

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/14/2022
NAME OF PROVIDER OR SUPPLIER VILLAS OF HOLLY BROOK INDIANA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1941 W US HIGHWAY 40, BRAZIL, , 47834			
(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 a State Residential Licensure Survey. Survey dates: December 13 and 14, 2022 Facility number: 013946 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 27, 2022.	R 0000			
R 0030	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(e)(1-6) (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates.	R 0030	Dementia Care Disclosure form was completed and submitted. Next Dementia Care Disclosure form is due 12/31/2023.	01/06/2023	

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(3) A written statement of all facility services (including those offered on an as needed basis).

(4) Information on related charges, admission, readmission, and discharge policies of the facility.

(5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9.

(6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form.

Based on interview and record review, the facility failed to complete and submit a Dementia Care Disclosure form, State Form 48896. This deficient practice had the potential to effect 16 of 16 residents who resided in the Memory Care Unit.

Finding includes:

On 12/13/22 at 9:30 a.m., during the entrance conference with the Administrator and the Director of Nursing (DON), a copy of the Dementia Care Discloser form was requested.

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During an interview, on 12/13/22 at 10:27 a.m., the Administrator indicated he could not recall completing the form for the closed dementia unit.

On 12/14/22 at 12:10 p.m., the Administrator indicated the facility had not completed and submitted a Dementia Care Disclosure form, State Form 48896 for the closed dementia unit.

Based on interview and record review, the facility failed to complete and submit a Dementia Care Disclosure form, State Form 48896. This deficient practice had the potential to effect 16 of 16 residents who resided in the Memory Care Unit.

Finding includes:

On 12/13/22 at 9:30 a.m., during the entrance conference with the Administrator and the Director of Nursing (DON), a copy of the Dementia Care Disclosure form was requested.

During an interview, on 12/13/22 at 10:27 a.m., the Administrator indicated he could not recall completing the form for the closed dementia unit.

On 12/14/22 at 12:10 p.m., the Administrator indicated the facility had not completed and submitted a Dementia Care Disclosure form, State Form

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	48896 for the closed dementia unit.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure reference checks were completed for 5 of 5 new employees reviewed. Findings include: During review of the facility's employee files, on 12/14/22 at 1:31 p.m., the following was observed: a. Registered Nurse (RN) 8 had been hired on 3/1/22. The employee's file lacked documentation of pre-employment references being checked and verified. b. Licensed Practical Nurse (LPN) 9 had been hired on 6/7/22. The employee's file lacked documentation of pre-employment references	R 0116	Facility created a document to be used to assure that reference checks are done for new hires.	12/15/2022

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being checked and verified.

c. Certified Nursing Assistant (CNA) 11 had been hired on 8/23/22. The employee's file lacked documentation of pre-employment references being checked and verified.

d. Certified Nursing Assistant (CNA) 10 had been hired on 9/13/22. The employee's file lacked documentation of pre-employment references being checked and verified.

e. Qualified Medication Aide (QMA) 12 had been hired on 9/13/22. The employee's file lacked documentation of pre-employment references being checked and verified.

During an interview, on 12/14/22 at 2:19 p.m., the Business Office Manager (BOM) indicated she had contacted their corporate office and had been told no reference checks had been completed on the new employees. The company did not have any policy related pre-employment reference checks.

Based on record review and interview, the facility failed to ensure reference checks were completed for 5 of 5 new employees reviewed.

Findings include:

During review of the facility's

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employee files, on 12/14/22 at 1:31 p.m., the following was observed:

a. Registered Nurse (RN) 8 had been hired on 3/1/22. The employee's file lacked documentation of pre-employment references being checked and verified.

b. Licensed Practical Nurse (LPN) 9 had been hired on 6/7/22. The employee's file lacked documentation of pre-employment references being checked and verified.

c. Certified Nursing Assistant (CNA) 11 had been hired on 8/23/22. The employee's file lacked documentation of pre-employment references being checked and verified.

d. Certified Nursing Assistant (CNA) 10 had been hired on 9/13/22. The employee's file lacked documentation of pre-employment references being checked and verified.

e. Qualified Medication Aide (QMA) 12 had been hired on 9/13/22. The employee's file lacked documentation of pre-employment references being checked and verified.

During an interview, on 12/14/22 at 2:19 p.m., the Business Office Manager (BOM) indicated she had contacted their corporate office and had been

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	told no reference checks had been completed on the new employees. The company did not have any policy related pre-employment reference checks.			
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter 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 monitoring of the sanitizer solution used during manual warewashing (the process of cleaning the wares used in the preparation or service of food) during 1 of 1 kitchen observation. Findings include: During the initial kitchen tour at 12/13/22 at 9:49 a.m., Dietary Aide (DA) 7 was observed washing pots and pans in the 3 compartment sink (a warewashing method which requires three separate sink compartments, one for each step of the warewash procedure: wash, rinse, and	R 0154	Facility created a document to be used to assure that sanitizer solution gets measured regularly. This will assure that it is diluted to the right amount at all times.	01/03/2023

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sanitize). At the same time, the Dietary Manager (DM) indicated she had not checked the sanitizer concentration in the final sink compartment to verify it was at the proper concentration to ensure adequate sanitizing of the items being washed.

During an interview, on 12/13/22 at 9:51 a.m., DA 7 indicated the 3 compartment sink was used to wash pots and pans. One compartment was detergent, one was a rinse, and the last was a sanitizing solution. She was not aware of any requirement to monitor and/or document the concentration of the sanitizing solution.

During an interview, on 12/13/22 at 10:06 a.m., the DM indicated she periodically would check the sanitizer concentration in the 3-compartment sink, but it was not checked regularly. When she checked it, she did not log the readings. She was not aware of the requirement to check the concentration with each use, or that a log should be maintained. The sanitizer was a chlorine based sanitizer. At the same time, when requested to perform a check the sanitizer concentration, the DM had a difficult time locating the test strips. The DM indicated she believed the sanitizer concentration should read at least 600 to 800 parts per

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million (ppm-a method of describing the concentration of something), but she would had to check the manufacturer's guidance to be sure.

On 12/14/22 at 9:50 a.m., the Administrator provided a document, with a revision date of 3/26/19, titled, "Kitchen Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Staff must follow sanitation procedures and guidelines when performing...duties to ensure the safety of residents and employees....Procedures: 1. The Executive Director or designee will ensure staff maintain kitchen sanitation in accordance with local and state codes or rules...."

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The Indiana State Department of Health, Retail Food Establishment Sanitation Requirements Manual, dated November 13, 2004, indicated under 410 IAC (Indiana Code) 7-24-270, "...Manual warewashing; sink compartment requirements...Section 270...(c) a sink with at least three (3) compartments shall be provided for manually washing, rinsing, and sanitizing equipment and utensils...(B) The cleaning and sanitizing solutions shall be made up immediately before use and drained immediately after use...."

Based on observation, interview, and record review, the facility failed to ensure monitoring of the sanitizer solution used during manual warewashing (the process of cleaning the wares used in the preparation or service of food) during 1 of 1 kitchen observation.

Findings include:

During the initial kitchen tour at 12/13/22 at 9:49 a.m., Dietary Aide (DA) 7 was observed washing pots and pans in the 3 compartment sink (a warewashing method which requires three separate sink compartments, one for each step of the warewash procedure: wash, rinse, and sanitize). At the same time, the

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During an interview, on 12/13/22 at 10:06 a.m., the DM indicated she periodically would check the sanitizer concentration in the 3-compartment sink, but it was not checked regularly. When she checked it, she did not log the readings. She was not aware of the requirement to check the concentration with each use, or that a log should be maintained. The sanitizer was a chlorine based sanitizer. At the same time, when requested to perform a check the sanitizer concentration, the DM had a difficult time locating the test strips. The DM indicated she believed the sanitizer concentration should read at least 600 to 800 parts per million (ppm-a method of

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R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure a trash receptacle was in place next to a handwashing station, which allowed for sanitary disposal of handwashing supplies, during 1 of 1 kitchen observations. Findings include: During the initial kitchen tour, on 12/13/22 at 9:49 a.m., the trash receptacle next to the handwash station was observed with a large lid attached which required manual manipulation to remove to allow for disposal of trash materials. At the same time the Dietary Manager (DM) indicated it was difficult to throw paper towels and other trash away without touching the lid of the trash receptacle. She would have to open the lid with a barrier (glove or towel) in her hand and pull away quickly while tossing the barrier into the trash receptacle, to prevent the	R 0155	Placed a new waste receptacle by the hand washing sink. This waste receptacle will make it so that staff do not re-infect their hands when disposing of paper towel.	12/15/2022
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lid from coming into contact with her clean hand. There was no other available trash receptacle, in the kitchen, which did not require manually lifting off the lid to dispose of trash items.

On 12/13/22 at 10:01 a.m., Dietary Aide (DA) 6, was observed washing her hands at the handwash station. When finished, she dried her hands with paper towels. While using the used paper towels as a barrier, she lifted the lid on the trash receptacle to dispose of paper towels. When she pulled her hand away from the trash receptacle, the lid of the trash she was observed to come into contact with the top of her clean hands.

On 12/14/22 at 9:50 a.m., the Administrator provided a document, with a revision date of 3/26/19, titled, "Kitchen Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Staff must follow sanitation procedures and guidelines when performing...duties to ensure the safety of residents and employees....Procedures: 1. The Executive Director or designee will ensure staff maintain kitchen sanitation in accordance with local and state codes or rules...."

The Indiana State Department

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of Health, Retail Food Establishment Sanitation Requirements Manual, dated November 13, 2004, indicated under 410 IAC (Indiana Code) 7-24-349, "...Waste receptacles for disposable towels...Section 349. (a) A hand washing sink or group of adjacent sinks that is provided with disposable towels shall be provided with a waste receptacle as specified under section 386(c) of this rule...(c) If disposable towels are used at hand washing sinks, a waste receptacle shall be located at each sink or group of adjacent sinks...."

Based on observation, interview, and record review, the facility failed to ensure a trash receptacle was in place next to a handwashing station, which allowed for sanitary disposal of handwashing supplies, during 1 of 1 kitchen observations.

Findings include:

During the initial kitchen tour, on 12/13/22 at 9:49 a.m., the trash receptacle next to the handwash station was observed with a large lid attached which required manual manipulation to remove to allow for disposal of trash materials. At the same time the Dietary Manager (DM) indicated it was difficult to throw paper towels and other trash away without touching the lid of the trash receptacle. She would

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have to open the lid with a barrier (glove or towel) in her hand and pull away quickly while tossing the barrier into the trash receptacle, to prevent the lid from coming into contact with her clean hand. There was no other available trash receptacle, in the kitchen, which did not require manually lifting off the lid to dispose of trash items.

On 12/13/22 at 10:01 a.m., Dietary Aide (DA) 6, was observed washing her hands at the handwash station. When finished, she dried her hands with paper towels. While using the used paper towels as a barrier, she lifted the lid on the trash receptacle to dispose of paper towels. When she pulled her hand away from the trash receptacle, the lid of the trash she was observed to come into contact with the top of her clean hands.

On 12/14/22 at 9:50 a.m., the Administrator provided a document, with a revision date of 3/26/19, titled, "Kitchen Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Staff must follow sanitation procedures and guidelines when performing...duties to ensure the safety of residents and employees....Procedures: 1. The Executive Director or designee will ensure staff

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OMB NO. 0938-0391

maintain kitchen sanitation in accordance with local and state codes or rules...."

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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