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	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITLOCK PLACE	1719 S ELM ST CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00417654. Complaint IN00417654 - No deficiencies related to the allegations are cited. Survey dates: September 26 and 27, 2023 Facility number: 004419 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 4, 2023.	R 0000	/p> Whitlock Place 1719 S Elm St Crawfordsville, IN 47933 Dear Ms. Buroker, On Sept 27, 2023, an annual survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Oct 25, 2023. Please feel free to call me with any further questions on (765) 364-1880. Respectfully submitted,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lasha Batemane	Executive Director	10/20/2023

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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			Lasha Batemane Whitlock Place 1719 S Elm St Crawfordsville, IN 47933	
R 0054 Bldg. 00	410 IAC 16.2-5-1.2(x) Residents' Rights - Deficiency (x) Residents have the right to confidentiality of all personal and clinical records. Information from these sources shall not be released without the resident ' s consent, except when the resident is transferred to another health facility, when required by law, or under a third party payment contract. The resident ' s records shall be made immediately available to the resident for inspection, and the resident may receive a copy within five (5) working days, at the resident ' s expense. Based on observation, interview, and record review, the facility failed to ensure staff-maintained confidentiality of medical records during medication pass administration for 1 of 5 residents reviewed (Resident 33). Finding includes: During medication administration, on 9/26/23 at 12:55 p.m., Qualified Medication Aide (QMA) 3 left the medication book open to Resident 33's clinical record on the medication cart. The QMA proceeded to go into the resident's room and administered the medication. The cart and medication book were no longer visible to the aide. Anyone walking down the hallway could see	R 0054	**R054 Resident Right Deficiency** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because***	10/25/2023

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	the clinical record. The clinical record contained resident's name, diagnoses, physician orders, allergies, room number, and date of birth. During an interview on 9/26/23 at 2:13 p.m., the Director of Nursing (DON) indicated staff should not leave the medication book/clinical record open on the medication cart when not visible to staff. That was a violation of confidentiality. On 9/26/23 at 2:41 p.m., the DON provided a document, dated 5/22, titled, "Resident Bill of Rights," and indicated it was the policy currently being used by the facility. The policy indicated, " ... (v) Residents have the right to confidentiality of all personal and clinical records ...."		***it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** QMA 3 was educated by DHW on HIPPA and close resident medication chart. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. Inservice provided to all nursing staff on HIPPA and securing resident information's. **3) Measures put into place/ System changes:** DHW / Designee will do visual rounds on random shifts 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks and 1-time weekly x 4 months to ensure QMA and licensed nurses and keep resident medical records secured while passing meds. **4) How the corrective actions will be monitored:** DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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			5) Date of compliance: 10/25/2023	
R 0093 Bldg. 00	410 IAC 16.2-5-1.3(j)(1-4) Administration and Management - Noncompliance (j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the following: (1) the responsibilities of both the facility and the outside resource; (2) the qualifications of the outside resource staff; (3) a description of the type of services to be provided, including action taken and reports of findings; and (4) the duration of the agreement. Based on record review and interview, the facility lacked documentation that fire drills had been conducted, at least quarterly on all shifts, during review of 12 of 12 months of fire drills. Finding includes: During the facility observation review, on 9/26/23 at 10:10 a.m., the facility lacked documented evidence of completed fire drills for the period of September 2022 through September 2023. During an interview, on 9/26/23 at 10:58 a.m., the	R 0093	**R093 Administration and management** **The facility requests paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The***	10/25/2023

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	Administrator (ADM) indicated she was certain that the facility did not have any documentation of the fire drills, that had been completed, for the past year. The long-term Facilities Director had been terminated in August 2023. When she had taken over as the facility ADM in May 2023, much of the documentation from the facilities department, was never found. She believed that the Facilities Director had taken the documentation when he left the facility. She had been told that fire drills had been completed as required, until August, when the termination had taken place. A new Facilities Director had been hired earlier in the month and had been working on getting fire drills scheduled. On 9/26/23 at 1:03 p.m., the ADM provided a document, with a revised date of 2022, titled, "Emergency, Crisis and Disaster Plan," and indicated it was the policy currently being used by the facility. The policy indicated, "...Fire Drills: Fire drills will be conducted...at least quarterly for each shift...evaluate staff knowledge to ensure they know the following: ...How to document the drill and who is responsible for completing the report...."		***plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified:** Fire drill has been completed by Facility maintenance director on 10/17/2023. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected and none were noted. **3) Measures put into place/ System changes:** The Maintenance Director was educated on performing fire drill at least quarterly for each shift. DHW/designee or ED will create a calendar and will review accuracy of fire drill timings to ensure compliance. **4)How the corrective actions will be monitored:** ED and DHW or Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:**	

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R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a minimum of one staff person was CPR (cardiopulmonary resuscitation-an emergency procedure consisting of chest compressions often combined with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to	R 0117	**R117 Personal Deficiency** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of***	10/25/2023

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	restore spontaneous blood circulation and breathing in a person who is in cardiac arrest) and first aid certified was onsite at all times for 7 of 7 scheduled days reviewed. This deficient practice had the potential to affect 51 of 51 residents residing at the facility. Findings include: On 9/27/23 at 1:45 p.m., the facility's staffing schedule from 9/20/23 to 9/27/23, and employee records were reviewed. The records lacked documentation the facility staff had first aid and CPR certifications for the second shifts on 9/20/23, 9/21/23, and 9/22/23, the second and third shifts on 9/23/23, the first and third shifts on 9/24/23, the third shift on 9/25/23, and the second shifts on 9/26/23 and 9/27/23. During an interview, on 9/27/23 at 3:10 p.m., the Director of Nursing indicated, most of the staff had expired CPR and first aid certifications and staff needed to get the certifications renewed. The DON was unsure if the facility had a policy specific to the requirement for staff to be fully certified in both CPR and first aid to work. She indicated she was aware of the residential regulation and the facility would be expected to follow all residential regulations. The Indiana Residential Regulation, dated 2008, 410 IAC 16.2-5-1.4(b) indicated, "...A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times...."		***this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified:** All nursing staff will have CPR and first aid certification completed by 10/25/2023. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. Audit completed on all staff to verify the expiration of their CPR and first aid cards.HR was educated to keep a logbook with expiration dates of CPR and first aid cards and advise staff to renew it before it expires. **3)Measures put into place/ System changes:** DHW/Designee will review schedule daily to ensure that facility has at least 1 person with CPR and first aid certification on all shifts. **4)How the corrective actions will be monitored:** DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these	

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			audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 10/25/2023**	
R 0144 Bldg. 00	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. Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary environment, for 1 of 1 facility observation tour. Finding includes: During the initial facility observation tour, on 9/26/23 at 10:10 a.m., the carpet throughout the facility had multiple dark stains of various sizes in all of the hallways. During an interview, on 9/27/23 at 11:46 a.m., the Administrator (ADM) indicated she had noticed the carpets were severely stained when she first had taken over as ADM of the facility in May 2023. She had come across an invoice that	R 0144	**R144 Sanitation and Safety Standards** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions***	10/25/2023

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	indicated the carpet had been professionally cleaned in May, prior to her start at the facility. Some of the residents had voiced their complaints about the condition of the hallway carpets. The new corporation had been through the facility to inspect the environment and condition of the facility to make a capital improvement plan for the facility going forward. She was unsure if the carpet was going to be part of the capital improvement plan for next year or not. During an interview, on 9/27/23 at 11:54 a.m., the Resident Council President indicated the stains on the hallway carpet had been brought up in the resident council meetings in the past. The facility had a professional cleaning service come into the facility in the spring and cleaned the carpet, but the stains were not fully removed and now had come back darker than before. During an interview, on 9/27/23 at 11:57 a.m., Residents 09 indicated the carpets had been stained for a long time. The carpet company had attempted to clean it, but it really had done nothing. The condition of the carpets was an eyesore. During an interview, on 9/27/23 at 12:01 p.m., Resident 042 indicated the carpets were in bad shape all throughout the building. She was aware that a new company had taken over the facility and was hoping that they would recognize how bad they were and replace them. At the same time, Resident 051 indicated she was sometimes embarrassed to have company over to her apartment because the carpets made the facility look bad. On 9/27/23 at 2:00 p.m., the ADM provided a copy of an invoice from the carpet cleaning company.		***of federal and state law.*** **1)Immediate actions taken for those residents identified:** Residents 09,042, and 051 were assured that carpet stained will be removed or carpet will be replaced. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. None noted. **3) Measures put into place/ System changes:** Professional Carpet cleaning company was scheduled to clean the carpet stain or replace the carpet if stain doesn't come out. DHW and Facilities Director or Designee will do visual environmental rounds 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks and 1-time weekly x 4 months to ensure the building looks clean and sanitary to ensure compliance. Any issues reported during the rounds will be immediately corrected. **4) How the corrective actions will be monitored:** DHW and Facilities Director or Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will	

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	The invoice indicated the company had provided carpet cleaning service on 5/11/23. On 9/27/23 at 2:37 p.m., the ADM provided a document, dated 2022, titled, "Physical Environment Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Housekeeping Policy...Keep the residence safe, clean...." On 9/27/23 at 2:37 p.m., the ADM provided a document, dated 2/1/22, titled, "Housekeeping," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The Community will have procedures in place...to ensure a safe and clean environment...Common areas: Cleaning will be performed per schedule established by the Community which should include the location, task, and frequency...." On 9/27/23 at 2:37 p.m., the ADM provided a document, dated 2/1/22, titled, "Maintenance," and indicated it was the policy currently being used by the facility. The policy indicated, "...Develop and adhere to a schedule for routine...inspection for the building...which may include, but not be limited to...floors/walls/ceilings...."		identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 10/25/2023**	
R 0273 Bldg. 00	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. A. Based on observation, interview, and record review, the facility failed to ensure the stove hood	R 0273	**R273 Food and Nutritional Services.**	10/25/2023

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	filter vent was cleaned for 3 of 3 kitchen observations. B. Based on observation, interview, and record review, the facility failed to ensure sanitary handwashing equipment was provided for staff to dry their hands 2 of 2 kitchen observations. Finding includes: A. On 9/26/23 at 10:35 a.m., during the initial kitchen observation grease was observed dripping down from back of the vent over the stove. On 9/26/23 at 12:30 p.m., during a random kitchen observation hood vent grease was observed along the bottom of the vent. On 9/27/23 at 9:45 a.m., during a random kitchen observation vent hood above the stove had grease along the bottom of the vent. On 9/26/23 at 10:35 a.m., Cook 3 indicated, the vent was scheduled for weekly cleaning today. Review of the September cleaning schedule indicated the stove vent was scheduled to be cleaned every Tuesday. The record lacked documentation of cleaning 3 of the 4 weeks. On 9/26/23 at 10:55 a.m., Cook 3 provided a document titled, "September" and indicated it was the daily and weekly cleaning schedule. Documentation lacked evidence the hood had been cleaned as scheduled 3 of 4 weeks. On 9/26/23 at 12:30 p.m., the Dietary Manager indicated the vent had been cleaned weekly and there was possibly an issue with the vent not working properly causing the grease to drip down		**The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified:** No residents were affected by this citation. The kitchen was deep cleaned, and paper towels were placed in paper towel dispensers. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. All Dietary staff were in-service on kitchen cleaning and followed daily, weekly, and monthly schedule and document when completed. All staff were in-service on handwashing. **3) Measures put into place/ System changes:** DHW and Chef or Designee will visually audit staff members 3 times weekly for 4 weeks, then 3 staff members 2 times weekly for 4 weeks, then 3 staff member 1 times weekly for 4 months for	

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	the bottom. She indicated the service provider for the vent hood had been at the facility to inspect the vent. On 9/27/23 at 3:40 p.m., the Administrator provided an undated document, titled, "Daily, Weekly. Bi-Monthly Kitchen Cleaning Checklist", and indicated it was the policy currently being used by the facility. The policy indicated, "...Date when completed and keep on file...All cleaning tasks to be done by Chef, Assistant Chef & Dining Services Assistant or as Assigned by Executive Director...Weekly (or more as needed) Cleaning Schedule...Wipe down return air vent and hood...Pull filters above cooking equipment and clean in dishwasher...." B. On 9/26/23 at 10:35 a.m., rolled paper towels were observed at the employee wash sink. Cook 3 was observed unrolling paper towel after washing her hands, leaving the paper towel damp. On 9/26/23 at 12:35 p.m., Certified Nurse Aide (CNA) 4 was observed assisting with meal service. CNA 4 washed her hands and unrolled paper towel to dry her hands, leaving the rolled paper towel wet. On 9/27/23 at 9:45 a.m., a roll of paper towel was observed on the sink designated for handwashing. On 9/26/23 at 10:40 a.m., Cook 3 indicated they were out of paper towels for the paper towel dispensers since the weekend. On 9/26/23 at 10:35 a.m. the Administrator indicated the facility was out of paper towels for the paper towel dispensers. Paper towels were ordered and were due to be delivered by the end		proper Handwashing and Hand Hygiene. Administrator, Director of Health & Wellness, or Designee will inspect kitchen 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then 1 time weekly for 4 months to ensure kitchen is clean and sanitized and documentation is completed on timely manner. Any concerns will be addressed immediately. **4) How the corrective actions will be monitored:** DHW and chef or Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **10/25/2023**	

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		A. BUILDING 00 B. WING	09/27/2023

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	of the week. On 9/26/23 at 12:40 p.m., CNA 4 indicated she should have paper towels from the dispenser to dry her hands and acknowledged using the rolled paper towels was not sanitary practice for hand washing. On 9/26/23 at 12:30 p.m., interview with the Dietary Manager, indicated she was not aware they should not use rolled paper towel in the kitchen when paper towel for the dispenser was not available. She indicated they did not have paper towels for the dispenser, and they were on backorder. She indicated they go to hardware store and other vendors when they need supplies, before ordered supplies were delivered. On 9/26/23 at 2:35 p.m., the Administrator provided an undated document, titled, "Handwashing", and indicated it was the policy currently being used by the facility. The policy indicated,"...Proper handwashing will be used by all staff to prevent the spread of pathogens...PROCEDURE...Employee shall gather the following supplies...3. Disposable paper towels...Rinse well under running water and dry hands with paper towel...Use dry paper towel to turn off faucet...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (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.			

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	(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 observation, interview, and record review, the facility failed to maintain sanitary conditions during medication administration for 3 of 5 residents reviewed (Residents 10, 1, and 33). Findings include: 1. On 9/26/23 at 11:20 a.m., Qualified Medication Aide (QMA) 3 was preparing medication for Resident 10. The QMA punched out the pills from the pill pack by touching the pills with her bare hands and placed the pills in the medication cup. The resident had 6 pills in her medication cup, and all were touched by the QMA with her bare hands. QMA proceeded into the resident's room to administer the medication after locking her medication cart and closing the medication book. 2. On 9/26/23 at 12:40 p.m., QMA 3 was preparing medication for Resident 1. The QMA punched out two capsules for the resident to take and placed them in a medication cup with her bare hands. The QMA proceeded into the resident's room to administer the medication after locking her medication cart and closing the mediation book. 3. On 9/26/23 at 12:55 p.m., QMA 3 was preparing medication for Resident 33. The QMA took medication out of pill bottle and placed them on the lid of the pill bottle, the QMA touched a pill with her bare hands so that only one pill was placed in the medication cup for the resident from the lid. She proceeded to lock her cart and walked into the resident's room to administer her medication.	R 0407	**R407 Infection control** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified:** QMA 3 was educated by DHW on infection control and medication administration. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. Inservice provided to all QMA and Licensed nursing staff on infection control and medication administration. **3) Measures put into place/ System changes:** DHW/ Designee will do visual rounds on random shifts 3 times	10/25/2023

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	During an interview, on 9/26/23 at 2:13 p.m., the Director of Nursing (DON) indicated staff should not touch pills with their bare hands during medication administration. On 9/26/23 at 3:00 p.m., the DON provided an undated document, titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Medications will not be handled by hand ...."		weekly x 4 weeks, then 2 times weekly x 4 weeks and 1-time weekly x 4 months to ensure QMA and licensed nurses are passing meds accurately. **4) How the corrective actions will be monitored:** DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **10/25/2023**	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing			

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	should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review, and interview the facility failed to ensure residents were assessed for Tuberculosis through assessment and administration of Mantoux skin test upon admission to the facility for 3 of 3 residents reviewed (Residents 27, 57, and 58). Finding includes: On 9/27/23 at 11:41 a.m., the Director of Nursing (DON) provided an undated form titled, "Immunization and Tuberculosis Testing Consent" record for Resident 027.The document indicated all residents were to complete this form upon move-in and prior to receiving the Mantoux skin test. The Mantoux skin test, using Purified Protein Derivitive (PPD), was used for screening. Documentation lacked evidence indicating the 1st and 2nd step Mantoux test was administered upon admission. On 9/27/23 at 2:30 p.m., medical record for Resident 057 lacked documentation of initial Mantoux test prior to admission and 2nd step Mantoux administration. On 9/27/23 at 2:30 p.m., medical record for Resident 058 lacked documentation of initial	R 0410	**R410 Infection control.** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** Resident 27,57, and 58 charts were reviewed and Mantoux 2 step test was administered and documented by DHW. MD was notified. **2)How the facility identified other residents:** Any resident residing in the facility had the potential to be affected.	10/25/2023

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	Mantoux test prior to admission and 2nd step Mantoux administration. Interview with the DON on 9/27/23 at 12:00 p.m., the DON indicated they do not do chest xray unless the resident tests positive from a Mantoux test. She indicated an assessment and Mantoux test was completed prior to admission according to Mantoux testing guidelines including two step Mantoux testing upon admission. An annual assessment completed yearly after admission. On 9/27/23 at 12:28 p.m., the DON provided a document, titled, "Tuberculosis (TB) Testing Policy" dated, 7/7/23, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy...Tuberculosis testing will be completed per state regulations for residents...See the chart of state-specific TB Testing Requirements in the appendix of this guide...Procedure...2) State regulations will be followed for any required follow-up for residents...who have had a positive skin test and a negative chest Xray...."		Audit completed on all resident to ensure 2-step Mantoux was administered and Mantoux test administered if no documentation was available. Education provided to all licensed nurses to administer 2 step Mantoux step upon admission. **3)Measures put into place/ System changes:** DHW / Designee will review all new admissions to ensure testing is completed prior to move in. Additionally, charts will be audited weekly for compliance. **4)How the corrective actions will be monitored:** DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **10/25/2023**	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their			

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	hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure sanitary hand hygiene practices when individual paper towels were not available in the community restrooms. Finding includes: During the initial facility observation tour, on 9/26/23 at 10:10 a.m., the community women's and men's restrooms were observed to have no individual paper towels in the paper towel dispensers. A roll of paper towels was observed sitting on the sink. The paper towels, on the roll, were wet to the touch when paper towels were dispensed for use. During an interview, on 9/26/23 at 10:35 a.m., the Administrator (ADM) indicated the facility had run out of paper towels. An order for additional paper towels had been placed and were due to be delivered by the end of the week. During an interview, on 9/26/23 at 12:30 p.m., the Dietary Manager, indicated the facility had ordered more paper towels, but they were on back order. In the past, they had gone to the local supply store or other vendors when waiting on supplies to be delivered. On 9/26/23 at 2:15 p.m., the ADM indicated she understood how having rolls of paper towels, that had to be touched by anyone drying their hands, could be an infection control concern. On 9/26/23 at 2:35 p.m., the ADM provided an undated document titled, "Handwashing," and	R 0414	**R414 Infection control** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** Paper towel dispenser with new paper towel placed in community men's and women's restroom. **2)How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. None noted. The maintenance and housekeeping director were educated on ordering paper towel and supplies in a timely manner to ensure supplies are always available. **3)Measures put into place/ System changes:** DHW and ED or Designee will visually audit common areas 3	10/25/2023

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	indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Proper handwashing will be used by all staff to prevent the spread of pathogens...Employee shall gather the following supplies: ...3. Disposable paper towels...."		times weekly for 4 weeks, 2 times weekly for 4 weeks, then 3 staff member 1 times weekly for 4 months to ensure that paper dispenser always has paper towel. **4)How the corrective actions will be monitored:** DHW/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 10/25/2023**	