STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRADITIONS AT REAGAN PARK	1176 KINGWOOD DRIVE AVON, IN 46123

(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 Complaint IN00396818. Complaint IN00396818 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 19 and 20, 2022. Facility number: 013264 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 30, 2022.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review	
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
CJ Boswell	Executive Director	01/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on interview and record review, the facility failed to ensure Residents had the right to receive a copy of the facility's Dementia Care Disclosure form (State form 48896) upon their admission and failed to ensure an updated copy of the Disclosure form was submitted to the Indiana Department of Health. This deficient practice had the potential to effect 20 of 20 residents who resided in the Memory Care Unit. Findings include: On 12/20/22 at 9:30 a.m., following the entrance conference, a copy of the facility's admission agreement was provided for review. The documents did not include the Dementia Care Disclosure (State form 48896). On 12/20/22 at 11:00 a.m., the Dementia Care Disclosure form was requested for review. During an interview, on 12/20/22 at 1:46 p.m., the Executive Director (ED) indicated he was working on filing the 2022 Dementia Care Disclosure Form. They were not able to access the forms from the FSSA (Family and Social Services Administration) website. They sent an email (to FSSA) on December 6, 2022 and had reached out again today. He did not have a copy of the 2021 filing in the building, that was (submitted) before he was in this role. He had not been able to access the previous filing from the website either. The	R 0030	R 030 ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All memory care residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Alzheimer's and dementia special care unit disclosure form has been filed and is attached to POC. Executive and CRD educated on R 030 and requirement to provide	02/09/2023

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	admission agreement packet did not contain a copy, it did not appear it had been provided to residents and family members on admission. On 12/20/22 at 2:20 p.m., a policy was requested. On 12/20/22 at 3:05 p.m., the ED indicated he was not able to locate a policy, the facility followed all the State Rules related to Dementia Care Disclosure.		Alzheimer's and dementia special care unit disclosure form to all memory care residents. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Community Relations Director or designee will audit all current memory care resident files for provision of special care unit form, and if form was not provided upon admission community will provide that information. Ongoing, CRD or designee will audit all new mc admission leases for provision of form weekly x 4 weeks, monthly x 4 months and randomly on going. ***By what date the systemic changes will be completed: 2/9/2023***	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:			

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	(A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation, interview, and record review, the facility failed to ensure an unusual occurrence was reported to the Department of Health after a resident (Resident 4) was struck by a car in the facility parking lot which resulted in a skin tear and effusion to his left elbow, abrasions	R 0090	R 090 ***What corrective actions will be accomplished for those residents found to have been affected by the finding:***	02/09/2023

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	of multiple sites, and the impact of the motor vehicle dislodged his right prostatic leg which was left dented for 1 of 1 resident reviewed for unusual occurrences. Findings include: On 12/19/22 at 1:00 p.m., Resident 4's medical record was reviewed. He had current diagnoses which included but were not limited to amputation of his right leg below the knee, type II diabetes, and chronic kidney disease. A nursing progress note, dated 9/1/22 at 11:30 a.m., indicated Resident 4 had been struck by a car in the front parking lot. Upon the staff's arrival, he remained seated in his electric scooter chair, and had sustained a skin tear to his left elbow. There was bruising noted to his left knee. Resident 4 denied pain and indicated he had not hit his head. He was escorted back inside and to his room to await the arrival of paramedics, and initially refused to go to the hospital. However, his daughter arrived and convinced him to go to the ER for follow up. The corresponding hospital physician progress note, dated 9/1/22, indicated Resident 4 was evaluated in the emergency department for a chief complaint of a minor motor vehicle crash. "He was hit at a low speed in the parking lot while he was on his motorized scooter. Patient reports he had gone outside to have a cigarette and was in the parking lot at his assisted living facility when another one of the residents hit him with her car at a low speed on the right side of his scooter. He and his daughter report abrasions to the left elbow and left knee but he denies any pain or other symptoms. The patient has a history of a right below the knee amputation and wears a		No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Executive Director re-educated on IDOH incident reporting policy and procedure. Incident has been reported via incident reporting system and record of reporting is attached to POC. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Executive Director or designee will audit all incidents weekly x 4 weeks, then monthly x 4 months and then randomly to insure reporting policy is followed. ***By what date the systemic changes will be completed:*** ***2/9/23***	

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	prosthesis ... The impact caused his prosthetic to come off." X-rays were obtained and revealed small left elbow effusion (An abnormal collection of fluid in hollow spaces or between tissues of the body). The document indicated "given presence of effusion, recommend follow-up elbow radiograph in 7-10 days to assess for radiographic occult [hidden] fracture." Resident 4 did see his primary care physician on 9/12/22 (11 days after the accident). A copy of his visit was not scanned into his electronic medical record, nor found in his hard chart, but the Administrator provided a copy of the visit summary on 12/20/22. The Physician's Evaluation note, dated 9/12/22, indicated he was seen on that day for an Annual Medicare Wellness Assessment. While the note did indicate in the summary, " ...was hit 9/1/22 in the parking lot of assisted living parking lot ...he was hit in his electric wheelchair by a vehicle in the assisted living facility when we went out to smoke. His right prosthesis was apparently bent but he is still wearing it ...." The note lacked documentation that a follow-up radiograph had been conducted for his left elbow. During an interview on 12/19/22 at 1:45 p.m., the Administrator indicated Resident 4's accident had not been reported to the Department of Health. In consult with cooperate support it was not reported because Resident 4 had not sustained a serious injury. During a follow up interview on 12/20/22 at 9:37 a.m., Resident 4 recalled the accident in the parking lot. He indicated he had been out to smoke and on his way back on his scooter to the building when the driver came up the road, "and			

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	just didn't stop." Resident 4 indicated, "she hit me hard enough to knock off my fake leg." He indicated at first he didn't want to go to the hospital, but his daughter wanted him to get checked out. He did not have any broken bones, but indicated he was sore the next day. During an interview on 12/20/22 at 11:00 a.m., the Director of Nursing (DON) indicated she had been in the building at the time the accident occurred but had not witnessed the event. When she got to Resident 4 he was seated in his scooter, and the driver was getting out of her car. She said the sun was in her eyes and she hadn't seen him. The DON indicated Resident 4 had gone out to smoke, which he did regularly. During an interview on 12/20/22 at 11:11 a.m., Licensed Practical Nurse (LPN) 10 indicated she responded to a call from help she heard over the radio, in which Resident 4 had been involved in a car accident in the parking lot. When she arrived, Resident 4 was alert and oriented to his baseline, although his elbow was bleeding from a skin tear. His prosthetic leg had been knocked off and was slightly bent. At first, he refused to go to the hospital, but when they called his daughter, she "was freaking out and came right over." She was able to convince him to go with EMS to the hospital to get evaluated. On 12/20/22 at 11:45 a.m., the Administrator provided a copy of a portion of the Residential tags (Rule 0090), and a copy of the Residential rules for incident reporting which the Administrator indicated were used for applicable policies related to this incident. At this time the Administrator indicated after consultation with corporate, it was determined because the Resident was able to be treated at the hospital and was sent			

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	back the same day the incident had not been reported as a major accident. But perhaps it could have been considered in the "not limited to" category.			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the dishwasher maintained the correct temperature to clean the dishes and the sanitizer bucket had adequate chemicals to correctly clean the kitchen. This deficiency had the potential to effect 95 of 120 residents who received food from the kitchen. Findings include: 1. On 12/19/22 at 9:55 a.m., the dishwasher temperatures were observed. The wash cycle was 147 degrees Fahrenheit (F), the sanitizing temperature was 181 F. The Certified Dietary Manager (CDM) ran the dishwasher a second time. The wash and sanitizing temperatures remained the same. She indicated she would call the manufacturer to repair it. She indicated the dishwasher was running 3 degrees too low. The wash temperature should have been 150 F and the sanitizer 180 F. On 12/19/22 at 10:04 p.m., after knowing the dishwasher temperatures were too low, the CDM told Dietary Aide 8 to wash everything twice. She notified the maintenance man (MM) to call the manufacturer for repair. She indicated she would provide the Manufacturer's instruction for the	R 0154	R 154 ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No resident was adversely affected. ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Culinary staff re-educated on dishwasher temperatures and	02/09/2023

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	dishwasher. On 12/20/22 at 10:03 a.m., the CDM indicated lunch service for the facility started at 11:00 a.m., and they prepared meals for 95 residents per meal. They had 25 to 45 residents eating in the dining room every day and the Memory Care (MC) unit received its own meal cart with trays. Some residents would get their meals trays in their rooms and some residents did not get meal trays because they had food in their rooms. She did not use Styrofoam paper products for the 12/19/22 lunch service because she thought since the dishwasher sanitizing temperature reached 180 degrees the dishes were sanitized and were ok. The manufacturer had arrived yesterday at 12:00 p.m., and left at 1:07 p.m. The internal dishwasher thermostat was set at 152 F, the manufacturer employee turned it up to 162 to be sure the dishwasher reached a high enough washing temperature. An observation of the dishwasher showed the wash temperature reaching 160, with the sanitizing temperature at 181. On 12/20/22 at 10:26 a.m., Dietary Aide 9 indicated she came in at 5:00 a.m., and she checked the dishwasher water temperatures on 12/19/22. She logged in wash temperature at 158 F, and the sanitizing temperature at 185 F. She indicated the dishwasher temperatures were dropping all day and the dishes were not clean. On 12/20/22 at 11:17 a.m., the Administrator indicated his expectation were the dishes should have been cleaned per the manufacturer's recommendations. 2. The litmus (paper strip testing for chemical levels) test of the sanitizer bucket in the galley kitchen was 150 part per million (ppm). The CDM		sanitizing bucket chemical density. Dish machine manufacturer arrived at community the day temperature variation was noted and repaired the machine to wash in desired temperature range. Sanitizing water chemical density adjusted immediately to adhere to appropriate ppm range. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Culinary Director or designee will audit dishwasher temp log and sanitizer ppm log 5 x weekly x 4 weeks, then monthly x 4 months and then randomly to ensure proper dish machine temperature and chemical density in sanitizing water. ***By what date the systemic changes will be completed:*** ***2/9/23***	

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	indicated it was too low, it should have been 200 ppm. She indicated it was used this morning to clean the galley kitchen before breakfast. On 12/20/22 at 12:00 p.m., requested from the Administrator the manufacturer's dishwasher instruction for the dishwasher, and a policy for the sanitizing bucket. The dishwasher manufacturer instructions and the sanitizing bucket policy were not received upon exit. A current policy, titled, "Infection Control - Cleaning and Sanitizing Equipment and Utensils," was provided by the Administrator, on 12/20/22 at 12:50 p.m. A review of the policy indicated, " ...All food service equipment and utensils will be washed, rinsed and sanitized using the three-compartment sink or commercial dishwasher. If the commercial dishwasher malfunctions or needs repair, the resident and staff dishes and utensils will also be cleaned using the approved procedure ...Wash items in warm water and dishwasher detergent ...Rinse items in clear water ...Sanitize items in a solution of water and bleach or quaternary or appropriate chemical sanitizer ...."			
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to ensure a Medicaid resident (Resident 8), with a chronic major mental illness (MMI) had a comprehensive care plan created in cooperation with her psychiatric physician, to provide person-centered goals and interventions to address her MMI for 1 of 1 resident reviewed for MMI Care Plan Services.	R 0382	R 382. ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** No negative outcome identified for	02/09/2023

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	Findings include: On 12/20/22 at 8:45 a.m., Resident 8's medical record was reviewed. She had current diagnoses which included, but were not limited to, chronic Schizophrenia and she received a scheduled antipsychotic medication. A Psychiatry evaluation, dated 12/2/22, indicated Resident 8 was being seen for "behaviors health services consulted to evaluate/treat effectiveness of psychotropic medications related to schizophrenia and verbal hallucinations. Mood Factor: "feeling more anxious, like my head isn't right, feels like my eyes are crossing and I feel lightheaded/dizzy. Haven't heard voices in a while but heard it the other night calling my name." Commentary on Psych Functioning: "Patient is having auditory hallucinations and experiencing depression and anxiety. Forgetfullness and confusion noted. Patient has been on same dose of Risperidone (an anti-psychotic medication) since 2017. Will increase Risperidone to 2.25 milligrams at night. Nursing informed to monitor for any worsening symptoms or side effects, will follow up in 1 month or as needed ...." She had a care plan initiated 5/4/22 which indicated, "Behaviors Assistance Monitor for any increase in behaviors, (depression, anxiety) report to Primary Care Provider and family. The care plan lacked documentation of her MMI diagnoses, the risks it posed, goals for improvement in her quality of life, and/or person-centered interventions for staff on who/what/when/where to provide care and assistance.		those residents affected. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents with a major mental health diagnosis had the potential to be affected. No resident was adversely affected ***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Wellness Director educated on R 382 and requirement for comprehensive care plan for Medicaid Waiver residents with Major Mental Illness. Wellness Director communicated with facility mental health provider and developed comprehensive care plan as required by R 382 for resident 8. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director or designee will audit charts of residents who see mental health provider due to MMI monthly x 6 months, then randomly, to ensure comprehensive care plans with	

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	During an interview on 12/20/22 at 9:15 a.m., the Director of Nursing (DON) indicated the Care Plan was generated from the service plan and did not really have a space to add interventions. There was a place in the Service Plan evaluation where nursing could type in a sentence or two related to the area, but when she reviewed Resident 8's service plan and care plan, she indicated it lacked documentation of her MMI and did not include goals or interventions as a care plan should.		mental health providers are current and in compliance with R 382. ***By what date the systemic changes will be completed: 2/9/23***	