was identified as having ice buildup and leaking water onto boxes of food on the morning of April 3, 2023 during the survey process. A weekly deep cleaning and inspection of the kitchen had occurred the week before and the walk-in freezer was not identified as experiencing issues. While all residents had the potential to be negatively impacted by the compressor not properly functioning, there were no residents who experienced gastrointestinal symptoms between the date of deep cleaning and identifying the issue on the morning of April 3, 2023. A repair company was called immediately and was on site on the date of April 3, completing necessary repairs. Staff members completing the freezer temperature log will also be instructed to note any condensation, ice or other issues identified while completing the temperature log. The Culinary Services Director and/or her designee will be asked to audit the freezer temperature log and corresponding notes in	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	(Administrator). The policy indicated, "Prevention of infection in food service department requires healthy personnel, properly maintained equipment, uncontaminated supplies, and an ongoing awareness of proper sanitation and hygiene."		comparison to the condition of the freezer daily for the first 30 days, weekly for the next 30 days and monthly for an additional 60 days.	
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 involved in identification and documentation of the services to be provided.	R 0217	On January 1, 2023, RPM	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	Based on interview and record review, the facility failed to assure a resident's power of attorney was invited to attend service plan meetings, and to revise a resident's service plan to identify and/or document services provided/required for a diagnosis of bipolar disorder and another resident's diagnosis of diabetes for 3 of 7 service plans reviewed. (Residents D, Resident H and Resident L) Findings include: 1. The clinical record for Resident L was reviewed on 4/3/23 at 11:41 a.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and protein calorie malnutrition. During an interview on 4/3/23 at 5:08 p.m., Family Member 19 indicated that she had been invited to one service plan meeting in the three years Resident L had resided at the facility. The facility did not communicate with her when there were changes. On 4/4/23 at 11:24 a.m., the DON (Director of Nursing) 2 provided a copy of Resident L's service plans, which indicated the last service plan review was completed on 2/03/22 and was not signed. On 4/4/23 at 11:24 a.m., DON 2 provided the current Resident Service Plan policy, which read "...The Service Plan is a communication tool that provides associates education related to each resident's needs and preferences and assists associates in providing quality, person-centered services...Service plans shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change... The service plan is reviewed and revised at a		Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. Existing staff members were not present nor are aware of the details involved in the identified service plans. After assessing performance and implementing policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing had failed to complete assessments and service plans timely and had failed to hold service plan meetings with residents, responsible parties, case managers and other relevant parties. The Director of Nursing failed to implement necessary changes, including completing assessments timely, completing service plans timely or holding interdisciplinary service plan meetings with vested parties. The Director of Nursing was terminated in March of 2023. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, each of	

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	04/06/2023

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

(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
	minimum on every 6 months or following a change in condition and shall be signed and dated by the resident...Residents, responsible parties, family, case managers and other parties as designated by the resident should be notified of service plan reviews in advance of the organized meeting..."2. The clinical record for Resident D was reviewed on 4/4/23 at 11:19 a.m. Resident D's diagnoses included, but not limited, to bipolar disorder. An interview with Resident D's Psychosocial NP conducted on 4/5/23 at 2:37 p.m. indicated, Resident D has behaviors related to past trauma in his life, bipolar disorder, and depression. Psych NP indicated, she has spoke to staff regarding methods to use when approaching a difficult subject with Resident D, such as his personal hygiene, such as trying a secondary approach by another staff member, re-approaching a different day, and asking him "how do you feel about...". Psych NP also stated, a counseling service had started to see Resident D to encourage him to talk and take a more active role in his life. Resident D's most recent Service Plan dated 12/23/22 did not contain a focus for bipolar disorder nor interventions which could assist resident and staff with managing bipolar disorder such as: medication use and/or reviews, methods to de-escalate situations, needed psychosocial services, triggers for verbal aggressiveness, coping skills, or understanding his history, etc. 3. The clinical record for Resident H was reviewed on 4/5/23 at 11:21 a.m. Resident H's diagnoses included, but not limited to, type II diabetes. Resident H's Service Plan dated 9/13/22 did not contain a focus for her diabetes type II nor any interventions to used to manage her diabetes		the residents is at risk for failure to complete service plans under the prior leadership. The interim administrator terminated the Director of Nursing for failure to follow policies, procedures and regulations, and hired a new Director of Nursing, who's first day after general orientation was that of the start of the state survey. The interim administrator also engaged a nurse consultant to assist with bringing the building into compliance with assessment and service plans. The Director of Nursing and Nurse Consultant will complete all assessments, create person centered service plans and hold service plan meetings per the recovery schedule. The Executive Director and/or her designee will audit charts weekly assessments, service plans and service plan meetings are accomplished as scheduled. After recovery, the Executive Director will audit the EMAR weekly the following 90 days for due dates of assessments, service plans and scheduled service plans to ensure that all are compliant.	

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	04/06/2023

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

(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
	such as: blood glucose monitoring, notify medical doctor of sign/symptoms of hyper/hypoglycemia, or medication use, etc. A Resident Service Plan policy was received on 4/4/23 at 11:24 a.m. from Director of Nursing (DON) 2. The policy indicated, "The community utilizes an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident that are based on the resident's preferences and priorities. The Service Plans is a communication tool that provides associates education related to each resident's needs and preferences and assists associates in providing quality, person-centered service...The service plan and services offered to the individual resident shall be appropriate to the: a. scope b. frequency c. need;and d. preference of the resident... Service plans shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change...The service plan is reviewed and revised at a minimum of every 6 months or following a change in condition...A thorough assessment, including the resident, requested participants and responsible party input, will be completed prior to the service plan review." This Residential tag relates to Complaint IN00393659.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.			

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	04/06/2023

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

(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
	Based on observation, interview, and record review, the facility failed to assure a resident's facial hair was shaved for 1 of 4 residents reviewed for ADL (Activities of Daily Living) care (Resident L). Findings include: The clinical record for Resident L was reviewed on 4/3/23 at 11:41 a.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and anxiety. A service plan, last revised on 9/25/2020, indicated that she needed assistance with grooming and personal hygiene. The goals were for staff to offer assistance when needed and that she would maintain appropriate grooming and hygiene with staff assistance. The interventions included, but were not limited to, she requires assistance with grooming needs. On 4/3/23 at 11:41 a.m., Resident L was observed sitting in the dining room. She was dressed in a pink sweat suit and a black sweater. She had some whiskers, which were approximately 1/4 inch long, present on her chin. On 4/3/23 at 2:56 p.m., Resident L was observed with QMA (Qualified Medication Aide) 22. Resident L was sitting in a chair in her room. She continued to have whiskers present on her chin. During an interview on 4/3/23 at 5:08 p.m., FM (Family Member) 19 indicated that she visited Resident L often. The staff did not make sure that Resident L was shaved. FM 19 had told the facility she would like for Resident L to be shaved daily. FM 19 had provided an electric razor in the past for them to use when shaving Resident L.	R 0240	The resident identified as requiring shaving was shaved. This resident's service plan involved an outside agency, Purpose Home Health, to provide this service Monday through Friday. The interim administrator had made the DON of the agency aware of issues with the care providers in the community not completing services or relaying resident refusals to the community. Following a transition in their leadership, the external agency was updated regarding this issue during a meeting on April 27, 2023. All residents who previously made requests to be shaved have the potential to have not been shaved. The community has been unable to identify other people who have requested to be shaved but were not able to identify any other such residents. The community has notified the outside care agency of the concern and asked them to communicate the concerns and need to complete this task to their care givers. The outside agency has met with their caregivers, noting the concerns about failure to provide the services as well as the need to communicate resident refusals. This will be done on their documentation and left in a secure binder at the front desk in the event they are unable to speak with the Memory Care Coordinator	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	On 4/4/23 at 10:51 a.m., Resident L was observed sitting in the common area. She continued to have whiskers present on her chin. During an interview on 4/4/23 at 10:55 a.m., CNA (Certified Nursing Assistant) 23 indicated she did not provide shaving to Resident L. Resident L had a personal aide to assist with her care. During an interview on 4/4/23 at 3:50 p.m., Director of Nursing 2 indicated that she would expect Resident L to be shaved daily. This Residential tag relates to Complaint IN00393659.		at the time of the refusal. The Director of Nursing and/or her designee will monitor the care needs and preferences and notes from the outside agency to ensure that they are carried out with residents by auditing 10% of residents daily for 2 weeks, weekly for 6 weeks and monthly for an additional 60 days.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to address a change in condition for a resident who was having seizures and falling by not timely scheduling a recommended neurology consultation, not administering seizure medications as ordered, not obtaining monthly labs for Dilatin levels as ordered, to ensure the administration of a resident's Zolpidem as ordered, to obtain monthly weights, as ordered, to ensure laboratory orders were done timely and/or as ordered, administer insulin as ordered and not ensuring a blood pressure medication order contained parameters for use as ordered by a	R 0241	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. After assessing performance and implementing	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	physician for 6 of 15 residents charts reviewed. (Resident B, Resident C, Resident D, Resident H, Resident F and Resident L) Findings include: 1. A clinical record review for Resident C was reviewed on 4/4/23 at 10:00 a.m. Resident C's diagnoses included, but were not limited to, epilepsy with recurrent seizures and traumatic brain injury. A Level of Care Assessment dated 3/13/23 indicated Resident C cognitive function "1. Receptive Communication: understands information conveyed without difficulty...2. Expressive Communication: Communicates information and is understood...3. Orientation: Oriented to person, place and time or sufficiently oriented to function independently if in familiar surroundings...4. Adaption to change: Actively adapts and makes plans, handles crises well, is confident, adjusts to major changes or needs reassurance only at time of major decisions..." A physician order dated 7/3/22 indicated Resident C's Dilatin level should be obtained monthly due to seizures. A physician order dated 5/8/22 indicated Resident C was to receive 1.5 tablets of 1000 milligrams of keppra every 12 hours for seizures. A physician order dated 12/18/20 indicated Resident C was to receive 200 milligrams of lacosamide twice a day. A physician order dated 10/28/22 indicated Resident C was to receive 60 milligrams of Dilantin two times a day. Discontinued on 12/13/22.		policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing had failed to complete assessments and service plans timely and had failed to hold service plan meetings with residents, responsible parties, case managers and other relevant parties. A former NP for the community indicated that the Director of Nursing was not properly entering physician orders for administration. The Director of Nursing failed to implement necessary changes, and Director of Nursing was terminated in March of 2023 for this and other performance issues. This company is unable to retroactively address the entering of physician's orders for these residents, but the resident's documented orders were audited to ensure compliance with the current orders from the physician's office. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, each of the residents is at risk for medication errors due to the former DON's entering inaccurate orders or failing to enter orders. An audit of all resident orders will be completed by sending current orders to the MD for verification.	

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	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician order dated 12/13/22 indicated Resident C was to receive 60 milligrams of Dilantin four times a day. Discontinued on 1/7/23. A nursing progress note dated 12/12/22 at 4:15 p.m. indicated Resident C was showing signs and symptoms of a seizure and had fallen. He obtained an abrasion to his head while in the smoking area. The medical provider was notified, and she had ordered to send the resident to the emergency room for evaluation. A hospital discharge summary for Resident C dated 12/12/22 indicated "...Reason for visit: Seizures Diagnoses: recurrent seizures, head injury, abrasion...Instructions...Follow up with your neurologist..." Medical Provider 2 progress note dated 12/13/22 indicated "Resident is being seen today to follow up to seizure activity. Resident fell after seizure activity....Dilantin level obtained on 12/11/22. Results not available at this time. Resident has an order for monthly Dilantin levels. Nursing aware....Assessment/Plan: Dilantin increased. Discussed with nursing...." Medical Provider 2 progress note dated 12/15/22 indicated "...Resident is being seen today to follow up to seizure activity. No new seizure activity noted per nursing and wife. Dilantin recently increased. Will continue to monitor seizures. With further seizure activity will refer to Neurologist..." A nursing progress note dated 12/22/22 at 12:05 p.m. "...Notified by nrsg [nursing] staff that res [resident] missed scheduled neurology appt [appointment] in August. Appt rescheduled.		Nursing Staff members are being educated on all regulations, operations of the EMAR for which they were previously not trained or had access as well as policies and procedures of the new management company to include notice of change of condition. All orders will be sent monthly to physicians to verify the orders are correct and all orders are present monthly going forward. The Director of Nursing and/or her designee will audit 25% of charts after orders are sent to the MD for verification to for the first 30 days and 10% of charts for an additional 60 day.	

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	04/06/2023

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

(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
	Neurologist notified of res recent seizure activity. NP [Nurse Practitioner] aware. NP to order labs to monitor anticonvulsant medications to adjust meds as needed. Res reeducated on seizure precautions and to notify nrsg staff of s/s [signs and symptoms] of seizures activity..." The December 2022 Medication Administration Record (MAR) indicated Resident C had not receive his Dilantin on 12/28/22 at 12:00 a.m., 6:00 a.m. and 12:00 p.m., because the medication was not available. The resident's clinical record did not include a December 2022 Dilantin monthly lab that had been obtained. A nursing note dated 1/7/23 indicated "...Incident Note...Notified by nrsg staff that res with s/s of seizure activity while in dining room. NP notified. Res fell to floor striking back of head. Res assisted to chair and monitored until gait steady. New order rec'd..." Medical Provider 2 note dated 1/7/23 indicated "...Writer noticed that resident had seizure activity at the facility. Resident refused to go to ER [emergency room]. Orders given to DON [Director Nursing] 1 to increase Dilantin for breakthrough Seizure Activity, Obtain a Dilantin and Lacosamide level on 01/09/2023 and Refer resident out to Neurology." A physician order dated 1/8/23 Resident C was to receive 100 milligrams of Dilantin four times a day. The January 2023 MAR indicated the following days, times and Dilatin dosages staff had not administered to Resident C:			

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	04/06/2023

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

(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
	1/6/23 and 1/7/23 at 6:00 p.m., Resident C did not receive 60 milligrams of Dilantin, 1/8/23 at 12:00 p.m. and 1/11/23 at 12:00 p.m., and 6:00 p.m., the resident had not received 100 milligrams of Dilantin. An administration note dated 1/8/2023 at 12:22 p.m., indicated "...Orders Administration Note:...Dilantin Capsule Give 100 mg [milligrams] by mouth four times a day for seizures NP notified NP was sending a one time order to the DON [1] to put on PCC [electronic medical chart] 100 mg not available." An administration note dated 1/11/2023 at 12:18 p.m., indicated "...Orders Administration Note...Dilantin Capsule Give 100 mg by mouth four times a day for seizures awaiting delivery from pharmacy." An administration noted dated 1/11/2023 at 5:05 p.m., indicated "...Orders Administration Note:...Dilantin Capsule Give 100 mg by mouth four times a day for seizures awaiting delivery from pharmacy." A lab report collection date of 1/16/23 indicated Resident C's Dilantin level was 5.9 micrograms per milliliter. The lab report indicated the resident's Dilantin level was low. The clinical record did not include a Dilatin level that had been obtained on 1/9/23 as ordered. A nursing note date 1/19/2023 at 10:35 a.m., indicated ".. NP in facility and notified of res cont [continuing] seizures. N.O [new order] rec'd [received] to increase Dilantin, schedule neuro [neurology] appt and labs..."			

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	04/06/2023

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

(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
	Medical Provider 3 progress note dated 1/19/23 indicated Resident C had a seizure on 1/14/23, and refused to go to hospital. He indicated he was feeling fine. The medical provider ordered to increase Dilantin at night. A physician order dated 1/19/23 indicated 100 milligrams of Dilantin three times a day. A physician order dated 1/19/23 indicated 200 milligrams of Dilantin at bedtime. The scheduled time was 8:00 p.m. A Medical Provider 3 note dated 2/9/23 indicated Resident C had a follow up appointment with his neurologist in March. A Medical Provider 3 progress note for Resident C dated 2/23/23 indicated "...He was started on the Hydrocodone after sustaining a right rib fx [fracture] post a fall caused by seizure activity. Today he denies any rib pain, he has not taken the Hydrocodone in 30+ days, we will discontinue this today. An incident report for Resident C dated 3/6/23 indicated "...Res noted having a seizure outside in resident smoking area, area checked and res located in safe space during incident. Confusion noted r/t [related to] seizure res a/o [alert and oriented] x 2 able to voice wants and needs neuro check initiated..." A Medical Provider 3 progress note for Resident C on 3/14/23 indicate the resident had a neurology consultation scheduled for 3/23/23. A nursing note dated 3/22/23 indicated Resident C's neurology appointment had been rescheduled			

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	04/06/2023

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

(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
	to 5/31/23 at 8:00 a.m. "Transportation still being arranged." The resident's clinical record did not indicate reason Resident C's 3/23/23 neurology consultation was rescheduled. During a Confidential Interview 5, they indicated Resident C had a seizure on 1/7/23. Medical Provider 2 had ordered an increase in his Dilantin. The Dilantin was 60 mg at that time, and Medical Provider 2 was increasing it to 100 mg of Dilatin. DON 1 did not put the order for the increase in until 1/8/23. The 100 mg was not in the cart to give at 12:00 p.m. on 1/8/23, so staff notified Medical Provider 2. She ordered a one time order to give the 60 mg until the 100 mg came in from the pharmacy. The resident had been having seizures, so Medical Provider 2 did not want him to miss any dosages. The staff notified DON 1 to report Medical Provider 2 was sending over an order. DON 1 stated to go ahead and give the resident "whatever we have." and would not put the order in the system. The staff person refused to give until the order was put in. The staff person did not administer any Dilantin to the resident at 12:00 p.m. on 1/8/23, because DON 1 would not put the order in the system. DON 1 did not put orders in timely frequently. She had a habit of "back dating" orders or changing the medical providers orders. As of today, that one time order has never been put in the system. They indicated DON 1 would blame Medical Provider 2 for not sending the orders over, but DON 1 wouldn't enter or follow the orders sent. During a Confidential Interview 6, they indicated DON 1 would not follow Medical Provider 2's orders. DON 1 would received orders from Medical Provider 2, and would delay putting them			

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	04/06/2023

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

(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
	in the system. Resident C had a seizure on 1/7/23, and Medical Provider 2 had increased his Dilantin. The order was not put in the system until 1/8/23. The Medical Provider 2 had given a one time order of 60 mg of Dilantin on 1/8/23 at 11:00 a.m., to give to Resident C, because the 100 mg of Dilantin was not in the facility. The one time order was not put in the system. An interview was conducted with DON 2 on 4/5/23 at 3:52 p.m. She indicated Medical Provider 2 had given a one time order of 60 mg of Dilantin to Resident C. DON 1 had not entered the order in the system. It looks like Resident C had missed 2 dosages of his Dilantin in January. She was unable to locate any lab reports for his Dilantin levels that were to be obtained in December 2022, February 2023, and March 2023. She indicated Resident C refuses to go to the neurologist. An interview was conducted with Resident C on 4/6/23 at 9:53 a.m. He indicated he was unsure the reason the staff have been rescheduling his neurology appointments. He would like to go to the neurologist due to his seizures. He believed he did have one schedule, and it was coming up. He has not refused to go to any neurologist appointments. 2. A clinical record review for Resident F was reviewed on 4/5/23 at 1:30 p.m. Resident F's diagnosis included, but was not limited to, sleep disorder. Medical Provider 2 note for Resident F dated 1/3/23 indicated "...Medication Reaction. Resident being seen today to follow up to ER visit for Medication Reaction. Resident reports that she had a medication reaction toTrazadone. Discharge Summary from hospital diagnosis			

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	04/06/2023

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

(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
	reports Medication reaction to Trazodone..." Medical Provider 2 note for Resident F dated 1/7/23 indicated "...Writer notified by QMA [Qualified Medication Aide] that resident upset regarding discontinuation of Trazadone discontinuation. Resident recently went to the ER with c/o [complaints of] reaction toTrazadone. Discharge summary stated that resident had a reaction to Trazadone. Trazadone added to allergy list. DON [1] notified and new order given. A physician order dated 1/10/23 indicated Resident F was to receive 5 milligrams of Zolpidem at bedtime for 5 days. The January 2023 Medication Administration Record (MAR) indicated Resident F received the 5 milligrams of Zolpidem on 1/10/23, 1/12/23, 1/13/23, and 1/14/23. She did not receive on 1/11/23. An Administration Note dated 1/11/23 at 7:26 p.m. indicated "...Zolpidem TartrateTablet 5 MG Give 1 tablet by mouth atbedtime for Insominia for 5 Days. awaiting delivery from pharmacy." The clinical record did not include a controlled substance record for 5 mg of Zolpidem. An interview was conducted with DON 2 on 4/5/23 at 3:52 p.m. She indicated she was unable to locate Resident F's controlled substance record. During a Confidential Interview 5, they indicated DON 1 did not put orders in timely. She had a habit of "back dating" orders or changing the medical providers orders. She would blame Medical Provider 2 for not sending the orders over, but DON 1 wouldn't enter or follow the			

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	04/06/2023

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

(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
	orders sent. During a Confidential Interview 6 they indicated Medical Provider 2 had provided a order on 1/7/23 for Resident F to receive 5 mg of Zolpidem nightly for 5 days. DON 1 had not put the order in until 1/9/23. 3. The clinical record for Resident L was reviewed on 4/3/23 at 11:41 a.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and protein calorie malnutrition. A physician's order, dated 10/14/22, indicated a full set of vitals and weight were to be done monthly. Resident L's weight was recorded on 12/1/22 as 144.0 Lbs. (Pounds). There were no weights recorded in the clinical record for January 2023 or February 2023. Resident L's weight was recorded on 3/11/23 as 128.0 Lbs., showing an 11.1% weight loss from 12/1/22. During an interview on 4/5/23 at 3:52 p.m., the Director of Nursing 2 indicated Resident L should have had her weight taken monthly.4. a. The clinical record for Resident B was reviewed on 4/3/23 at 12:24 p.m. Resident B's diagnoses included, but not limited to, diabetes type I, Parkinson's disease, binge eating disorder, and dementia. A written physician's order dated 2/9/23 indicated, Resident B was to have a CBC drawn. A Medical Provider (MP) 4 progress note dated 2/16/23 indicated, Resident B was visited to			

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	04/06/2023

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

(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
	review recent labs drawn on 2/3/23. The note went on further to indicate the CBC (complete blood count) lab was still pending. Resident B's clinical record did not results from a CBC drawn on 2/3/23. A copy of the CBC results for Resident B were received from the laboratory on 4/4/23 at 10:45 a.m. The report indicated, the CBC was collected on 2/14/23 and was reported on 2/15/23. An interview with DON (Director of Nursing) 2 was conducted on 4/4/23 at 11:13 a.m. indicated, the expectation was when a resident has a lab ordered, it should be completed on the next scheduled lab day unless the order was for a STAT (immediate) lab. DON 2 further indicated, the facility, prior to her becoming the DON, did not have a set lab day. b. The clinical record for Resident D was reviewed on 4/4/23 at 11:19 a.m. Resident D's diagnoses included, but not limited to, bipolar disorder, hypertension, and diabetes type II. Medical Provider (MP) 3 progress note dated 2/23/23 at 3:58 p.m. indicated, Resident D was seen that day for concerns of urinary incontinence. The resident stated, he was having trouble holding his urine and it has been going on for the last couple months. MP 3 discussed with Resident D of getting a PSA (a blood test used primarily to screen for prostate cancer) to which he was agreeable. The Action/Plan indicated to order a PSA lab and indicated the following labs, which were already ordered, were still pending: CBC, CMP (complete metabolic panel), Depakote level (a medication used to treat manic stages of bipolar disorder and can increase the risk of liver damage or pancreatic inflammation, among other			

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	04/06/2023

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

(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
	side effects), Vitamin D level, and HgbA1c (Hemoglobin A1c was a blood test used to indicate control of blood glucose over 3 months time). Furthermore, the progress note stated, Resident D's medication regimen was to be adjusted based on lab results. An interview with DON 2 conducted on 4/5/23 at 3:42 p.m. indicated, Resident D's CBC, CMP, HgbA1c, PSA, or Depakote level labs had never been placed thus they hadn't been completed as of the time of the interview. 5. a. An email from MP 2 dated 1/6/23 at 5:49 p.m. and sent to DON 1's facility email. The email indicated the following insulin orders for Resident B: "[sic, DON 1's name] these orders need to start in the am for [sic, Resident B's name]. - Increase Lantus to 16 units at night. - Novolog changes: Breakfast increase to 8 units Lunch increase to 12 units Dinner increase to 12 units - Sliding scale as follows: <140 no additional insulin 141-180: 1 units 181-220: 2 units 221-260: 3 units 261-300: 4 units 301-340: 5 units 341-380: 6 units >380: 7 units" An email from MP 2 dated 1/7/23 at 11:03 a.m. was sent to DON 1's facility email. The email indicated the following insulin order for Resident B: "[sic, Resident B's name] needs an extra 2 units of Novolog of his sliding scale now please. POCT [sic, point of care test] glucose greater than			

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	04/06/2023

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

(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
	sliding scale. Please contact the Q [sic, QMA, qualified medication assistant]." An email from MP 2 dated 1/7/23 at 3:06 p.m. was sent to DON 1's facility email. The email indicated the following insulin order for Resident B: "Add to the sliding scale the following: 381-420: 7 units >420 8 units Novalog corrections needs to be at least 3 hours after dinner." A copy of an email from MD (Medical Doctor) 1, an Endocrinologist (a physician who is specialized in glands and the hormones they produce which affect important processes that control metabolism, blood pressure, cholesterol, and blood glucose levels, among others) dated 1/23/23 at 4:03 p.m. was in Resident B's hard chart. This email listed the subject as "Insulin Dosing Changes" and indicated the following orders: Use this dosing schedule for 1/23/23 and through 1/24/23: - Administer Lantus (long acting insulin) 16 units at night, Novolog dosing correction at bedtime if at least 3 hours out from dinner Novolog dose. - Novolog before meals: At breakfast give 8 units; at lunch give 12 units; and dinner give 12 units. Correction of 1:4 over 140 before meals sliding scale: Below 140; no additional insulin 141-180: 1 unit 181-220: 2 units 221-260: 3 units 261-300: 4 units 301-340: 5 units 341-380: 6 units 381-420: 7 units above 420: 8 units			

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	04/06/2023

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

(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
	On Wednesday 1/24/23, starting with breakfast through 1/31/23: - Administer 19 units of Lantus each night at bedtime if at least 3 hours out from the dinner dose of Novolog (short acting insulin) - Novolog dosing: At breakfast give 10 units; lunch time give 12 units; and dinner time give 14 units. - Correction of 1:3 carbohydrate ratio over 140 before meals sliding scale: Below 140: no additional insulin 140-170: 1 unit 171-200: 2 units 201-230: 3 units 231-260: 4 units 261-290: 5 units 291-320: 6 units 321-350: 7 units 351-380: 8 units 381 or above: 9 units A handwritten note on the bottom of the copied email indicated, this order was faxed to the facility at 4:31 p.m. on 1/23/23 as well as hand delivered to the facility for DON 1 to input the orders. An interview with MP 2 was conducted on 4/6/23 at 1:31 p.m. MP 2 indicated, she was told by the facility soon after the new management company took over that she was no longer allowed to place orders into their system directly but rather, needed to use either text message services or email to give orders to DON 1 to place into the system. She stated, the facility then took away her access to their charting system so she was not able to place orders for residents herself. She indicated, because of this her orders weren't being entered timely and considered this a delay in care for her patients. She stated, on 1/7/23 at 11:56 a.m. she emailed DON 1 to place insulin orders for Resident B related to his elevated blood glucose			

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	04/06/2023

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

(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
	reading. She then called DON 1 to inform her of the new order and it was at that time when DON 1 stated to her that all non-emergent orders will be handled during normal business hours and if it were emergent, then he will need to go the the emergency room because he was not appropriate for the assisted living. Resident B's blood glucose levels for January 2023 were as follows per the vitals tab in his EHR (electronic health record): 1/23/23 at 7:33 a.m.: 348 1/23/23 at 10:23 a.m.: 159 1/24/23 at 8:47 a.m.: 313 1/24/23 at 11:28 a.m.: 95 1/24/23 at 10:08 p.m.: 257 2/25/2023 at 9:17 a.m.: 389 2/25/2023 at 11:56 a.m.: 137 2/25/2023 at 4:22 p.m.: 190 2/26/2023 at 9:59 a.m.: 400 2/26/2023 at 12:47 p.m.: 268 2/26/2023 at 4:47 p.m.: 210 2/27/2023 at 7:39 a.m.: 329 2/27/2023 at 11:07 a.m.: 292 2/27/2023 at 4:05 p.m.: 188 Resident B's January 2023 MAR (medication administration record) was reviewed on 4/4/23 at 11:15 a.m. It indicated the following: -1/23/23: did not receive the scheduled breakfast or dinner doses of Novolog (per order, 8 units in a.m. and 12 units at dinner time); did not receive the Novolog sliding scale for bedtime for blood glucose of 159 (per order, 1 units); or Lantus at night (per order, 16 units each night) - 1/24/23: did not receive scheduled breakfast dose of Novolog for a blood glucose of 313 (per order, 10 units in a.m.) received 10 units of Novolog at 5:30 p.m. (per order, 14 units at dinner time); did not receive Novolog sliding scale for			

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	04/06/2023

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

(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
	breakfast blood glucose of 313 or bedtime blood glucose of 257. - 1/25/23: did not receive scheduled breakfast dose of Novolog for blood glucose of 389 (per order, 10 units); did not record a bed time blood glucose nor did he receive bedtime Novolog sliding scale insulin. - 1/26/23: did not receive record bed time blood glucose nor did he receive bedtime Novolog sliding scale insulin. - 1/27/23: did not receive record bed time blood glucose nor did he receive bedtime Novolog sliding scale insulin. b. The clinical record for Resident H was reviewed on 4/5/23 at 11:21 a.m. Resident H's diagnoses included, but not limited to, diabetes type II. Resident H's blood glucose reading on 1/9/2023 at 5:31 p.m. was 442 per the vitals tab in EHR. A physician's order dated 1/9/23 indicated, to administer to Resident H 10 units of Novolog insulin intramuscularly one time for elevated blood glucose. The order had an incorrect route of administration and should have been a subcutaneous administration not intramuscular. This order was placed into the EHR on 1/9/23 at 8:31 p.m. A progress note from Medical Provider 4 was dated 1/10/23 at 11:04 a.m. It indicated, Resident H was seen to follow-up on hyperglycemia over the weekend. "On 1/9/2023 resident has an elevated blood sugar at 442. Order given." A review of Resident H's January 2023 MAR conducted on 4/4/23 at 1:04 p.m. indicated, Resident H did not receive the 10 units of			

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	04/06/2023

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

(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
	Novolog as ordered. An interview with MP 2 conducted on 4/6/23 at 1:31 p.m. indicated, on 1/9/23, DON 1 did not place her order for Resident H's 10 units of coverage until 8:31 p.m. and because of this delay, the resident did not receive the 10 units of coverage that day. A confidential interview (CI) was conducted with CI 5. They indicated, DON 1 would change MP 2's orders without MP 2's approval, was delayed in placing orders for Resident B and H into the system, and would tell nursing staff to just give medications without the orders in the system. CI 5 indicated, there had been times when Resident B and H did not receive their additional insulin as ordered related to DON 1 not placing the order in the system timely. 6. A progress note for Resident D was written by MP 4 and dated 2/7/23 at 3:22 p.m. indicated, "Monthly blood pressure reviewed, appears stable. Heat rate appears stable also, I recommend we monitor his B/P [sic, blood pressure] and HR [sic, heart rate] medications are monitored, and have hold parameters" A progress note written for Resident D by MP 3 and dated 2/23/23 at 3: 58 p.m. indicated, "A/P [sic, action/plan]...amlodipine Besylate Tablet 10 mg [sic, milligrams and a blood pressure medication] Hold for HR <60 or >120" A progress note written for Resident D by MP 3 and dated 3/28/23 at 3:03 p.m. indicated, Resident D's amlodipine was to be held if heart rate was less than 60 bpm [beats per minute] or greater than 120 bpm.			

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	04/06/2023

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

(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
	Resident D's physician orders dated 3/10/22 indicated to give Resident D one 10 mg tablet of amlodipine, once a day for hypertension. The order did not contain the parameters to hold medication if HR was less than 60 or greater than 120 bpm. This state tag relates to complaint IN00399970.			
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review, the facility failed to ensure a resident's diet order was reviewed and revised timely for 1 of 9 residents reviewed for diet modifications. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/4/23 at 11:19 a.m. Resident D's diagnoses included, but not limited, to bipolar disorder and diabetes type II. A Diet Modification list, updated on 8/23/22 and received on 4/3/23 at 1:37 p.m. from ADM (Administrator) indicated, Resident H's diet was mechanical soft with gravy and thin liquids. Under the "Diet Upgraded" column for Resident H it stated, "Needs order-not updated in PCC [sic, Point Click Care, electronic charting system]. Resident D's physician's order for his modified diet of mechanical soft with gravy and thin liquids was not placed into PCC until 3/29/23. An interview with DON (Director of Nursing) 2 was conducted on 4/5/23 at 3:42 p.m. DON 2	R 0275	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. No additional staff members were present or involved in the orders for the resident named in this occurrence. After assessing performance and implementing policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing had failed to meet expectations. The Interim administrator also was made aware by a former nurse practitioner of concerns related to	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	indicated, she was not aware of why the modification diet order for Resident D was not placed in his orders as she was not the DON back in August 2022.		inputting physician orders. The interim administrator requested that the pharmacy review orders. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company for all residents, the former Director of Nursing failed to implement necessary changes in her performance, and was terminated in March of 2023. The nurse consultant was asked to review all diet orders and document any necessary changes, resulting in the documentation of the order on March 29, 2023. 100% of diet orders had already been audited and documented appropriately prior to the survey in April of 2023. These orders were consistent with the requirement at the time of the survey. The Director of Nursing will audit 100% of new diet orders to ensure documentation in the EMAR for 90 days to ensure continued compliance.	
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 timely address a pharmacist's recommendations to the prescriber for 1 of 5 records reviewed for pharmacy medication review.	R 0299	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	(Resident H) Findings include: The clinical record for Resident H was reviewed on 4/5/23 at 11:21 a.m. Resident H's diagnoses included, but not limited to, generalized anxiety disorder, dementia with behavioral disturbance, diabetes type II, major depressive disorder, and dysphagia, oral phase (difficulty with eating or swallowing). A physician's order dated 9/19/19 indicated, to give Resident H one 10 mg (milligram) tablet of Bethanechol Chloride by mouth three times a day. A pharmacist's medication review and recommendation completed for the time frame of 1/2/23 to 2/2/23 indicated, Resident H "has been receiving Bethanechol 10 mg TID [sic, three times a day] since 2019. This is typically used for urinary retention. Could we attempt a reduction to 5 mg TID [sic] if she is not having any symptoms?" A pharmacist's medication review and recommendation (MRR) completed on 3/27/23 indicated, Resident H "has been receiving Bethanechol 10mg [sic] TID [sic] since 2019. This is typically used for urinary retention. Could we attempt a reduction to 5mg [sic] TID [sic] if she is not having any symptoms?" The MRR was not addressed as of 4/4/23. A review of Resident H's January, February, March, and April 2023 MARs (medication administration record) was conducted on 4/5/23. The MARs indicated, Resident H received the Bethanechol three times a day except on the following days and times:		administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. No additional staff members were present or involved in the pharmacy services for the resident named in this occurrence. After assessing performance and implementing policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing could not produce pharmacy recommendations and had failed to complete follow up to pharmacy recommendations. The Director of Nursing failed to implement necessary changes and was terminated in March of 2023. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, each of the residents is at risk for failure to follow up to pharmacy recommendations. The Director of Nursing, for whom it was the first day following orientation, is aware of the need to follow up on pharmacist recommendations but had not been within the community to allow follow up from the March 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	1/6/23: received only 2 of the 3 doses 2/10/23: received only 2 of the 3 doses 3/10/23: received only 1 of the 3 doses An interview with DON (Director of Nursing) 2 was conducted on 4/5/23 at 3:42 p.m. DON 2 indicated, a pharmacist's MRR should have been addressed in a timely manner and Resident H's pharmacy recommendation was not addressed timely.		recommendations, but has since done so for all residents. Going forward, this Director of Nursing and/or her designee will follow up on all pharmacy recommendations within 2 weeks of receiving the recommendations from pharmacy, documenting the follow up in the EMAR, as is the practice of this management company. The Executive Director and/or his designee will audit 100% of pharmacy recommendations within 30 days of receipt of the recommendation for follow up and documentation in the emar for 120 days.	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview and record review, the facility failed to ensure a medication cart was appropriately locked at all times and a resident's Norco and Ambien tablets were under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit for 1 of 3 medication carts reviewed and one medication storage room within the facility. Findings include:	R 0304	The QMA was educated regarding securing his cart when not immediately in front of it when the incident was brought the attention of nursing leadership. The leadership team was unaware of any prior incidents of this staff member or others failing to secure the medication cart. However, each resident has the potential to have been negatively impacted by	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	An observation made on 4/6/23 at 10 a.m. of QMA (qualified medication assistant) 22's medication cart. The medication cart was parked in the bistro area of the facility against a wall. There were two residents present in the bistro when the observation was made. QMA 22's medication cart was found to be unlocked. When asked where QMA 22 was, another staff member indicated, he was on a break. When QMA 22 returned, the review of his medication cart began. Inside QMA 22's med cart the following was observed: - An opened bottle of ofloxacin 0.3% (antibiotic eye drop) for Resident CC with "d/c" hand written on the label; QMA 22 reviewed Resident CC's current orders at the same time and indicated, the ofloxacin drops were discontinued on 12/28/22. - A opened tube of mometasone furoate 0.1% (ointment for skin conditions) did not have a cap on it inside a medication drawer for Resident DD. QMA 22 immediately reviewed Resident DD's current orders and found that Resident DD did not have a current order for the ointment. The mometasone ointment had been discontinued on 6/23/22. Immediately following the review of QMA 22's medication cart, the facility medication storage room was observed with NC (nurse consultant). The medication storage room had an office area off the main room. Inside the office area, was a large, clear, plastic bag containing multiple medication cards and packages of tablets for Resident FF on top of a box. NC had indicated, Resident FF was not in the facility currently but, the plastic bag of medications came from a rehabilitation facility she was at prior to coming back to the facility. A review of the contents of the plastic bag found 12 tablets of Norco 5/325 mg (milligram) tablets as well as 1 tablet of Ambien 5		this occurrence but a review of residents was unable to identify any such occurrences. Medications counts revealed no missing medications, and residents did not exhibit any symptoms indicating that additional medications had been taken. The QMA was educated on the need to secure his cart at the time of the incident. All other nurses and QMAs were provided this education during an in-service on April 20, 2023. The Director of Nursing and/or her designee will audit the medication carts to ensure compliance 1 cart per day daily for 30 days and 1 cart weekly for 60 additional days.	

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	04/06/2023

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

(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
	mg. Neither of these medications had narcotic count sheets, nor were they under double lock. A Medication Administration policy was received on 4/6/23 at 11:43 a.m. from ADM (Administrator). The policy indicated, "11. Medications will be securely stored at all times in the applicable medication cart. 12. Authorized staff will maintain control of keys to medication carts at all times...13. Authorized staff must remain in attendance during access to Medication room by any unauthorized person...14. Controlled (Schedule II, III, and IV) medications will be secured under double lock in the narcotic compartment of the medication cart...29. Controlled drug inventory will be maintained at all times."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure a medication cart was free from discontinued medications for 1 of 3 medication	R 0306	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	carts reviewed for medication storage. Findings include: An observation made on 4/6/23 at 10 a.m. of QMA (qualified medication assistant) 22's medication cart. The medication cart was parked in the bistro area of the facility against a wall. There were two residents present in the bistro when the observation was made. QMA 22's medication cart was found to be unlocked. When asked where QMA 22 was, another staff member indicated, he was on a break. When QMA 22 returned, the review of his medication cart began. Inside QMA 22's med cart the following was observed: - An opened bottle of ofloxacin 0.3% (antibiotic eye drop) for Resident CC with "d/c" hand written on the label; QMA 22 reviewed Resident CC's current orders at the same time and indicated, the ofloxacin drops were discontinued on 12/28/22. - A opened tube of mometasone furoate 0.1% (ointment for skin conditions) did not have a cap on it inside a medication drawer for Resident DD. QMA 22 immediately reviewed Resident DD's current orders and found that Resident DD did not have a current order for the ointment. The mometasone ointment had been discontinued on 6/23/22. An interview with DON 2 was conducted on 4/6/23 following the review of QMA 22's medication cart. DON 2 indicated, expired and/or discontinued medications should not be stored in the medication carts.		management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. Existing staff members were not present nor are aware of the details involved in the failure to properly dispose of medications. Despite being informed of numerous performance failures, the Director of Nursing failed to implement necessary changes and was terminated in March of 2023. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, each of the residents is at risk for failure to destroy expired or discontinued medications under the prior leadership. The failure to destroy expired or discontinued medications was identified by nurse consultant brought in to assist in bringing the building into compliance and implementing the new management company's policies and procedures following the termination of the former Director of Nursing. The Director of Nursing and Nurse Consultant audited the nursing carts and documented and destroyed all medication found by	

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	04/06/2023

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

(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
			the nurse consultant to be discontinued or expired. Nurses and QMAs were educated on the proper procedures to destroy medications. A nurse will audit nursing carts weekly to ensure all discontinued or expired medications are removed from the carts and destroyed. The Director of Nursing or her designee will audit nursing carts weekly for 1 month and monthly for 120 days to ensure 100% of discontinued or expired medications are removed from the carts and destroyed.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records 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 provide complete and accurate medical records for 2 of 15 residents records reviewed. (Resident F) Findings include: A clinical record review for Resident F was reviewed on 4/5/23 at 1:30 p.m. Resident F's diagnosis included, but was not limited to, sleep disorder.	R 0349	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician order dated 1/10/23 indicated Resident F was to receive 5 milligrams of Zolpidem at bedtime for 5 days. The January 2023 Medication Administration Record (MAR) indicated Resident F received the 5 milligrams of Zolpidem on 1/10/23, 1/12/23, 1/13/23, and 1/14/23. She did not receive on 1/11/23. An Administration Note dated 1/11/23 at 7:26 p.m. indicated "...Zolpidem Tartrate Tablet 5 MG Give 1 tablet by mouth at bedtime for Insomnia for 5 Days. awaiting delivery from pharmacy." The clinical record did not include a controlled substance record for 5 mg of Zolpidem. An interview was conducted with Director of Nursing (DON) 2 on 4/5/23 at 3:52 p.m. She indicated she was unable to locate Resident F's controlled substance record for Zolpidem.		their leadership. No additional staff members were present or involved in the orders for the resident named in this occurrence. After assessing performance and implementing policies, procedures and systems of the new company for a period of one month, the interim administrator was aware that the Director of Nursing had failed to meet expectations. The interim administrator requested that the pharmacy review orders. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, the former Director of Nursing failed to implement necessary changes in her performance. The former Director of Nursing was terminated in March of 2023. While all residents with controlled substances are at risk for failure to have a controlled substance record, the community was unable to find any residents with negative consequences. 100% of controlled substances were audited to ensure that a controlled substance record is in place and any missing records were added. The Director of Nursing educated all persons passing medications on the need for controlled substance record and the need for documenting in that record on April 20, 2023.The	

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	04/06/2023

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

(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
			Director of Nursing also clarified which medications meet the controlled substance requirements. The Director of Nursing or designee will audit 100% of new controlled substance orders to ensure a controlled substance record is in place for 90 days. The Director of Nursing will also audit 10% of existing resident charts monthly to ensure a controlled substance record is in place for all controlled substances for 90 days.	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure transfer forms that included: resident's personal property when transferred to an acute care facility, nurse's notes related to the resident's functional abilities and physical limitations, nursing care, and condition on transfer	R 0354	On January 1, 2023, RPM Indianapolis LLC d/b/a Crown Senior Living changed management companies and administrators. The former management company removed	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	were provided to the receiving medical facility for 2 of 2 residents reviewed for discharge. (Resident K and Resident M) Findings include: 1. A clinical record review for Resident K was reviewed on 4/3/23 at 2:21 p.m. Resident K's diagnosis included, but was not limited to, stage 5 kidney disease. The resident was discharged on 10/18/22. An incident noted dated 9/21/22 indicated "...Notified by nrsg [nursing] staff that res [resident] on floor in apartment. Res unable to state nature of fall. Res with confusion at that time.Alert to self and place only. Res request evaluation via ER [emergency room] services. 911 called and res transported to [name of hospital] for eval [evaluation] and treatment. Attempted to contact [name of family member], unable to leave voicemail d/t [due to] mailbox full...Res transported to [name of hospital] for eval and treat. The resident's clinical record did not include a transfer form that was provided to the receiving medical provider. A Notice of Transfer or Discharge form was provided by the Administrator Interim on 4/5/23 at 4:13 p.m. It indicated Resident K was discharged on 9/21/22 to a skilled nursing facility, because the residents needs were unable to be met. A documented form regarding Resident K was provided by the Administrator Interim on 4/5/23 at 4:13 p.m. It indicated the staff were unable to provide documented reason Resident K had discharged from the facility. The resident had		their policies and procedures as well as any soft files, reportable occurrences, grievances, or other files pertinent to investigating this alleged violation occurring under their leadership. No additional staff members were present or involved in the discharge planning for the resident named in this occurrence. Existing staff members were not present nor are aware of the details involved in Resident K or M's discharge or notifications that were made or attempted to be made. After reconciling the census in the EMAR system, the interim administrator requested that Resident M be discharged from the EMAR system because this resident had not been in the community since her discharge to the hospital in December and was living at another community. The interim admin requested to see copies of Notice of Transfer/Discharge for this resident, but neither the Business Office Manager or Director of Nursing were aware of the form. The Director of Nursing failed to implement necessary changes in her performance, and the Director of Nursing was terminated in March of 2023. While this management company and leadership is unable to retroactively correct issues from the prior leadership and management company, each of	

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	04/06/2023

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

(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
	discharged from the facility in 2022, and was under the care of another management company. The new current management company took over the facility on 1/1/23. 2. A clinical record review for Resident M was reviewed on 4/4/23 at 9:03 a.m. Resident M's diagnosis included, but was not limited to, chronic kidney disease. The resident was discharged on 1/9/23. An administration note dated 12/13/22 indicated Resident M was in the hospital. An administration note dated 1/28/23 indicated Resident M was discharged. The resident's clinical record did not indicate where the Resident M had discharge to or reason she discharged. A documented form was provided by the Administrator Interim on 4/3/23 at 3:15 p.m. It indicated "...ED noted that nursing staff were not providing Notice of transfer and Discharge, The Appeal form and the Bed hold policy to all discharges. DON [1] stated that she was unaware of this requirement..."		the residents is at risk for failure to provide notifications under the prior leadership. Upon identifying that the former leadership had failed to provide Notice of Transfer/Discharge, the Memory Care Coordinator completed the training for all nursing staff members regarding provision of the Notice of Transfer/Discharge prior to the start of this survey. The interim administrator provided copies of the Notice of Transfer/Discharge Notices, Appeal form and Bed Hold Policy to be maintained in the nurses' station. The nursing staff were provided additional training on this topic. The Executive Director and/or his designee will review all transfers or discharges to ensure that they have received the appropriate notices and forms for 90 days.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents,			

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	04/06/2023

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

(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
	including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices were maintained with disinfecting of glucometers per manufactures instructions for 2 of 2 random observations of blood sugar readings obtained, and ensure appropriate hand hygiene practices were conducted using gloves while touching of food and medications for 1 of 7 medication administrations observed and 1 of 1 random observations of dining in the memory care unit. (Resident R, Resident S, Resident T and Resident MM) Findings include: 1a. A clinical record review for Resident R was reviewed on 4/3/23 at 2:15 p.m. Resident R's diagnosis included, but was not limited to, diabetes mellitus type 2. A physician order dated 3/20/23 indicated staff was to obtain Resident R's blood sugars three times a day. An observation was made of medication administration with Qualified Medication Aide (QMA) 10 on 4/3/23 at 11:18 a.m. QMA 10 was observed prepping to obtain a blood sugar reading utilizing a multiple used glucometer on Resident R. She removed the glucometer from the drawer of the medication cart and then wiped the glucometer with an alcohol pad. After, she obtained the blood sugar reading from Resident R, she then wiped the glucometer again with an alcohol pad. QMA 10 indicated at that time, she	R 0407	All residents have the potential to be impacted by failure to sanitize equipment and improper hand hygiene and glove usage. A review of 100% of residents' infection did not reflect any pattern of infection related to this failure. After verifying the type of glucometer and the methods for cleaning, all medication carts were provided sanitation wipes for all glucometers. All nursing employees providing blood sugar testing were provided education on the need to sanitize the glucometer between uses. All nursing staff members also were educated on proper hand hygiene and glove usage during medication administration and preparation of food trays. The Director of Nursing and/or her designee will be responsible to audit 1 insulin administration daily for and 1 meal set up once daily for 1 week, once weekly for once weekly for one month and monthly for an additional 60 days.	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/06/2023

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

(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
	used alcohol wipes to clean the glucometers after use. 1b. A clinical record review for Resident S was reviewed on 4/3/23 at 2:25 p.m. Resident S's diagnosis included, but was not limited to, cirrhosis of liver. A physician order dated 9/16/22 indicated Resident S was to receive 5 capsules of creon three times a day. An observation was made of medications administrations with QMA 10 on 4/3/23 at 11:32 a.m. QMA 10 had reported Resident S liked his creon capsule medications to be opened and poured into his drink. At that time, QMA 10 donned on gloves, opened the medication cart and removed Resident S's creon capsule medications. She then with her gloved hands opened each capsule and poured the remnants in a medication cup she removed from a stack of cups on top of the cart. After, she poured the creon in Resident S's drink. QMA 10 was not observed using hand hygiene and donning on a new set of gloves prior to touching of Resident S's creon medications. 1c. A clinical record review for Resident T was reviewed on 4/3/23 at 2:21 p.m. Resident T's diagnosis included, but was not limited to, diabetes mellitus. A physician order dated 2/20/23 indicated Resident T was to receive humalog sliding scale with meals. An observation was made of medications administrations with QMA 10 on 4/3/23 at 11:42 a.m. QMA 10 was observed obtaining Resident			

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	04/06/2023

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

(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
	T's blood sugar reading using a multiple use glucometer. After completion of the blood sugar reading, QMA 10 wiped the gluometer with an alcohol wipe. An interview was conducted with QMA 9 in the memory care unit on 4/3/23 at 11:52 a.m. She indicated she used alcohol wipes to clean and disinfect the glucometers, because there were no germicidal wipes on the medication cart. An observation was made of QMA 10's medication cart with the Director of Nursing (DON) 2 on 4/3/23 at 12:15 p.m. During the observation of the cart, germicidal wipes were unable to be located in the medication cart. DON 2 indicated germicidal wipes should be on all the carts. She had obtain blood sugars last week for the residents and germicidal wipes were on the carts at that time. There were no residents that have an infectious disease that require blood sugar readings. A ON Call glucometer manufacture procedure was provided by the DON 2 on 4/6/23 at 10:51 a.m. It indicated "Cleaning and Disinfection the ON Call Pro Blood Glucose Monitoring System. The Discide Ultra Disinfecting Towelette and the PDI Super Sani-Cloth Germicidal Disposable wipes are validated for use with the On Call Pro Blood Glucose Meter...Note: Only one of the two disinfectants listed should be used on the device for the lifespan of the device. The effect of using more than one disinfectant interchangeably has not been evaluated..." 2. An observation was made of QMA 9 in the memory care dining room serving lunch to the residents on 4/3/23 at 11:56 a.m. QMA 9 was observed donning gloves, then pulling food trays			

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	04/06/2023

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

(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
	out of a food mobile cart and passing trays out to residents sitting at tables in the memory care. She indicated there were an approximately 15 residents that reside in the memory care unit. During the meal service, QMA 9 was observed assisting residents with pushing the residents' chairs closer to the tables, opening condiments and handling of silverware using her gloved hands. QMA 9 then pulled Resident MM's tray. She picked up hush puppies off the tray with her gloved hands and placed the hush puppies in a Styrofoam cup. She indicated at that time, Resident MM liked the hush puppies in a cup instead of on the tray. There was no observation of QMA 9 doffing her gloves, using hand hygiene and donning on a new set of gloves prior to touching Resident MM's hush puppies nor did she utilize hand hygiene during the dining observation with each resident contact. An interview was conducted with the Administrator Interim on 4/4/23 at 9:15 a.m. She indicated the hand hygiene procedure and policy in which staff follow should be in the infection control - transmission based precaution policy. The transmission based precaution policy was provided by the DON 2 on 4/4/23 at 2:18 p.m. It indicated "...Procedure: Fundamentals of Isolation Precautions. 1. Handwashing and Gloving: Handwashing is considered the single most important measure to reduce the risks of transmitting microorganisms from one person to another or from one site to another on the same resident. Washing hands as promptly and thoroughly as possible between resident contacts and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important role in reducing the risks of transmission or			

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	04/06/2023

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

(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
	microorganisms...Note: Wearing gloves does not replace the need for handwashing, because gloves have small, unapparent defects or may be torn during use, and hands can become contaminated during removal of gloves. Failure to change gloves between resident contacts is an infection control hazard..."			