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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00397084 and IN00393841. Complaint IN00397084 - Substantiated. State deficiency related to the allegation is cited at R0273 Complaint IN00393841 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 4 and 5, 2023 Facility number: 013994 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 10, 2023.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure an employee's references were documented for 1 of 5 personnel files reviewed. (LPN 4)	R 0116	Please accept this submission of our Plan of Correction for R 116. It is prepared and submitted because of requirement under state and federal law.	01/19/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peter Hastings	Executive Director	01/30/2023

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.

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The review of the personnel files on 1/5/23 at 10:00 a.m., indicated the following: - LPN (License Practical Nurse) 4's personnel file lacked documentation of employee references. During an interview on 1/5/23 at 1:32 p.m., The DON (Director of Nursing) indicated LPN 4's references could not be located. The current ... (Facility Name) Team policy, provided by the Executive Director on 1/5/23 at 1:49 p.m., included, but was not limited to, "... Employees of ... (Facility Name) are required to provide/consent to/maintain... 4. Reference Checks..."		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All new employees will have at least two references checked and verified prior to working their first shift. An Employee Reference Check form has been initiated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected. All new employees will have two references checked and verified, prior to working their first shift. Director of Nursing or Designee will assure this is in employee's personnel file. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur. DON/ Designee will assure all staff have at least two references checked and verified prior to working their first shift. An employee reference check document will be initiated upon hire. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. DON/Designee will review four random employee personnel files weekly for four weeks	

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			beginning on 1/19/23, then Biweekly for four weeks and then monthly for three months. A review of findings will be discussed with the administrator weekly for four weeks beginning 1/19/23, then biweekly for one month and then monthly for three months. By what date the systemic changes will be completed. 1/19/2023. Please see attachment for full response. the Quality Assurance program and meeting will be extended by an additional 2 weeks and re-evaluated for compliance and/or continuation at each additional Quality Assurance meeting until facility reaches 100% compliance. Quality Assurance Committee responsible for monitoring, conducting at each meeting.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration			

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure documentation of general orientation and specific orientation was completed for 2 of 5 personnel files reviewed. (CNA 5 and LPN 3) Findings include: The review of the personnel files on 1/5/23 at 10:00 a.m., indicated the following: - CNA (Certified Nurse Aide) 5's personnel file lacked documentation of the specific orientation. - LPN (Licensed Practical Nurse) 3's personnel file lacked documentation of both the general and specific orientation. During an interview on 1/5/23 at 1:27 p.m., the DON (Director of Nursing) indicated they couldn't find the orientations for either staff member in their personnel files. The current ... (Facility Name) Team policy, provided by the Executive Director on 1/5/23 at 1:49 p.m., included, but was not limited to, "... New Employee Orientation... Orientation is a formal welcoming process that is designed to assist the new employee in learning about the company,	R 0123	Please accept this submission of our Plan of Correction for R 123. It is prepared and submitted because of requirement under state and federal law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All new employees will have documented General orientation on the first day of employment and shall be a Job-Specific orientation checklist to be completed within 14 days after of hire. An Orientation checklist and New Hire checklist have been updated and will be initiated during the orientation process. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. All new employees will have General orientation prior to working their first shift and job-Specific orientation within 14 days of date	01/19/2023

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preparation for their position, and presentation of expectations... Orientation will include an overview of the company, mission, commitment, and goals. The employee will be presented with a review of the employee rights and responsibilities..."		of hire. An Orientation checklist and New Hire checklist has been created and will be initiated during the orientation process. Director of Nursing or Designee will assure this is in employee's personnel file. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; DON/ Designee will assure all employees have an Orientation checklist and New Hire checklist initiated on day one of orientation. These forms will be added to Orientation packets at General Orientation on 1st day of employment.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; DON/Designee will review four random employee personnel files weekly for four weeks beginning on 1/19/23, then Biweekly for four weeks and then monthly for three months. A review of findings will be discussed with the administrator weekly for four weeks beginning 1/19/23, then biweekly for one month and then monthly for three months.¿ By what date the systemic changes will be completed. 1/19/23 Please see attachment for full response. the Quality Assurance program and meeting will be extended by an additional 2 weeks 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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			re-evaluated for compliance and/or continuation at each additional Quality Assurance meeting until facility reaches 100% compliance. Quality Assurance Committee responsible for monitoring, conducting at each meeting.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observations and interviews, the facility failed to ensure the kitchen and equipment were clean and in good repair during 3 of 3 kitchen observations. This deficient practice had the potential to affect 102 of 102 residents who received meals from the kitchen. Findings included: 1. During the initial tour of the kitchen with the Executive Chef on 1/4/23 between 9:20 a.m. and 9:50 a.m., the following was observed: - In the walk-in refrigerator there was a light coating of gray dust on the condenser fan grates. - In the walk-in freezer there were pieces of cardboard and tape on the floor. There was also a build-up of frost/ice on the top left inside door and saucer sized frosted ice on the left side of the floor. The floor just inside the door had a 2 foot by 2 foot area which was black.	R 0273	Please accept this submission of our Plan of Correction for R 273. It is prepared and submitted because of requirement under State and Federal law. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* An already-planned Dining/Kitchen Department in-service was conducted by the Executive Chef on Friday, January 6th . In addition to general departmental topics, Department staff were informed of the forthcoming implementation and posting of a weekly (with a major daily cleaning task) cleaning schedule, educated on proper Freezer door closing procedure. A “blanket” (vertical plastic barrier) was purchased on 1/16/2023 that will	01/19/2023

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- The reach-in freezer had a moderate amount of food particles on the bottom shelf. - The entire left side of the convection oven had a heavy build-up of grease from the fryer next to it. There was a 4 foot width by 5 foot length of wall behind the fryer and convection oven, which had a heavy build-up of grease. The floor under the fryer, between the fryer and the convection oven; and under the convection oven, had a heavy layer of clear grease with pieces of fries, black specks and bag ties in it. The left side of the fryer had whitish/pale yellow streaks down the entire side. - The burners to the stove had multiple dried yellow and brown spots on them. 2. During an observation of the kitchen on 1/4/23 between 10:50 a.m. and 11:30 a.m.., the areas identified at 9:20 a.m. remained the same. The fryer was also observed to be in use during this observation. 3. During an observation of the kitchen with the Executive Chef on 1/5/23 between 10:00 a.m. and 10:30 a.m., the following was observed: - All areas identified on 1/4/23 remained the same. - In the walk in freezer there was now an 18 inch length by 2 inch width of frost build up on the left side of the floor, connected to the saucer sized frost build up. The entire door edges and inside door frame had a thick coating of frost. During an interview with Cook 1 on 1/5/23 at 10:10 a.m., he indicated the staff frequently had to try to clean the frost off the door so the door would close. He was unaware of how long the frost build up on the floor had been there or if		be installed, if deemed necessary after door realignment, inside the freezer to eliminate frost buildup on freezer door and out into walk-in space. Maintenance Director inspected Freezer door to ensure it closed properly, scheduled specific date to realign. Executive Chef Initiated a total deep clean of walk-in fridge, freezer, de-iced freezer door, degreased and cleaned buildup on convection oven, wall space, floor, burners, and fryer and created and posted a cleaning schedule to maintain the affected areas while kitchen is not in use. *How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents have the potential to be affected. All current and new employees will be in-serviced on the weekly cleaning schedule and where it's posted, as well as education on proper freezer door closure. Executive Chef/Designee will monitor cleaning schedules and completion of checklists by dining staff. *What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur?* Executive Chef/Designee will ensure that all staff receive proper department-specific orientation	

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintenance had been made aware of this. During an interview with the Executive Chef on 1/5/23 at 10:14 a.m., she indicated staff cleaned the frost build up off the door every other day as she did not think the door was being closed properly. Maintenance had not been notified of the frost build-up, but she would put in a work order today. It was difficult to clean the wall behind the fryer and convection oven as the convection oven could not be moved away from the wall, since it had no wheels. The last time the area was cleaned was in November 2022. An observation of the fryer, at this time, indicated it was on wheels and could be moved out of the way in order for staff to get to the back wall. The cleaning schedule was requested on 1/5/23 at 10:14 a.m., the Executive Chef indicated there had been no cleaning schedules in place for as long as the building was open that she was aware of. This State Residential deficiency was related to Complaint IN00397084.		including weekly cleaning assignments, and proper procedures related to job. Freezer door "blanket" will be installed as soon as it's delivered to the facility. Monitoring cleaning schedule to ensure facility remains in compliance will be conducted by Executive Chef/Designee. 1/18/2023 Walk in fridge fan grates have been deep cleaned and on posted cleaning schedule and also on maintenance schedule to be cleaned 1x/month. 1/16/2023 Walk in floor has been swept and mopped and going forward will be swept/mopped daily. 1/19/2023 Freezer door reset by Maintenance Director with noticeable improvement in alignment and no frost observed. Monitored daily, added to posted daily cleaning schedule. 1/16/2023 Reach in freezer has been cleaned and is now on weekly cleaning rotation. 1/16/2023 Fryer area: Area has been cleaned. Purchased guard for Left side, then put weekly cleaning. Will install guard as soon as it arrives in shipment. 1/16/2023Burners: Area has been deep cleaned and are now on posted weekly cleaning schedule. *How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place?*	

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	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Executive Chef/designee will review weekly cleaning schedule and observe physical kitchen space weekly for four weeks beginning on 1/19/2023, then biweekly for four weeks, and then monthly for 3 months. *By what date the systemic changes will be completed.* 1/19/23 Please see attachment for full response: Please explain the criteria or threshold the Quality Assurance Program will use to determine whether monitoring is necessary or if the monitoring can be stopped:	