STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/31/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 2335 N MADISON AVE, ANDERSON, , 46011		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00423216. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00423216 - State deficiencies related to the allegations are cited at R407. Survey dates: January 31, 2024 Facility number: 010409 Residential Census: 56 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 5, 2024.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Keystone Woods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third	

			party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies	
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (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. Based on interview and record review, the facility failed to maintain COVID-19 testing documentation regarding staff testing and positive infections. This had the ability to effect 56 of 56 residents residing in the facility. Findings include: During an interview on 1/31/24 at 11:24 a.m., the DON	R 0407	1 The facility has implemented and will maintain a COVID-19 testing log for all staff and residents. 2 The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Executive Director and Wellness Director received in-service training on COVID-19 procedures, including how to maintain a COVID-19 testing log for all staff and residents. The facility is now using the COVID-19 testing log to ensure the deficient practice does not recur. 4	02/14/2024

	indicated she had no documentation or a surveillance list of staff who were tested for COVID-19 or of staff who had tested positive for COVID-19. During an interview on 1/31/24 at 2:31 p.m., the Administrator indicated she was not sure where the staff testing documentation was kept. She had not been able to find any documentation regarding the staff testing in November and December when the facility had a COVID-19 outbreak. She had no documentation regarding staff who had tested positive during that time but indicated there were three staff members involved. A current facility policy, revised 9/28/23, titled, "Novel Coronavirus (2019-nCoV) (COVID-19)," provided by the Administrator on 1/31/24 at 10:25 a.m., indicated the following: "...Monitoring and Surveillance:...All surveillance documents will be maintained by the facility Wellness Director and will be reviewed by the Executive Director...." This citation relates to Complaint IN00423216. Based on interview and record review, the facility failed to maintain COVID-19 testing documentation regarding staff testing and positive infections.		The Wellness Director or designee will audit once per week for six weeks to ensure that the COVID-19 testing log is ready and available to use. During the next COVID-19 outbreak, the Wellness Director or designee will be responsible for ensuring that the COVID-19 testing log is being used for all staff and residents. 5 This systemic change will be completed by 02/16/24	

This had the ability to effect 56 of 56 residents residing in the facility.

Findings include:

During an interview on 1/31/24 at 11:24 a.m., the DON indicated she had no documentation or a surveillance list of staff who were tested for COVID-19 or of staff who had tested positive for COVID-19.

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A current facility policy, revised 9/28/23, titled, "Novel Coronavirus (2019-nCoV) (COVID-19)," provided by the Administrator on 1/31/24 at 10:25 a.m., indicated the following: "...Monitoring and Surveillance:...All surveillance documents will be maintained by the facility Wellness Director and will be reviewed by the Executive Director...."

This citation relates to

	Complaint IN00423216.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE