DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOWNE PARK ASSISTED LIVING	503 S MURPHY AVE BRAZIL, IN 47834

(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. Survey dates: February 15 and 16, 2023 Facility number: 014623 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 2, 2023.	R 0000	The facility respectfully requests a paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keona Parkison	HFA	03/17/2023

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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	employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interview, the facility failed to ensure an employee was provided annual in-service training for 1 of 5 employees' files reviewed. Findings include: On 2/16/23 at 1:45 p.m., Dietary Aide (DA) 9's employee file was reviewed. The file indicated DA 9 received in-service training for abuse, resident rights, and dementia in 2019, but lacked documentation the employee had received training since. Her date of hire was 8/17/19. During an interview, on 2/16/23 at 1:05 p.m., the Administrator (ADM) indicated she was unable to find any more recent in-service training for DA 9 for abuse, resident rights, or dementia. She still worked at the facility, and should have received in-service training in these areas in the last year, but was unable to obtain the documentation stating her completion. During an interview, on 2/16/23 at 2:27 p.m., the ADM indicated that they do not have a policy in	R 0119	R 119 Personnel-Noncompliance What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Dietary Aide #9 has completed up to date training for abuse, resident rights and dementia. How be identified and what corrective actions will be taken? All staff have been audited and no other deficient practices were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All newly hired staff will complete the required training during the orientation process. or designee will receive and review weekly of overdue Relias training. Any staff member who has failed to complete any required annual training timely will be removed from schedule/working with residents until all required	03/25/2023

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	regard to employee in-services but they follow the state regulations.		training is completed. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? or will review weekly Relias training reports to ensure newly hired staff and all staff annual are completed on time. This will take place on a weekly basis and continue ongoing to ensure deficient practices not recur. Date the systemic changes for the deficiency will be completed: 3/25/2023	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be			

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	performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure an employee received an annual tuberculin (TB) skin test (one method of determining whether a person is infected with Mycobacterium tuberculosis), or annual risk assessment for 1 of 5 employee records reviewed. Findings include: During a review of the Residential Care Employee Records document (State Form 53877), on 2/16/23 at 1:30 p.m., the form lacked documentation of a completed annual risk assessment or annual TB skin test for the Maintenance Director. During an interview, on 02/16/23 at 2:00 p.m., the Maintenance Director indicated he had not received his annual TB skin test or annual risk assessment in the last year. During an interview, on 2/16/23 at 2:15 p.m., the Administrator (ADM) indicated the Maintenance	R 0121	R 121 Personnel-Noncompliance What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director was immediately given tuberculin (TB) skin test. How be identified and what corrective actions will be taken? An audit of all employees' TB skin tests was conducted, and no other occurrence of deficient practices was found. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	03/25/2023

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	Director had not received his annual TB skin test and they will be administering it tomorrow on 02/17/23. On 2/15/23 at 3:15 p.m., ADM provided a document, dated 11/1/2022, titled, "Tuberculosis Infection Control Program," and indicated it was the policy currently being used by the facility. The policy indicated, "...a. Unless the community becomes a Medium risk facility employees will have a Tuberculosis risk/symptom screening completed annually and TST (tuberculosis skin test) annually and placed in the employee file ...."		The Director of Nursing will ensure that all newly hired staff have received the required TB skin test prior to working with residents. The Director of Nursing will also review employees' annual TB skin tests to ensure they are within compliance. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or will audit all employees required tuberculin (TB) skin tests weekly for four weeks, monthly for three months and then quarterly until deficient practice is resolved. Date the systemic changes for the deficiency will be completed: 3/25/2023	
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			

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	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 cleanliness and sanitation of the kitchen, food preparation areas, and storage areas for 1 of 1 kitchen observation. This had the potential to effect 32 of 32 residents who received food prepared in the kitchen. Findings include: During a kitchen tour, on 2/15/23 at 9:55 a.m., with the Food Service Director (FSD), the refrigerator and the turbo air prep refrigerator were observed with dried food particles inside the units, the "Hot Box" meal tray cart was observed soiled with food debris on the inside and outside of the unit, and the flooring throughout the kitchen, dry storage rooms, walk-in refrigerator, and walk-in freezer were observed soiled, dingy, and littered with dried food particles, fresh food items, paper debris, plastic utensils, and dated sticker labels stuck to the floor. The flooring had a heavy soilage buildup with black residue at the cove bases, around the floor drains, under the wheeled storage cabinets, under the food preparation area, under the storage shelving units, and underneath, as well as, behind the appliances. A yellow-brown greasy build-up was observed on the front and down the sides of the stove and a burnt black food substance was observed on a cookie sheet in the oven, while chicken was in the oven baking. The FSD removed the soiled cookie sheet from the oven, replaced it with a clean cookie sheet and indicated, the soiled baking sheet had been used the previous day in the oven to catch the overflow, when a ham was baked. A clean cookie sheet should have been placed in the oven, prior	R 0154	R 154 Sanitation and Safety Standards What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Service Director immediately ensured all items found to be soiled were cleaned and sanitized. How be identified and what corrective actions will be taken? All residents were found to be affected by this deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Service Director will dietary staff on the importance of sanitation policy and requirements of kitchen cleaning log tasks. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? or will audit kitchen cleaning logs daily for four weeks, weekly for four weeks and then monthly until deficient practice does not occur.	03/25/2023

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	to baking the chicken. On 2/15/23 at 10:13 a.m., the FSD indicated the kitchen should be cleaned daily and indicated the appliances, meal tray cart, and food preparation areas should have been wiped down and cleaned after every meal. The kitchen had been short staff and she had not had time to clean the kitchen. She was the only staff for the breakfast meal service from 6:00 a.m. to 10:00 a.m. She cooked and served the residents breakfast by herself. A dietary aide was scheduled to come in at 10:00 a.m. to assist with the 11:00 a.m. lunch service. The FSD indicated she was unable to locate January and February kitchen cleaning logs. She wrote, "Feb 23," and "5, 6, 7, 8, 9, 10, 11," across the top of a document titled, "PM COOK." The FSD indicated staff had not documented the dates on the cleaning log, but she was sure the log was for February 2023. Dietary staff had initialed on the cleaning log a few of the cleaning tasks for four of the days, but most of the cleaning log was blank. The FSD indicated the dietary staff were forgetting to sign off on cleaning logs. On 2/15/23 at 10:30 a.m., the Administrator (ADM) entered the kitchen and indicated the kitchen was running short staffed, but the kitchen should have been cleaned daily. The FSD should have removed the soiled baking pan from the oven prior to baking the chicken in the oven. The ADM indicated the facility followed the Indiana Retail Food Establishment Sanitation Requirements. On 2/15/23, the facility provided one week of the dietary staffing schedule, dated 2/12/23 to 2/18/23. The dietary schedule indicated, one dietary staff daily for the breakfast meal, two dietary staff daily for the lunch service, and one dietary staff daily for the evening meal.		Date the systemic changes for the deficiency will be completed: 3/25/2023	

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	On 2/15/23 at 10:50 a.m., the ADM provided and identified a document as a current facility policy, titled "General Sanitation of Kitchen," dated 8/14/2019. The policy indicated, "...Purpose: ...The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule...Procedure: ...A. Cleaning and sanitation tasks for the kitchen will be recorded...E. A cleaning schedule will be posted and employees will initial and date tasks when completed...."			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			
	Based on record review and interview, the facility failed to ensure a medication self-administration assessment (an assessment to ensure a residents capability to safely administer their own medications) had been completed for a resident who requested to self-administer their medications for 1 of 7 residents records reviewed (Resident 024).	R 0216	p paraid="1539473504" paraeid="{49ed85f5-bbb1-444d-9c11-58690e5d6f7d}{161}" >R 216 Evaluation-Noncompliance What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	03/25/2023

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	Findings include: Resident 024's record was reviewed on 2/15/23 at 1:42 p.m. The census indicated the resident had been admitted to the facility on 5/20/22. Review of the resident's initial service plan, completed on admission, indicated the resident was able to self-administer her medications. The record lacked documentation that a medication self-administration assessment had been completed on the resident. During an interview, on 2/15/23 at 2:26 p.m., the Director of Nursing (DON) indicated she was unable to locate any medication self-administration assessment had been completed on the resident. On 2/16/23 at 10:50 a.m., the Administrator (ADM) provided a document, dated 8/14/19, titled, "Medication Self Administration Evaluation," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The resident's desire to self-administer medications will be determined during the admission process...Procedure: 1. A Medication Self-Administration Evaluation shall be completed for each resident...prior to admission, and will be repeated as deemed necessary, or upon request by the resident...."		An assessment for medication self-administration was completed for Resident #24. How be identified and what corrective actions will be taken? An audit of all residents who self-administer medications was conducted and no other deficient practices were found. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing will ensure that each resident who wishes to self-administer medications has required assessments completed timely. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or will audit all residents' charts who wish to self-administer medications for required assessments. This audit will take place weekly for four weeks, monthly for four months and quarterly thereafter until deficient practice does not occur. Date the systemic changes for the	

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			deficiency will be completed: 3/25/2023	
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on			

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	a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview, and record review, the facility failed to ensure a sufficient number of food service staff were on duty to ensure proper food preparation, serving, and sanitation of the kitchen. This had the potential to effect 32 of 32 residents who received food prepared in the kitchen. Findings include: During a kitchen tour, on 2/15/23 at 9:55 a.m., with the Food Service Director (FSD), the refrigerator and the turbo air prep refrigerator were observed with dried food particles inside the units, the "Hot Box" meal tray cart was observed soiled with food debris on the inside and outside of the unit, and the flooring throughout the kitchen, dry storage rooms, walk-in refrigerator, and walk-in freezer were observed soiled, dingy, and littered with dried food particles, fresh food items, paper debris, plastic utensils, and dated sticker labels stuck to the floor. The flooring had a heavy soilage buildup with black residue at the cove bases, around the floor drains, under the wheeled storage cabinets, under the food preparation area, under the storage shelving units, and underneath, as well as, behind the appliances. A yellow-brown greasy build-up was observed on the front and down the sides of the stove and a burnt black food substance was observed on a cookie sheet in the oven, while chicken was in the oven baking. The FSD removed the soiled cookie sheet from the oven, replaced it with a clean cookie sheet and indicated, the soiled baking sheet had been used the previous day in the oven to catch the	R 0274	R 274 Food and Nutritional Services-Noncompliance What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Additional staff were immediately brought into the kitchen to address noncompliance. How be identified and what corrective actions will be taken? All residents were affected by deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Administrator will review Dietary schedule to ensure sufficient number of staff are scheduled to be on duty to ensure proper food preparation, serving, and sanitation of the kitchen. Back-up coverage will be put in place in the form of leadership staff coverage in the event of Dietary staff call-ins. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	03/25/2023

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	overflow, when a ham was baked. A clean cookie sheet should have been placed in the oven, prior to baking the chicken. On 2/15/23 at 10:13 a.m., the FSD indicated the kitchen should be cleaned daily and indicated the appliances, meal tray cart, and food preparation areas should have been wiped down and cleaned after every meal. The kitchen had been short staff and she had not had time to clean the kitchen. She was the only staff for the breakfast meal service from 6:00 a.m. to 10:00 a.m. She cooked and served the residents breakfast by herself. A dietary aide was scheduled to come in at 10:00 a.m. to assist with the 11:00 a.m. lunch service. On 2/15/23 at 10:30 a.m., the Administrator (ADM) entered the kitchen and indicated, the kitchen was running short staffed, but the kitchen should have been cleaned daily. The ADM indicated the FSD was the only dietary staff scheduled for the residents' breakfast meal service, but oftentimes, an activities staff, the Director of Nursing, or the ADM, herself, would assist with the residents' breakfast meal service and clean-up. The residents came at different times for breakfast and usually there were no more than five residents eating breakfast in the main dining room at one time and one dietary staff member should be able to complete the breakfast meal service. The facility followed the Indiana Retail Food Establishment Sanitation Requirements. On 2/15/23, the facility provided one week of the dietary staffing schedule, dated 2/12/23 to 2/18/23. The dietary schedule indicated, one dietary staff daily for the breakfast meal, two dietary staff daily for the lunch service, and one dietary staff daily for the evening meal.		program will be put into place? The Administrator or will audit Dietary schedule to ensure staff are scheduled daily. Audit will take place daily for , weekly for four weeks and bi-weekly thereafter until deficient practice does not occur. Date the systemic changes for the deficiency will be completed: 3/25/2023	

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	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The ADM, on 2/15/23 at 10:50 a.m., provided and identified a document as a current facility policy, titled "Dining Room Service," dated 8/19/2020. The policy indicated, "...Purpose: ...Encourage individuals to receive dining room service. Maintain a comfortable, attractive atmosphere in the dining room area...Deliver food promptly to assure quality...Procedure: ...E. There should be enough available staff in the dining areas to assist those who need help and to handle any situation that may arise...."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to ensure a resident received a two-step tuberculin (TB) skin test series (one method of	R 0410	R 410 Infection Control-Noncompliance What corrective action will be accomplished for those residents	03/25/2023

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	determining whether a person is infected with Mycobacterium tuberculosis [the bacterium which causes tuberculosis]), for 1 of 7 resident records reviewed (Resident 024). Findings include: Resident 024's record was reviewed on 2/15/23 at 1:42 p.m. The census indicated the resident had been admitted to the facility on 5/20/22. The record lacked documentation that the resident had received a two-step TB skin test series upon admission. During an interview, on 2/15/23 at 2:26 p.m., the Director of Nursing (DON) indicated she was unable to find documentation that the resident had been given a 2-step TB skin test series upon her admission. The facility policy was that all newly admitted residents would be given a two-step TB skin test series upon admission. On 2/15/23 at 3:15 p.m., the Administrator (ADM) provided a document, dated 11/1/22, titled, "Tuberculosis Infection Control Program," and indicated it was the policy currently being used by the facility. The policy indicated, "...Resident Screening Procedure...Resident Tuberculin Skin Testing: 1. Upon admission, the resident will be provided a 1st Step Tuberculin Skin Test unless contraindicated...c. In 48-72 hours, the 1st step will be read and...documented in the resident's electronic health record...2. In 1 to 3 weeks, the 2nd step...should be administered unless the 1st step was positive or is contraindicated...a. In 48-72 hours, the 2nd step will be read and...documented in the resident's electronic health record....		found to have been affected by the deficient practice? Resident #24 was immediately given skin test upon return from LOA to the facility. How be identified and what corrective actions will be taken? An audit of all residents TB skin tests found that all other residents were found to be within compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Nursing will audit all new residents that move into the facility to ensure they receive a TB skin test within the required time frame of moving in and follow up to ensure each test is within 48-. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or will monitor residents that move into the facility for compliant TB skin test and follow up. DON or designee will audit all new resident move ins for compliant TB skin tests weekly for four weeks,	

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			monthly for four months and then quarterly until deficient practice does not occur. Date the systemic changes for the deficiency will be completed: 3/25/2023	