STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET, ANDERSON, , 46016

(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 Complaints IN00395485, IN00396376, and IN00395977. Complaint IN00395485 - Substantiated. State deficiencies related to the allegations are cited at R0039. Complaint IN00396376 - Substantiated. State deficiencies related to the allegations are cited at R0039. Complaint IN00395977 - Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited. Survey dates: February 1 and 2, 2023. Facility number: 014706 Residential Census: 75	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Sweet Galilee at the Wigwam desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective: 3/1/2023 Sweet Galilee respectfully requests paper compliance	

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 7, 2023.			
R 0039	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(n) (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on interview and record review, the facility failed to investigate and provide a response to the resident for grievances filed for 9 of 18 resident grievances reviewed. Findings include: Grievances for November 2022, December 2022, and January 2023, provided by the administrator on 2/1/23 at 11:06 a.m., were reviewed on 2/1/23 at 11:12 a.m. Nine grievances from November contained the resident's written concern and signature, with no additional documentation. During an interview, on 2/1/23 at 4:26 p.m., the Administrator	R 0039	· What corrective action will be accomplished for those residents found to have been affected by this deficient practice: 9 grievances identified will be overseen by the Administrator and will follow the grievance policy/procedure, reviewed and investigated by the responsible department with findings reported to the resident within 10 days of reporting. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by this deficient practice. No other outstanding grievances identified. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient	02/24/2023

	indicated she was unable to locate additional documentation for the grievances lacking investigations. She was uncertain if anyone had looked at the grievances, or if they had been ignored by the previous management team. A current facility policy, dated 1/6/22, provided by the Administrator on 2/1/23 at 4:26 p.m., and titled "Resident Grievance Policy and Procedure," indicated the following: " ...Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint ...." This Residential Tag relates to Complaints IN00395485 and IN00396376. Based on interview and record review, the facility failed to investigate and provide a response to the resident for grievances filed for 9 of 18 resident grievances reviewed. Findings include: Grievances for November 2022, December 2022, and January 2023, provided by the		practice does not recur A resident council was held initially upon identifying the deficiency. Administrator shared with Resident Council of the process and where/how to file a grievance. Education will be provided for all staff, ongoing in monthly staff meeting or other monthly inservice. Grievance forms will be easily accessible in identified areas.	

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R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical	R 0119	What corrective action will be accomplished for those residents found to have been affected by this deficient practice:	03/01/2023

	considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure newly hired employees had a completed and signed job-specific orientation for 3 of 5 employee records reviewed (DON (Director of Nursing), LPN (Licensed Practical Nurse) 3, QMA (Qualified Medication Aide) 5). Findings include: An employee record review, on 2/2/23 at 12:40 p.m., indicated LPN 3 and QMA 5 lacked job-specific orientations. The DON's job-specific orientation was signed by herself with no supervisor initials or supervisor signatures. During an interview, on 2/2/23 at 1:02 p.m., the Business Office Manager (BOM) indicated she had no additional employee records. A current facility policy, dated 4/24/21, provided by the			

	Administrator on 2/2/23 at 1:40 p.m., and titled "General Orientation," indicated " ...All new employees will receive general orientation within their first 30 days of employment ...Specific job orientation will also begin on the first day of work ...Each new employee will be scheduled by the Department Head/Supervisor to receive orientation beginning on the first day of employment which is to be completed no later than by the 30th day of employment ...." Based on record review and interview, the facility failed to ensure newly hired employees had a completed and signed job-specific orientation for 3 of 5 employee records reviewed (DON (Director of Nursing), LPN (Licensed Practical Nurse) 3, QMA (Qualified Medication Aide) 5). Findings include: An employee record review, on 2/2/23 at 12:40 p.m., indicated LPN 3 and QMA 5 lacked job-specific orientations. The DON's job-specific orientation was signed by herself with no supervisor initials or supervisor signatures. During an interview, on 2/2/23 at 1:02 p.m., the Business Office Manager (BOM) indicated she had no additional employee			

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R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be	R 0121	What corrective actionwill be accomplished for those residents found to have been affected by this deficient practice	03/01/2023

screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on interview and record review, the facility failed to complete health screenings for tuberculosis (TB) upon hire for 5 of 5 newly hired employees (QMA (Qualified Medication Aide) 5, CNA (Certified Nurse Aide) 7, LPN (Licensed Practical Nurse) 3, the DON (Director of

Nursing), and the Activity Director).

Findings include:

An employee record review, on 2/2/23 at 12:40 p.m., indicated QMA 5, CNA 7, LPN 3, the DON, and the Activity Director lacked a second step TB test required for health screenings for tuberculosis.

During an interview, on 2/2/23 at 1:02 p.m., the Business Office Manager (BOM) indicated the employees had not received a second step TB test, as she did not know a second step TB test was required.

A current facility policy, dated 1/6/22, provided by the Administrator on 2/2/23 at 1:40 p.m., and titled "Personnel Records" indicated " ...The following documents will be retained in the personnel file or separate file as appropriate ...TB testing results ...."

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	Findings include: An employee record review, on 2/2/23 at 12:40 p.m., indicated QMA 5, CNA 7, LPN 3, the DON, and the Activity Director lacked a second step TB test required for health screenings for tuberculosis. During an interview, on 2/2/23 at 1:02 p.m., the Business Office Manager (BOM) indicated the employees had not received a second step TB test, as she did not know a second step TB test was required. A current facility policy, dated 1/6/22, provided by the Administrator on 2/2/23 at 1:40 p.m., and titled "Personnel Records" indicated " ...The following documents will be retained in the personnel file or separate file as appropriate ...TB testing results ...."			

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