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	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE MEMORY CARE OF ANDERSON	2101 N MADISON AVENUE ANDERSON, IN 46011

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00428014. Complaint IN00428014 - No deficiencies related to the allegations are cited. Survey dates: February 27 & 28, 2024 Facility number: 013811 Residential Census: 10 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 6, 2024.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to post the results of the most recent annual survey. Finding include: During an observation on 2/28/24 at 10:00 a.m., a binder labeled "State Survey Results," was displayed on the table near the entrance door. The binder did not contain an annual survey for the year 2023. The most current annual survey	R 0042	The State binder has been updated to include the last annual survey et all subsequent surveys since that time. All residents have the potential to be affected by deficient practice. The State binder has been updated to include the last annual survey et all subsequent surveys since that time. The ED or his designee will place	03/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hervey Lawrence	Administrator	03/19/2024

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	posted in the book was dated March 1, 2021. The survey history, available for review through the Indiana Department of Health, indicated the last annual survey was completed on 2/2/23. During an interview on 2/28/24 at 10:58 a.m., the sister facility DON, who was present to assist with the survey process, indicated the last annual survey was not posted in the survey binder.		a copy of the 2567 in the binder after each survey for public inspection. The ED or his designee will audit the binder after each survey to ensure the proper paperwork is posted. This audit will be reported to the QA committee for ongoing monitoring.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current			

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	standards of care for residents with dementia. Based on record review and interview, the facility failed to submit the Alzheimer's/Dementia Special Care Unit (State form 48896) annually. Findings include: A copy of the most recently submitted State form 48896, titled, "Alzheimer's/Dementia Special Care Unit," provided by the Acting Administrator on 2/28/24 at 3:29 p.m., was dated 12/13/2019. During an interview at the same time, she indicated this was the last time this form had been submitted.	R 0095	The Establishment with services form and the Alzheimer's/Dementia Special Care Unit form has been updated and posted in a binder et placed in an area that is easily accessible to the public. All residents have the potential to be affected by deficient practice. The Establishment with services form and the Alzheimer's/Dementia Special Care Unit form has been updated and posted in a binder et placed in an area that is easily accessible to the public. The ED or his designee will update and submit the forms each February. Once the forms are approved, they will be printed et posted in a binder for public inspection. The ED or his designee will audit the binder every February to ensure the form has been updated et approved. This audit will be reported to the QA committee for ongoing monitoring.	03/18/2024
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			

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	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 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 ensure a staff member was CPR (Cardiopulmonary Resuscitation) certified for 2 of 21 shifts reviewed. Findings include: Review of the employee schedule, provided following an entrance conference, indicated there was no CPR certified staff member present for 2 of 21 shifts for the week of 2/25/24 through 3/2/24. During an interview on 2/28/24 at 3:30 p.m., the Interim ADON indicated the night shifts on 2/26/24 and 2/27/24 lacked an employee certified in CPR.	R 0117	All employees not certified have completed their course online through the American Healthcare Academy. All residents have the potential to be affected by deficient practice. All employees not certified have completed their course online through the American Healthcare Academy. The Business Office Manager will ensure a new employee has an active CPR certificate upon hire. If one is not available, the employee will be required to complete the online course within 30 days of hire. The Business Office Manager will maintain a copy of CPR certifications for all employees. The BOM will notify the DON who will require the employee to renew his/her certification. The DON or her designee will ensure an	03/18/2024

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			employee certified in CPR is working on each shift. The BOM or her designee will audit the file monthly to ensure all employees are up to date with their certifications. The DON or her designee will audit the schedule weekly X30 days, then bi-weekly X30 days, then 1X monthly X30 days to ensure all shifts have an employee with an active CPR certification is on each shift.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview, the facility failed to ensure an inspection of the heating and ventilating systems were completed annually. Findings include:	R 0148	The heating and ventilation system has been inspected. All residents have the potential to be affected by deficient practice. The heating and ventilation system has been inspected with no	03/18/2024

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	During an interview on 2/28/24 at 2:40 p.m., the Maintenance Supervisor indicated the facility did not have an established program/procedure for an annual inspection of the heating and ventilation systems. The facility did clean the individual PTAC units (packaged terminal air conditioner), which provided both heating and cooling in each resident room. The facility lacked a plan for annual inspection and would address any heating or cooling issues as they arose. He was not aware of the need for annual inspections, nor did they have a program or policy to do so. During an interview on 2/28/24 at 2:42 p.m., the acting Administrator indicated she was unaware of the need for annual heating and ventilation inspections.		problems noted. A new policy and procedure was created for the inspection of the heating and ventilation systems for the community to ensure those systems are inspected on a regular basis. The inspections have been added to the Preventative Maintenance quarterly checklist. The PMT has been educated on the new policy and procedure. The ED or his designee will audit the maintenance logs quarterly to ensure the heating and ventilation systems have been inspected. Results of the audits will be reported to the QA committee ongoing.	
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on observation and interview, the facility failed to ensure menus were approved by a registered dietitian. This deficient practice had the potential to impact 10 of 10 residents who resided in the facility. Findings include: During an observation of the kitchen on 2/27/23 at 10:55 a.m., a week-at-a-glance style menu was posted. The menu lacked documentation that it had been approved by a registered dietitian (RD). The menu also lacked guidance regarding portion sizes.	R 0269	Current menus have been reviewed et signed off by our consultant RD. All residents have the potential to be affected by deficient practice. Immediate action was taken to have the menus reviewed and signed off by the RD. The Dining Services Director or designee will create 4 – 6 weeks of menus and send to RD for review and approval. If necessary, menus will be changed according to the RD's recommendations. Only menus that have been	03/18/2024

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	During an interview on 2/27/23 at 10:56 a.m., Cook 3 indicated this menu was the only menu available for use in the dietary department. There was no guide to portion sizes and she used her best judgement to determine portion sizes. She was a full time employee at the facility, and usually prepared all three meals each day she worked. Review of the weekly menu for 2/25/24 to 3/2/24 and 2/18/24 to 2/24/24, provided by the Acting Administrator following the entrance conference on 2/27/24, lacked indication that the menus had been approved by a registered dietician. No indication of portions was included with the menus. During an interview on 2/28/24 at 10:58 a.m., the Acting Administrator indicated the facility developed menus week by week. The 2/25/24 to 3/2/24 and 2/18/24 to 2/24/24 menus did not have documentation of RD menu approval until 2/27/24. She provided the menu and a portion size guide to accompany the menu on 2/28/24 at 10:58 a.m. This portion size guidance had not been available in the kitchen on 2/27/24 nor was the cook aware of any such guidance. Review of a current facility policy, dated 3/15/24, titled, "Registered Dietician," which was provided by the Acting Administrator on 2/28/24 at 10:58 a.m., indicated the following: "...The Registered Dietitian may assist in developing the Community menu...." Review of a current facility policy, dated 9/2018, titled, "Food Production," which was provided by the Acting Administrator on 2/28/24 at 2:59 p.m., indicated the following: "...Menus and spread		reviewed and approved by the RD will be used. The ED or his designee will audit menus to ensure RD approval prior to being used. These audits will be completed 1X weekly X30 days, then 1X monthly X60 days, then 1X quarterly X30 days to ensure compliance. Results of all audits will be reported to the QA committee for further monitoring.	

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	sheets are evaluated for nutritional adequacy, signed and dated by the dietitian...." 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, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
R 0407 Bldg. 00	Based on interview and record review, the facility failed to develop and implement an infection control program which enabled the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence. This deficient practice had the potential to impact 10 of 10 residents who resided in the facility. Findings include: Review of the infection control log, provided by the Infection Preventionist (IP) after the entrance conference on 2/27/24, included one log sheet dated February 2024, which indicated no infections had occurred that month. No other monthly records were provided. During an interview on 2/27/24 at 1:15 p.m., the IP indicated she was newer to her position and would attempt to locate the infection control logs for the past year.	R 0407	An infection control policy has been implemented. All residents have the potential to be affected by deficient practice. An infection control policy has been implemented. The community policies “General Infection Control” and “Infectious Disease Management Policy” were reviewed without change. All nursing staff have been educated on the above policies. The Charge nurse will enter all resident infections on the Infection Control Monitoring Log. The DON or her representative will review and maintain the log to track et monitor all infections. The DON or her designee will audit the log to ensure all infections are entered et updated. This audit will be done weekly X30 days, then	03/18/2024

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	Additional infection control logs were provided by the IP on 2/28/24 at 11:00 a.m. The following concerns were identified: March 2023 had a list of five residents with their apartment number, the word "infection" (no type listed) and the date the infection originated. No lab result/organisms were listed. The type of infection was not listed. The form and or a supporting log did not have a method to review the information for trends in organisms, possible geographic considerations, trending in types of infection, possible impact of employee care and services, and/or any plan to reduce the risk for recurrence. April, May, and June of 2023 had no log records. July 2023 had a list of three residents named, the onset of the infection, the type of infection, with no lab results or organisms, the type of antibiotic that was ordered, and the date the resident would stop taking the antibiotics. The form did not contain room numbers. The form and or a supporting log did not have a method to review the information for trends in organisms, possible geographic considerations, trending in types of infection, possible impact of employee care and services, and/or any plan to reduce the risk for recurrence. August 2023 had one residents name, urinary tract infection and the word antibiotic. No date of illness onset, no organism, lab result, or resident room was listed. The form and or a supporting log did not have a method to review the information for trends in organisms, possible geographic considerations, trending in types of infection, possible impact of employee care and services,		monthly ongoing. All audits will be reported to the QA committee for further monitoring.	

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	and/or any plan to reduce the risk for recurrence. September 2023 had one resident name and urinary tract infection. No date of illness onset, no organism/ lab result, or resident room was listed. The form and or a supporting log did not have a method to review the information for trends in organisms, possible geographic considerations, trending in types of infection, possible impact of employee care and services, and/or any plan to reduce the risk for recurrence. October 2023 had a blank form. November 2023 had one residents name, urinary tract infection and an antibiotic antibiotic name. No organism, lab result, or resident room was listed. The form and/or a supporting log did not have a method to review the information for trends in organisms, possible geographic considerations, trending in types of infection, possible impact of employee care and services, and/or any plan to reduce the risk for recurrence. December 2023 and January 2024 had no infection tracking log available. During an interview on 2/28/24 at 2:01 p.m., the IP indicated the current infection control log did not have a component to track for trends in location or infection types (organisms), nor assess for possible contributing factors, nor system to implement changes or actions to prevent spread or recurrence. Review of a current, 8/2/23, facility policy, titled, "General Infection Control," provided by the IP following the entrance conference on 2/27/24 indicated the following: "...The purpose of this policy is to establish clear			

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	guidelines and procedures for infection control within our community. This policy aims to prevent the spread of infection among resident and staff...."			