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		A. BUILDING 00 B. WING	04/22/2021

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 21 and 22, 2021. Facility number: 013846 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 28, 2021.	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 review and interview, the facility failed complete and thorough criminal background check for 2 of 2 employees hired in 2020 whose records were reviewed for criminal background checks. (RN 4, QMA 3) Findings include: 1. On 4/22/21 at 8:49 a.m., the employee record for RN 4 was reviewed. RN 4 had a hire date of 10/27/20. The criminal back ground check was	R 0116	· What corrective actions will be accomplished for those residents found to have been affected by the deficient practice Background checks will be done through the Indiana state police. Facility will utilize the new hire checklist when hiring new employees. · How the facility will identify other residents having the	05/05/2021

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

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	present, but lacked a criminal background check utilizing the Indiana State Police Repository. 2. On 4/22/21 at 8:50 a.m., the employee file for QMA 3 was reviewed. QMA 3 had a hire date of 6/17/20. The criminal background check was present, but lacked a criminal background check utilizing the Indiana State Police Repository. During an interview on 4/22/21 at 11:45 the Director of Nursing (DON) indicated that she had contacted the background verification service about the background checks that had been completed. She indicated that the company completed background checks for the county and state and was awaiting verification from the company about their source of information. During an interview on 4/22/21 at 1:04 p.m., the DON indicated that she was still waiting for verification from the background verification service on the type of background checks they do and what sources are used for their information. During an interview on 4/22/21 at 2:33 p.m., the DON indicated she had not received any information from the background verification service as of this time. During an interview on 4/22/21 at 3:28 p.m., the DON indicated she had still not received any information from the background verification service. The facility lacked documentation of a policy regarding background checks.		potential to be affected by the same deficient practice and what corrective action will be taken. Facility will run background checks on all employees. DON and admin assist will audit all employee files and all new hire charts. · What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Facility will have 2 people check off on all new employees' new hire checklist. · How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and by what date the systemic changes will be completed ED/DON will check on all employee files and correct as needed by the end of May 31, 2021. ED/DON will monitor as a 2nd check to make sure all new hires are properly screened, and results are in before starting employee in facility. ED/DON will sign off on all new hire checklists as they are completed indefinitely. Results from these audits will be reported to the monthly QA committee for further monitoring.	
R 0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance			

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Bldg. 00	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review the facility failed to ensure that annual inservice training was	R 0120	· What corrective actions will be accomplished for those residents found to have been	05/05/2021

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	completed for residents' rights, abuse, and dementia care for 3 of 5 staff members reviewed for inservice training. (Cook 3, LPN 2, CNA 3) Findings Include: 1. On 4/22/21 at 8:46 a.m., the employee record for Cook 3 was reviewed. Cook 3 had a hire date of 10/2/19. Cook 3's record lacked any residents' rights or abuse training, and had only 45 minutes of the required three hours of dementia training from January 2020 to April 2021. 2. On 4/22/21 at 8:46 a.m., the employee record for LPN 2 was reviewed. LPN 2 had a hire date 10/17/18. LPN 2's record lacked any documentation for residents' rights training from January 2020 to April 2021. 3. On 4/22/21 at 8:48 a.m., the employee record for CNA 3 was reviewed. CNA 3 had a hire date 2/15/19. CNA 3's record lacked any documentation for residents' rights training from January 2020 to April 2021. During an interview on 4/22/21 at 1:55 p.m., the DON (Director of Nursing) indicated that LPN 2 and CNA 3 did not complete residents' rights training but she had just assigned it to them to be completed. The DON indicated that Cook 3 had not completed training for residents' rights, abuse, or dementia. The DON stated that it is the policy of the facility to complete annual inservice training for residents' rights, abuse, and dementia. A current policy, reviewed 10/7/19, and titled "Home Care Orientation and Annual Inservice Training" was provided by the DON on 4/22/21 at 2:33 p.m. The policy indicated "...all home care staff must participate in required annual in-service		affected by the deficient practice ED/DON will have in-service on May 5, 2021 covering education and training requirements. All employees have been assigned Dementia training and resident rights as of May and will need to be completed by May 31, 2021. · 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. Facility will monitor employee education completion. Admin assistant will monitor completion and pass on to unit managers to keep employees on task for completion of education by the end of every month. · What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: ED/DON will assign online learning by the 7th of every month for employees to complete by the end of every month. Admin Assist or ED/DON will monitor education to make sure every employee completes in a timely manner. Admin assist will check on all online education by the 20th of every month to notify unit managers of which employees need reminders to complete tasks. · How the corrective action will	

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	training for each 12 months of employment..."		be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and by what date the systemic changes will be completed ED/DON or appointed representative will monitor employee education completion once a week for 60 days, then 2 times a month for 60 days, then once a month for 60 days. ED/ DON will monitor education completion monthly. Results from these audits will be reported to the monthly QA committee for further monitoring.	
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview, and record review, the facility failed to ensure foods were served at a safe temperature for 1 of 2 meals observed. (Kitchen) Findings include: On 4/21/21 at 10:55 a.m., Chef 2 was observed to be have a large bowl of "Caesar" slaw. Chef 2 was scooping the slaw and placing it into small bowls. The bowls were placed on trays then a cart for the lunch meal. On 4/21/21 at 11:25 a.m., the temperatures of the hot foods were obtained. On 4/21/21 at 11:40 a.m., the temperature of the "Caesar" slaw was	R 0272	· What corrective actions will be accomplished for those residents found to have been affected by the deficient practice ED/chef will have in-service on May 6, 2021, covering education and training requirements. All employees have been assigned Food Safety as of May and will be complete by May 31,2021 · 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. Chef/Sous chef will monitor kitchen staff when temping foods	05/05/2021

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	obtained after reminding the kitchen staff the slaw's temperature had not been obtained. The temperature of the slaw was 63 degrees F (Fahrenheit.) Chef 1 indicated she had removed the ingredients from the refrigerator and made the slaw prior to the slaw being placed into the small bowls. Chef 1 and Chef 2 indicated the temperature of the slaw should be between 30 and 70 degrees F with a holding time of 2 hours. Chef 1 indicated the dressing was mayonnaise-based. On 4/21/21 at 2:10 p.m., Chef 1 and Chef 2 indicated they would have never been able to keep the slaw cold enough, even if they had placed the slaw into the refrigerator. They indicated they had been instructed in their "ServSafe" class that cold foods, such as slaw, could be held for two hours between 30 and 70 degrees Fahrenheit. On 4/22/21 at 8:15 a.m., Resident 21 indicated the food is "so-so" and foods that should be served cold are at times warm. The current facility policy, "Primrose Dining Services Guidelines and Expectations," revised April, 2014, provided by the Director of Nursing (DON) on 4/22/21 at 2:33 p.m., included, but was not limited to, "Food must be served at appropriate temperatures. Chilled foods (e.g. salads or meat spreads) should be served at 40 degrees or less."		for all meals · What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Kitchen staff will temp cold foods after prep and before service. After prepping food items will be placed in cooler and taken out as needed during meal service. · How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and by what date the systemic changes will be completed Chef or appointed representative will audit the food temperature logs to ensure food temperatures are being taken and logged for each meal service. These audits will be conducted 5 x weekly for 30 days, then 3 x weekly for 30 days, then 1x weekly for 30 days to ensure compliance. Results of these audits will be reported to the monthly QA committee for further monitoring.	
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.			

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	Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 2 of 2 kitchens observed on 2 of 2 days of survey. Staff failed to perform hand hygiene upon entering the kitchen and between tasks, staff was observed to wear cloth masks or wear their masks under their nose or chin, and staff hair was not covered. The kitchen lacked towels at the hand washing sink, open food items were stored in the walk-in refrigerator with no label or date, refrigerators and freezers lacked internal thermometers, and the kitchen floor had dirt and debris on it. Social distancing was not maintained or encouraged during dining by the residents. (Assisted Living Kitchen, Memory Care Kitchen) Findings include: During an observation of the Assisted Living kitchen on 4/21/21 from 8:30 a.m. through 9:15 a.m., the following was observed: 1. The towel dispenser next to the front hand sink lacked paper towels for drying towels and had no trash can next to it for disposing the paper towels. 2. The large refrigerator in the kitchen lacked an internal thermometer and the outside and bottom of the refrigerator was soiled. An external thermometer gauge was visible above the door area. Chef 1 indicated they obtained the temperature from the external temperature gauge on the refrigerator and was unaware they needed to have internal thermometers in the refrigerators and freezers when they had an external thermometer. The facility did not have verification of accuracy of the external thermometer gauge.	R 0273	· What corrective actions will be accomplished for those residents found to have been affected by the deficient practice ED/DON will have an in-service May 6, 2021, to re-educate staff on proper hand hygiene, proper way to wear a mask, correctly wearing a hair net, label, and dating, covering food items in the refrigerator, and sanitation. Staff assigned Kitchen Sanitation and Cleaning, and Hand Hygiene (clean hands) · 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. ED/ chef will monitor during mealtimes and monitor that education has been complete · What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Kitchen staff must wear proper face masks/no cloth masks Kitchen staff must put on hair net then wash hands when entering the kitchen. Serving staff will use hand sanitizer/ wash hands after delivering plate and reentering the kitchen. Dishwasher will wash hands each time they move to clean dish rack. All uncovered and non-labeled food	05/05/2021

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	3. The outside of the large freezer in the kitchen was soiled with dirt and a dried substance on the bottom of it. 4. The free-standing white refrigerator lacked a thermometer and the door handle was broken off. 5. Three bananas were observed lying on a tray on a cart across from the back hand-washing sink next to the side of the large freezer and were split open. 6. A soiled scrub brush was observed lying in the back hand-washing sink. Chef 1 indicated the brush was for scrubbing the staff's hands and was "pretty bad looking." 7. The towel dispenser for the back hand washing sink was soiled where the towels came out with a white substance stuck on it. 8. Chef 1 was observed with a cloth mask on. 9. Cook 4 was observed with his mask under his chin. 10. A drawer with ladles had dirt and food particles in it. 11. The floor in the kitchen and dry storage area was soiled with dirt, grime, and food particles. During an observation of the Memory Care Kitchen on 4/21/21 at 9:15 a.m., the following was observed: 12. Plates with slices of red velvet cake were observed in the walk-in refrigerator unlabeled and undated.		items were thrown out immediately Housekeeping will be notified immediately when towels are low at hand washing station to replenish. Chef/Sous chef to oversee all kitchen staff is dating, labeling, and covering all food items. Missing thermometers were immediately placed in refrigerators/freezers Chef/Sous chef to oversee cleaning schedule for floor cleaning Kitchen staff to remind residents to Social Distance and showing them an area to sit if they wish to do so · How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and By what date the systemic changes will be completed ED/ chef will monitor meal service 3 x per week for 60 days, then 3 x per week for 30 days, then 1x per week for 30 days. Chef/Sous chef to monitor dating/labeling and covering of food in refrigerator 3 x per week for 60 days, then 2 x per week for 30 days, then 1 x per week for 30 days Chef/Sous chef to monitor cleaning schedule 3 x week for 60 days, then 2 x per week for 30	

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	13. The thermometer in the Memory Care unit dining room refrigerator was not working. The temperature for 4/21/21 had not been documented on the temperature log. The Activity Director indicated the night shift nursing staff was responsible for obtaining the refrigerator and freezer temperatures and she thought the thermometer probably needed a new battery. During an observation of the Assisted Living kitchen on 4/21/21 from 10:50 a.m. through 12:05 p.m., the following was observed: 14. Chef 1 and Chef 2 were observed with cloth masks. Chef 1 indicated the kitchen staff did not need to wear a surgical mask unless they left the kitchen. 15. The dry storage area had an open container of hot chili sauce with no open date on it. The squeeze top on the container was soiled. 16. A black rolling cart was soiled with food particles. 17. Chef 1 was observed to obtain pot holders and remove a large pan of green beans from the stove. She placed the pan on the steam table, removed the pot holders, and obtained a sieve from the drawer. After spooning the green beans into the steam table pan, she took the pan to the dishwasher, placed it in a dishwasher rack, and started the dishwasher. She pulled her cloth mask up on her nose and obtained a baking sheet. Chef 1 placed parchment paper on the baking sheet and sprayed the paper with cooking spray. No hand hygiene was observed. 18. While serving the lunch meal, HHA (Home		days, then 1 x per week for 30 days. Chef/ sous chef to monitor towels at hand washing station 2 x per week Results from these audits will be reported to the monthly QA committee for further monitoring.	

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	Health Aide) 1 was observed to enter the kitchen, stand in front of a drink dispenser, remove and replace her hairnet, leaving hair hanging out from under the hairnet. HHA 1 opened a drawer and obtained a pad of paper. She exited the kitchen and obtained food orders from the residents. Upon re-entering the kitchen, she placed the individual papers from the pad onto the serving table, and placed her hands onto the table, leaning across it. No hand hygiene was observed. 19. QMA 1 was observed with hair hanging out of her hairnet. QMA 1 indicated she usually wore her hair in a ponytail. 20. QMA 2 was observed to have hair hanging out of her hairnet and her jacket sleeves were touching the inside of her palms. QMA 1 made no attempt to roll her jacket sleeves up while serving the meal. 21. Dietary Aide 1 was observed to place his hands on the inside of his apron and in his apron pockets. Dietary Aide 1 obtained 2 packages of cookies. No hand hygiene observed. 22. HHA 1 was observed to enter the kitchen, obtain a container of milk from the refrigerator, pour a cup of milk, place the container back into the refrigerator, and exit the kitchen. No hand hygiene was observed and HHA 1 was observed with hair hanging out of her hairnet. 23. During the lunch meal on 4/21/21 at 11:45 a.m., 37 residents were observed sitting at the dining room tables. The residents were sitting 4 residents to a table. No social distancing was observed or encouraged by the staff. 24. On 4/22/21 at 9:30 a.m., the dining room tables			

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	were observed to have water glasses, coffee cups, and eating utensils rolled up in cloth napkins setting on the tables. On 4/22/21 at 9:50 a.m., Cook 3 indicated she set up the dining room tables everyday that she worked between 8:00 and 9:00 a.m. for the lunch meal. 25. On 4/22/21 at 1:33 p.m., Cook 3 was observed in the kitchen with her mask under her chin and Cook 4 were observed with his masks under his nose. 26. On 4/21/21 during observation from 11:26 a.m. - 11:43 a.m., Dietary Aide (DA) 1 was observed be wearing gloves, offering and serving drinks from a tray to tables in the dining room. DA 1 returned to the kitchen to restock the tray with fruit, and returned to the dining room without performing hand hygiene and/or changing gloves. DA 1 returned to the dining area and continued to serve fruit and salad. DA 1 returned to the kitchen, removed his gloves, no hand hygiene was observed, and obtained a pen and pad to take orders. DA 1 returned to the dining room. On 4/21/21 at 2:33 p.m., the Administrator indicated their Corporate Office had told the facility the kitchen staff could wear cloth masks as it was "so hot" in the kitchen. The kitchen needed to be thoroughly cleaned but the facility had difficulty staffing the kitchen. On 4/22/22 at 9:50 a.m., the Director of Nursing (DON) indicated their Corporate office told the facility they could have the residents seated with 4 residents at the same table without social distancing. Masks should be worn the by the staff the entire time they were working and should cover the nose and mouth areas.			

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On 4/22/21 at 1:35 p.m., Chef 2 indicated he could not locate a cleaning schedule and he had ordered 6 new thermometers for the refrigerators and freezers. Chef 2 indicated he had reminded the kitchen staff several times regarding keeping their face masks on.

On 4/22/21 at 1:27 p.m., Cook 4 indicated he had been employed with the facility since January, 2021, and had never observed a cleaning schedule.

The current facility policy, "Primrose Dining services Guidelines and Expectations," revised April, 2014, provided by the DON on 4/22/21 at 2:33 p.m., included, but was not limited to, wash hands with warm water and hand soap in the following situations: before handling food, food utensils, and/or food equipment, after handling soiled articles, after hands have touched hair, face, or have been in mouth, and after handling dirty dishes. A schedule for routine and deep cleaning should be maintained and followed. The cleaning schedule included, but was not limited to, daily cleaning: sweep and mop floor, front of freezer and refrigerator, and clean/wipe down service carts, weekly cleaning: pantry walls and floor, inside the freezers and refrigerators, and inside drawers. All perishable foods must be stored in refrigerators with temperatures of 40 degrees F (Fahrenheit) or below or in freezers with temperatures of 0 degrees F or below. Staff may use the Kitchen Cleaning Schedule to initial tasks that have been completed as scheduled.

The current facility policy, "Masks," dated 7/21/20, provided by the DON on 4/22/21 at 2:00 p.m., included, but was not limited to, "All staff entering a Primrose Community will wear a

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	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE OF NEWBURGH	9800 LINCOLN AVE NEWBURGH, IN 47630

(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
	surgical mask while in the facility. Homemade masks are not considered PPE (personal protective equipment)..."			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure infection control standards were maintained for 3 of 6 residents observed with medication administration.. Staff failed to perform hand hygiene during administration of oral medication and eye drops. (Resident 40, Resident 12, Resident 16) Findings included: 1. On 4/21/21 at 3:28 p.m., QMA 1 was observed to obtain medication from the medication card and popped it into the medication cup, no hand hygiene was observed, and administered to Resident 40. QMA 1 returned to the medication cart, and no hand hygiene was observed. 2. On 4/21/21 at 3:34 p.m., QMA 1 was observed to obtain medication from the medication card and popped into the medication cup with no hand hygiene observed. QMA 1 handed the medication cup to Resident 12 and returned to the cart. No hand hygiene was observed. 3. On 4/21/21 at 3:38 p.m., QMA 1, no hand hygiene was observed, removed the medication card, popped the medication into the medication cup, and removed a box containing Systane	R 0414	· What corrective actions will be accomplished for those residents found to have been affected by the deficient practice ED/DON will hold in-service May 5, 2021 to reeducate on hand hygiene, watch hand hygiene video demonstrating hand hygiene so staff can complete a new competency. · 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. DON/ ADONs will monitor during med pass times, and during dining times for hand washing. Serving staff will wash hands every time they are entering kitchen. Staff will not serve and bus tables at the same time to not cross contaminate · What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	05/05/2021

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	(solution for dry eyes)1 drop in both eyes twice daily. QMA 1 walked to Resident 16's apartment, administered the oral medication, removed gloves from her pocket and applied, no hand hygiene was observed, applied drops to Resident 16's eyes and removed her gloves with no hand hygiene observed. On 4/21/21 at 3:45 p.m., QMA 1 indicated she was to perform hand hygiene in between rooms or each resident, before administering eye drops, and after removing gloves. On 4/22/21 at 2:00 p.m., the Director of Nursing provided the current facility policy, Hand Hygiene, dated November 2020. The Policy indicated, but was not limited to, "staff will use waterless hand rub or soap and water to clean their hands: before having direct contact with residents, before preparing or administering medication, before donning gloves and after removing gloves, after contact with resident's intact skin..."		ED/ DON or an appointed representative will monitor this practice monthly and continue education annually about hand hygiene. · How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and By what date the systemic changes will be completed Facility will monitor hand hygiene during medication administration times and during mealtimes 5 days a week for 60 days, then 3 days a week for 60 days, then twice a week for 30 days, and once a week for 30 days. ED/ DON or an appointed representative will monitor this practice monthly and continue education annually about hand hygiene indefinitely. Results from these audits will be reported to the monthly QA committee for further monitoring.	