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	04/22/2025

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: April 21 and 22, 2025 Facility number: 013811 Residential Census: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 28, 2025.	R 0000		
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on interview and record review, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 15 of 15 resident residing in the facility. Findings include: During review of the State Survey binder on 4/22/25 at 9:39 a.m., the binder lacked the previous annual State Survey report, completed 2/28/24. During an interview with the DON on 4/22/25 at 9:40 a.m., she indicated the State Survey binder did not contain the results of the last annual survey. During an interview with the Interim Administrator on 4/22/25 at 9:50 a.m., he indicated all survey reports should be kept up to date in the State	R 0042	A copy of the last annual survey with corrections has been replaced in the survey binder and is available to the public. Community policy “Required Postings,” was reviewed without change. The DMC will place a copy of all survey paperwork in the survey binder after each survey. The DMC will be responsible for making sure the binder is up to date according to State requirements. The DMC or her representative will audit the survey binder 1X monthly for 90 days to ensure it contains the proper postings. Results of audits will be reported to the QA committee for further monitoring.	05/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marlee Oleksy	Director of Memory Care	05/10/2025

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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	Survey binder and readily available for resident and visitor access. A current facility policy, revised 5/30/23, provided by the Interim Administrator on 4/22/25 at 12:56 p.m., titled "Required Postings," indicated the Executive Director or designee is responsible for posting results of State Surveys and making them readily available to residents and visitors.			
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance Based on record review and interview, the facility failed to ensure the Dementia Care Director completed the required minimum 12 hours of dementia-specific training within three months of employment as the Dementia Care Director for 1 of 6 employee training records reviewed for dementia-specific training. This deficiency had the potential to affect 15 of 15 residents residing in the secured dementia care facility. Finding includes: An employee training record, provided by the Interim Administrator on 4/22/25 at 1:00 p.m., indicated the Dementia Care Director completed 4.25 hours of dementia-specific training within three months of hire as the Dementia Care Director. During an interview, on 4/22/25 at 2:40 p.m., the DON indicated the Dementia Care Director had 4.25 hours of dementia-specific training within three months of assuming the role of Dementia Care Director. A current facility form, provided by the Interim Administrator on 4/22/25 at 3:06 p.m., titled	R 0095	The DMC has completed the initial twelve (12) hours of training for new Memory Care Directors. The onboarding training schedule for DMCs and the Director of Memory Care Job Description were reviewed without change. Upon hire, Primrose will assign the initial twelve (12) hours of dementia training to the DMC to be completed within ninety (90) days of employment. The Business Office Manager or her representative will audit training transcripts monthly X90 days, to ensure the DMC is current on her required training. Results of these audits will be reported to the QA committee for further monitoring.	05/11/2025

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	"Annual Training Plan for ADSCU Director," indicated six hours of dementia-specific training was scheduled annually for the Dementia Care Director. During an interview, on 4/22/25 at 3:09 p.m., the Interim Administrator indicated the facility did not have a policy for the education requirements for the Dementia Care Director. The facility followed an annual training plan protocol for the Dementia Care Director. During an interview, on 4/22/25 at 3:41 p.m., the Interim Administrator indicated he was not aware of the number of dementia-specific training hours the Dementia Care Director was required to complete upon hire to the position. The Dementia Care Director assumed her role as the Dementia Care Director on 9/22/24. He reviewed the Director of Memory Care job description and indicated it did not include a requirement of 12 hours of dementia-specific training within three months of hire into the position.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a minimum of one awake staff member certified in CPR (cardiopulmonary resuscitation) with a hands-on component was onsite for 13 of 21 shifts, and a first aid trained staff member was onsite for 10 of 21 shifts reviewed for staffing sufficiency. This deficiency had the potential to affect 15 of 15 residents residing in the facility. Findings include: Review of the facility's worked employee	R 0117	The current schedule has been reviewed to ensure there is at least one employee that is certified in CPR with the hands-on-component on every shift. All clinical staff have been audited to identify those who have not been certified in CPR. These individuals will be certified in CPR with hands-on-component at the earliest opportunity.	05/11/2025

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	schedule, provided by the DON on 4/22/25 at 1:03 p.m., indicated 13 of 21 shifts for the week of 4/14/25 through 4/20/25 lacked a staff member certified in CPR with a hands-on training component and lacked a first aid trained staff member for 10 of 21 shifts. During an interview, on 4/22/25 at 11:57 a.m., the DON indicated the American Health Care Academy did not have a hands-on training component. She did not believe the National CPR Foundation had one either. She was unaware that a hand-on training component was required. During an interview, on 4/22/25 at 3:05 p.m., the DON indicated she was unable to provide additional CPR and first aid certifications for the staff members that worked in the facility during the week of 4/14/25 through 4/20/25. Guidance from the National CPR Foundation website, accessed on 4/17/25 at 2:49 p.m., at https://nationalcprfoundation.com/support/, indicated the following: " ...Do I need hands-on training? ... if your employer or licensing board requires a hands-on component or a skills check, please visit CPRNearMe.com [an online company that provides a range of life-saving skills training providers, including hands-on and skills-check training for assessments] ...." A facility policy, dated 1/1/15, provided by the Interim Administrator on 4/22/25 at 4:15 p.m., indicated the following: " ...Staff are required to maintain current certification/training for CPR and First Aid, in accordance with state regulations ... 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 regulation ...."		The community policy “Life Safety Training” was reviewed without change. All management level nursing staff will be re-educated on this policy. The scheduler will ensure that there is at least one clinical staff member with proper CPR certification on each shift. The DON will review the schedule to ensure the schedule is compliant before the schedule is posted. The DON or her representative will audit the schedule weekly X30 days, then bi-weekly X30 days, then monthly X30 days to ensure the schedule has at least one clinical staff member with the proper CPR certification on each shift. Results of these audits will be reported to the QA committee for further monitoring.	

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure required dementia-specific training was completed for 2 of 5 employees records reviewed. This deficiency had the potential to affect 15 of 15 residents residing in the secured dementia care facility. (LPN 6 and QMA 7) Findings include: Employee training records, provided by the Interim Administrator on 4/22/25 at 1:15 p.m., indicated LPN 6 completed one half an hour of dementia-specific training of the six hours of dementia-specific training required within six months of her hire date, and QMA 7 completed two hours of dementia-specific training of the three hours of dementia-specific training required annually. During an interview, on 4/22/25 at 2:40 p.m., the DON indicated LPN 6 had 30 minutes of dementia-specific training within six months of her hire date in the facility. QMA 7 had two hours of annual dementia-specific training. She was unable to provide additional dementia-specific training for LPN 6 and QMA 7. A current facility form, provided by the Interim Administrator on 4/22/25 at 3:06 p.m., titled "Annual Staff Training (AL/MC)," indicated direct care staff were scheduled for 3 and one half hours of dementia training annually. During an interview, on 4/22/25 at 3:09 p.m., the Interim Administrator indicated he was unaware there were differences in dementia-specific	R 0120	LPN 6 and QMA 7 have completed the required dementia specific training. All staff training has been audited and all staff have completed their dementia specific training. The onboarding training schedule for direct care staff was reviewed and updated. Primrose will assign all newly hired direct care staff six (6) hours of dementia-specific training to be completed within six (6) months. Any direct care employee who has not completed their initial six (6) hours of dementia-specific training or their annual three (3) hours of dementia-specific training will not be permitted to work until they complete the required training. The Business Office Manager will audit training transcripts monthly to ensure assigned courses are completed. The DMC or her representative will audit training records monthly X90 to ensure compliance. Results of these audits will be reported to the QA for further monitoring.	05/11/2025

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	education required annually versus on hire, and the facility did not have a policy for the dementia-specific education required annually and upon hire.			
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance 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 15 of 15 residents who received meals from the facility. Finding includes: During an observation of the kitchen on 4/21/23 at 10:15 a.m., a week-at-a-glance style menu was posted. The menu lacked documentation of approval by a registered dietitian (RD). Review of the weekly menu for 4/21/25 to 4/27/25, provided by the Interim Administrator following the entrance conference on 4/21/25, lacked indication that the menus had been approved by a registered dietician. During an interview with the Interim Director on 4/22/25 at 11:04 a.m., he indicated the current weekly menus were not certified by an RD, but he would try and find previous menus certified by an RD as well as documentation from the last RD visit. During an interview with the Interim Director on 4/22/25 at 3:41 p.m. he indicated that the weekly menus were completed by the Dietary Manager. The RD visited quarterly. He was unable to find previous menus certified by an RD or documentation from the last RD visit.	R 0269	Menus have been reviewed and signed by the Registered Dietician The community policy “Registered Dietician” has been reviewed without change. The DSD will ensure the menus have been reviewed and signed by the Registered Dietician prior to use. Menus that have not been reviewed and signed by the RD will not be put in rotation. The RD will make quarterly onsite visits to the community. The DMC or her representative will audit the menus weekly X30 days, then bi-weekly X30 days, then monthly X 60 days to ensure the menus being used have been reviewed et signed by the RD. Results of these audits and a summary of the quarterly RD visits will be reported to the QA for further action.	05/11/2025

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	No RD documentation or policy regarding RD certified menus was provided prior to facility exit on 4/22/25.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to store, prepare, and distribute foods under safe sanitary conditions regarding dating and labeling foods, disposing of outdated items, and cleaning equipment. This deficient practice had the potential to impact 15 of 15 residents who received meals from the facility kitchen. Finding includes: During a kitchen observation beginning on 4/21/25 at 10:15 a.m. accompanied by the Dietary Cook who assisted with kitchen supervision, a countertop deep fryer was caked in a brownish-yellow substance on the control knobs, fryer baskets, and sides just above the fryer oil. The fryer oil was black and opaque, with unidentifiable particles floating in it. The Dietary Cook indicated the fryer was cleaned, "whenever", but was unsure of the last time it was cleaned. Several undated squirt bottles were on a tray beside the grill, containing, in separate bottles, a thick yellow liquid, white crystalline particles, and a clear liquid. The cook indicated the bottles contained liquid butter, salt, and water. She was unsure of when the ingredients were placed in the bottles. In the dry storage area, a large paper bag, labeled	R 0273	The fryer has been removed. The squirt bottles have been emptied, cleaned, re-stocked, labeled and dated. The breadcrumbs, Spanish rice, biscuit mix, dented cans, lemon bar crust mix, butterscotch chips, carton with cracked egg, ranch dressing, mushrooms and pasteurized eggs have been destroyed. The container with the lemons and bananas has been cleaned. All food has been audited to ensure proper storage. All food is labeled, dated, and properly stored. Community policies “Commercial Kitchen Equipment Maintenance and Use,” and “Community Food – Labeling and Dating,” have been reviewed without change. All kitchen employees will be re-educated on these policies related to kitchen equipment and food storage. The DSD will conduct audits of the kitchen weekly X30 days, then bi-weekly X30 days, then monthly X30 days to ensure all the kitchen	05/14/2025

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	as panko breadcrumbs, was opened and undated, and breadcrumbs were able to be seen without manipulating the bag. A box of "Spanish rice" was opened at the top, undated, and the rice was able to be observed without manipulating the package. A gray rectangular bin contained a single bunch of bananas and six lemons, the bottom of which was covered with unknown debris. A box containing buttermilk biscuit mix was opened and undated. A can containing diced peaches was observed with an approximately one centimeter (cm) dent along the bottom seal of the can, exposing the inner seal. A box of lemon bar crust mix was opened and dated 8/6/23 with package best by date of 8/16/23. A plastic package of butterscotch chips was opened and unlabeled. During observation of the walk-in fridge, a carton containing 12 eggs had one egg cracked circumferentially, and a clear desiccated material was along the bottom half of the egg. No date was observed on the carton. A large plastic jar of ranch dressing was observed with a dried white substance along the upper portion of the jar. A large container of mushrooms was unlabeled and undated. A carton of pasteurized eggs was open and undated, and a yellow liquid was seen inside without manipulation of the container. The Dietary Cook indicated these items should have been disposed of. During a second kitchen observation on 4/22/25 at		equipment is clean and food is properly stored, labeled, and dated. Results of these audits will be reported to the QA committee for further monitoring.	

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	10:51 a.m., the deep fryer remained caked with the brownish-yellow substance. The oil was a deep olive green and the bottom of the fryer trough was able to be seen. The liquid butter squirt bottle and Spanish rice was undated. The panko breadcrumbs bag was rolled closed, but remained undated. The large jar of ranch dressing remained with a dried white substance surrounding the upper portion of it. The can of diced peaches with the dent on the bottom remained in the dry storage area. During a concurrent interview with the Dietary Cook, she indicated she was not responsible for the cleanliness of kitchen equipment or the dating and storage of food. An undated, current facility policy titled, "GENERAL FOOD PREPARATION AND HANDLING," provided by the Interim Director on 4/22/25 at 11:31 a.m. indicated the following,: "...2. The kitchen and equipment area clean...." An undated, current facility titled, "FOOD STORAGE," provided by the Interim Director on 4/22/25 at 11:31 a.m. indicated the following,:"...6. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables and frozen products must be refrigerated immediately to ensure nutritive value and quality...8. Refrigeration:...d. All foods should be covered, labeled and dated...."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to verify by statement annually that residents were free from infectious tuberculosis for 2 of 7 residents reviewed for annual health statements. (Resident 14 and Resident 13)	R 0409	The annual health statements of resident 14 and resident 13 have been updated to show that they have no evidence of communicable disease.	05/11/2025

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	Findings include: Resident 14's clinical record was reviewed on 4/21/25 at 11:45 a.m. and lacked an annual health statement. Resident 13's clinical record was reviewed on 4/22/25 at 10:28 a.m. and lacked an annual health statement. During an interview, on 4/22/25 at 2:39 p.m., the DON indicated she was unable to locate current health statements for Resident 13 and Resident 14. During an interview, on 4/22/25 at 4:27 p.m., the Nurse Consultant indicated she had contacted the corporate office for a policy on the annual health statements, but she had not received it. No policy for annual health statements was provided prior to survey exit on 4/22/25.		All residents' records have been audited to ensure they have an annual health statement showing they have no evidence of communicable disease. Community policy "TB Control Plan" was reviewed without change. Staff will be re-educated on the importance of all residents having an annual health statement showing they have no evidence of communicable disease signed by each resident's primary care physician. The resident's medical record will be reviewed with each evaluation to ensure an annual health statement showing they have not evidence of communicable disease is documented. The Director of Nursing or her designee will audit 5 charts weekly X30 days, then another 5 charts bi-weekly X60 days, then another 5 charts monthly X30 days to ensure annual health statements showing no evidence of communicable disease signed by the primary physician is in place in the residents' charts. Results of these audits will be reported to the QA committee for further monitoring and action. A percentage of 95% compliance would be the acceptable threshold.	