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	02/02/2023

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. Survey dates: February 1 & 2, 2023 Facility number: 013811 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 8, 2023.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
HERVEY LAWRENCE	Administrator	02/23/2023

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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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were conducted 12 times in 2022 and occurred on all shifts. Findings include: Review of the current facility Fire Drill Report forms, provided by the Administrative Consultant on 2/1/23 at 2:10 p.m., indicated the following for the year 2022: a. The record lacked indication of a fire drill being completed in February and March. b. During the 1st quarter, the record lacked a fire drill on 1st and 2nd shifts. c. During the 2nd quarter, the record lacked a fire drill on 1st shift. d. During the 3rd quarter, the record lacked a fire drill on 3rd shift. e. During the 4th quarter, the record lacked a fire drill on 3rd shift. During an interview, on 2/1/23 at 2:31 p.m., the Property Maintenance Technician indicated no fire drills were completed in February or March of 2022. He was unaware of the need to complete a fire drill quarterly on each shift. Review of a current facility policy, dated 11/29/2017 and titled, "Fire Drill Best Practices," provided by the Executive Director on 2/2/22 at 4:00 p.m., indicated the following:	R 0092	a. The fire drill reports in question were reviewed. A fire drill was conducted immediately with adequate response. An in-service was completed immediately with both the maintenance technicians. The in-service was signed and placed in each employee's file. b. The safety of each resident, visitor, and employee has the potential to be affected by this noncompliance. ED completed an in-service for all staff members involved and the manager of maintenance has completed a schedule that at least one fire drill is conducted one each shift. c. Primrose policy "Fire Drill Best Practices" was reviewed without change. Fire drills will be performed on a routine basis to allow for safe evacuation of the building in case of a fire. Primrose policy "Fire Drill Report" was reviewed without change and will be completed by the PMT or designee after every fire drill conducted. d. PMT or designee will provide ED with the "Fire Drill Report" each month. The ED will complete an audit on the fire drill report monthly x6 to ensure compliance. ED will bring compliance concerns and or findings to be reviewed at the quality assurance meetings	02/22/2023

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	"...Scope and Applicability...The practicing of fire drills will be conducted by management of the building and shall be applicable to all Residents, Staff and Visitors. Policy Statement... For the safety of the Residents, Visitors and Staff, fire drills will be performed on a routine basis to allow the safe evacuation of the building in case of a fire...."		each month.	
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 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 trained in first aid for 7 of 21 shifts reviewed for the week of	R 0117	a. A current review was done on each employee file in question to assess for a first aid course. Each	02/22/2023

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	staffing provided by the facility. Findings include: A review of the employee schedule, on 2/2/23 at 9:31 a.m., indicated a lack any staff members certified in first aid for seven evening shifts, for the week of 1/27/23 through 2/2/23. During an interview, on 2/2/23 at 2:40 p.m., the Administrative Consultant indicated she had no further certifications to provide and 2nd shift staff for the reviewed week had not been certified in first aid. During an interview, on 2/2/23 at 2:45 p.m., the Executive Director indicated the facility had no specific, written policy regarding staff certification requirements, but the facility follows the state guidelines.		employee in question was immediately assigned a first aid course and completed. b. Each employee has the potential to be affected by this deficiency. An audit was conducted on each employee file to assess compliance with first aid. c. Primrose policy "Employee Safety" was reviewed without change. At least one staff member who has CPR and first aid training/certification should be on duty at all times unless otherwise required by state regulations. d. The DON or designee will complete an audit log on each employee file x4 weeks and in every month indefinitely to ensure compliance. DON or designee will bring compliance concerns and or findings to be reviewed at the quality assurance meetings.	
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			

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	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 interview and record review, the facility failed to ensure completion of resident tuberculin skin test (TB test) before or upon admission, for 1 of 1 residents reviewed for new admission. (Residents 11) Findings include: Resident 11's clinical record was reviewed on 2/2/23 at 10:37 a.m. The resident admitted to the facility on 1/9/23. The resident's record lacked documentation of a TB skin test or tuberculin health screening document. During an interview, on 2/2/23 at 2:10 p.m., the Administrative Consultant indicated Residents 11's TB testing upon admission had not been completed. Review of a current facility policy, revised 12/31/18, titled "TB Control Plan," provided by the Administrative Consultant on 2/2/23 at 1:50 p.m., indicated the following: "Procedure: ...2. Baseline Screening. All staff and residents (including respite residents) will receive baseline TB screening upon hire or admission, using the two-step Tuberculin Skin Test (TST) to test for infection with M. tuberculosis...."	R 0410	a. The resident's chart in question was reviewed. TB screening using the two-step tuberculin skin test to test for M. tuberculosis was completed immediately with no adverse outcomes. b. Each resident has the potential to be affected by this noncompliance. An audit was conducted on each resident chart to assess compliance with "Tuberculosis assessment and testing of long-term care residents per Indiana state regulations." c. Primrose policy "TB Control Plan" was reviewed without change. Once a resident moves in there will be a baseline TB screening upon admission, using the two-step Tuberculin Skin Test to test for infection with M. tuberculosis. d. The DON or designee will complete a chart audit log weekly x4 weeks and a monthly review indefinitely to ensure compliance. The DON or designee will bring compliance concerns and or findings to be reviewed at the quality assurance meetings.	02/22/2023

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R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to ensure residents received an annual tuberculin test or health screening for 4 of 4 residents reviewed for annual tuberculin health screening. (Residents 5, 7, 9 and 12) Findings include: 1. Resident 5's clinical record was reviewed on 2/1/23 at 3:42 p.m. Their last tuberculin test was dated 3/26/21. 2. Resident 7's clinical record was reviewed on 2/2/23 at 9:29 a.m. Their last tuberculin test was dated 11/8/20. 3. Resident 9's clinical record was reviewed on 2/1/23 at 10:52 a.m. Their last tuberculin test was dated 10/14/20. 4. Resident 12's clinical record was reviewed on 2/1/23 at 2:26 p.m. The clinical record lacked indication of an annual tuberculin test.	R 0412	a. The resident's charts in question were reviewed. An annual TB skin test/questionnaire was conducted immediately. An annual tuberculin skin test was done immediately for each resident in question. b. Each resident has the potential to be affected by this noncompliance. An audit was conducted on each resident's chart to ensure compliance with "Tuberculosis assessment and testing of long-term care residents per Indiana state regulations." c. Primrose policy "TB Control Plan" was reviewed without change. An annual tuberculin skin testing will be done using the one-step process or completion of an annual state specific risk assessment worksheet with ongoing TB screening determined by the level of risk identified will be	02/22/2023

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	During an interview, on 2/2/23 at 2:10 p.m., the Administrative Consultant indicated Residents 5, 7, 9 and 12's clinical record lacked a current tuberculin health screening. Review of a current facility policy, revised 12/31/18, titled "TB Control Plan," provided by the Corporate Administrator Consultant on 2/2/23 at 1:50 p.m., indicated the following: "...Procedure:...3. Ongoing Monitoring and Education. Following specific State regulations and/or findings of the community's annual risk assessment, routine ongoing monitoring will be done through one or more of the following means: I. Annual Tuberculin Skin Testing (TST) using the one-step process....III. Completion of an annual State specific risk assessment worksheet with ongoing TB screening determined by the level of risk identified...."		done. d. The DON or designee will complete a chart audit log weekly x4 weeks and a monthly review indefinitely to ensure compliance. DON or designee will bring compliance concerns and findings to be reviewed at the quality assurance meetings.	