

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/04/2013 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER DIGBY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
|--------------------|--|---------------|---|----------------------|
| R000000 | <p>This visit was for a State Residential Licensure survey.</p> <p>Survey dates: April 3, & 4, 2013</p> <p>Facility number: 004392 Provider number: 004392 AIM number: N/A</p> <p>Survey team: Rita Mullen RN TC Bobette Messman RN</p> <p>Census bed type: Residential: 32 Total: 32</p> <p>Census payor type: Private: 32 Total: 32</p> <p>Sample: 7 Supplemental: 3</p> <p>These State Residential findings cited are in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 10, 2013 by Brenda Meredith, R.N.</p> | R000000 | Submission of this response and Plan or Correction is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in response or Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/04/2013 | |
|--|--|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DIGBY HOUSE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 | | | |
| R000144 | <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to maintain the cleanliness of the library wall. This affected 1 of 4 library walls.</p> <p>The findings include:</p> <p>During an observation of the library on 4/3/2013 at 3:35 p.m., a dark brown substance was smeared on the wall. An area, 18 inches by 18 inches was smeared by a dried substance, in a circular pattern.</p> <p>During an interview with the Wellness Director, on 4/3/2013 at 3:40 p.m., she indicated the brown substance on the wall was fecal material. The area was cleaned appropriately with cleaning products and utilization of gloves by the Wellness Director.</p> | R000144 | <p>R 144 410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents were found to be affected. The library wall was cleaned.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p> <p>The Residence Director and Wellness Director were re-educated to Indiana state regulation R144 410 IAC 16.2-5-1.5(a). The housekeeper and third shift staff were reeducated to the daily cleaning responsibilities. The Residence Director and/or Designee will be responsible for ensuring compliance with the above referenced regulation.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> | 05/22/2013 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/04/2013 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DIGBY HOUSE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 | |
| | | | The Residence Director and/or Designee will perform random weekly audits to ensure continued compliance with the above referenced regulation for a period of six months. Findings will be reviewed through the Digby House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/04/2013 | |
|--|--|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DIGBY HOUSE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 | | | |
| R000273 | <p>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.</p> <p>Based on observation and interview, the facility failed to maintain the cleanliness of two stove ovens and two toasters, in the kitchen. This was observed in 1 of 1 kitchen.</p> <p>Findings include:</p> <p>During the kitchen tour with the Lead Cook, on 4/3/13 at 1:45 p.m., the two stove ovens were found to have a large amount of of burned on food and debris. The two toasters were found to have a large amount of blackened bread crumbs in the bottom catch pan.</p> <p>During an interview with the Lead Cook, on 4/3/13 at 2:10 p.m., he indicated the stove ovens and toasters are suppose to be cleaned by third shift and it had not been done.</p> | R000273 | <p>R273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected. The two stove ovens and the two toasters were cleaned. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No other residents were affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Residence Director and staff were re-educated to Indiana state regulation R273 410 IAC 16.2-5-5.1(f). . The cleaning schedule for staff has been updated</p> | 05/02/2013 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/04/2013 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER DIGBY HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--|---|--|
| | | | <p>to ensure kitchen areas are clean and maintained in a state of good repair. The staff was re-educated to the cleaning schedule requirements. The Residence Director and/or Designee will be responsible for ensuring compliance with R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Residence Director and/or Designee will perform random weekly audits of the kitchen area to ensure continued compliance with the above referenced regulation for a period of six months. Findings will be reviewed through the Digby House QA process after 6 six months to determine the need for an ongoing monitoring plan.</p> | |
|--|--|--|---|--|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/04/2013 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DIGBY HOUSE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 | |
| | | | Findings suggestive of compliance will result in cessation of the monitoring plan. | | |