| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155801 | A. BUILDING 00<br>B. WING | 04/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH | 305 E NORTH ST<br>BOONVILLE, IN 47601 |

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| F 0000<br><br>Bldg. 00 | This visit was for Investigation of Complaint IN00401287 and Complaint IN00400199. This visit included a COVID-19 Focused Infection Control Survey.<br><br>Complaint IN00401287 - Federal/State deficiencies related to the allegations are cited at F550, F685, and F9999.<br><br>Complaint IN00400199 - No deficiencies related to the allegations are cited.<br><br>Survey dates: April 12, 13, 14, 2023<br><br>Facility number: 000450<br>Provider number: 155801<br>AIM number: 100273890<br><br>Census Bed Type:<br>SNF/NF: 51<br>Total: 51<br><br>Census Payor Type:<br>Medicare: 10<br>Medicaid: 40<br>Other: 1<br>Total: 51<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on April 21, 2023. | F 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective May 5, 2023 to the state findings of the Complaint Survey conducted on April 14, 2023. | |
| F 0550<br>SS=E | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Emily Diedrich | Executive Director | 05/05/2023 |

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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| Bldg. 00 | §483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as | | | |

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| | required under this subpart.<br>Based on observation, interview, and record review, the facility failed to maintain resident dignity for 1 of 2 residents observed for dining assistance, and during 1 of 2 dining observations. A staff member stood beside a resident while feeding her, openly talked about other residents while sitting in the dining room, residents were seated over an hour before a meal was served, and residents waited 14 - 25 minutes to receive a tray after another resident was served at the same table. (Resident F, Resident H, Resident J, Resident K, Resident L, main dining room)<br><br>Findings include:<br><br>During a dining observation in the main dining room on 4/13/23 from 7:08 A.M. at 8:22 A.M., the following was observed:<br><br>1. At 7:08 A.M., CNA (Certified Nurse Aide) 5 assisted Resident L to sit at a table. At that time, there was a resident sitting at another table already.<br><br>At 7:20 A.M., Resident J and Resident K sat at the same table in the dining room. At that time, Resident J indicated breakfast was usually out by that time.<br><br>At 7:32 A.M., Resident J got up from the table, and came back with two snacks. After eating them, Resident J obtained a fortune cookie from a table by the kitchen door. At that time, Resident J indicated they were hungry and upset that the food was not out yet.<br><br>At 7:49 A.M., a breakfast tray was brought to Resident K. | F 0550 | *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the residents identified as residents L, J and K are now receiving their meals in a timely manner and all residents who are seated at the same table are served at the same time.<br>*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the staff member identified as therapy staff 7 is now seated while assisting each resident with their meal and refrains from discussing other residents' medical conditions, mental status, behaviors or moods in the presence of other residents.<br>*3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the staff member identified as therapy staff 7 is now seated while assisting the resident identified as resident H with their meals.<br>*4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the residents identified as residents F, J and K are now being served their meals at the same time.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all | 05/05/2023 |

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| | At 7:56 A.M., a cart was brought out of the kitchen, rolled by the residents in the dining room (there were eight residents in the dining room at that time), and taken down the hall.<br><br>At 8:06 A.M., Resident K finished the food on the tray, and left the table. At that time, Resident J got up from the table and came back with another snack. Resident J was still sitting at the same table Resident K was sitting.<br><br>At 8:10 A.M., another cart was brought out of the kitchen, rolled by the residents in the dining room, and taken down the hall.<br><br>At 8:12 A.M., Therapy Staff 7 picked up Resident K's empty tray and put it on a cart just outside the kitchen door.<br><br>At 8:14 A.M., the residents in the dining room were served. Resident J indicated to staff at that time that she was not hungry, as she had eaten snacks waiting on the breakfast tray.<br><br>2. Therapy Staff 9 rotated between sitting and standing at a table with four residents. Therapy Staff 9 was speaking off and on about several different residents' cognition level, mood, and behavior (some that were in the dining room, and some that were not) while waiting on the breakfast trays to be served.<br><br>3. At 8:22 A.M., Therapy Staff 9 was observed standing to the left side of Resident H while feeding her. At that time, there were three other residents sitting at that same table.<br><br>4. During a random observation of dining on 4/13/22 at 12:40 P.M., Resident F, Resident J, and Resident K were seated at a table together in the | | residents have the potential to be affected by this deficient practice. All residents seated at the same dining room table are now served simultaneously before moving on to serve the next table of residents. All staff members are now refraining from discussing any resident's condition, mental status, behaviors or mood in the presence of other residents.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing and therapy staff members on the facility's meal service and dignity policies. The staff members were reminded about resident confidentiality and were instructed to refrain from discussing other residents' medical conditions in the presence of other residents. The staff was also reminded to remain seated while assisting residents with their meals and to interact with the resident in a pleasant and friendly manner to enhance the dining atmosphere.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor meal service to ensure that all residents at the same table are being served their meals at the same time and that staff members assisting the residents | |

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| | dining room. Resident K received their food at 12:42 P.M. and had finished eating before Resident J received their food at 12:53 P.M., and Resident F at 12:56 P.M.<br><br>During an anonymous interview on 4/14/23, the following was indicated:<br><br>Staff should avoid talking about other residents while assisting to feed residents in the dining room, as well as sit beside the resident they are assisting.<br><br>At 4/14/23 at 10:41 A.M., a current Meal Service policy, revised 8/15/22, was provided and indicated "All residents seated at a table will be served before serving the next table ... Not standing over residents while assisting them with meals ... Keeping interactions with other staff to a minimum while assisting residents with meals"<br><br>This Federal tag relates to Complaint IN00401287.<br><br>3.1-3(t) | | with their meals remain seated while providing assistance. The tool will also monitor to ensure that the dining atmosphere is pleasant and friendly, and that no confidential resident information is discussed in the presence of other residents. This tool will be completed by the Social Service director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |
| F 0685 SS=D Bldg. 00 | 483.25(a)(1)(2)<br>Treatment/Devices to Maintain Hearing/Vision<br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of | | | |

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| | vision or hearing assistive devices.<br>Based on observation, interview, and record review, the facility failed to ensure residents had an appointment with an optometrist to receive proper treatment and assistive devices to maintain their vision for 2 of 3 residents reviewed for vision services. Residents made staff aware they would like an optometrist appointment for vision changes and to receive more contact lenses but appointments were not provided. (Resident B, Resident C)<br><br>Findings include:<br><br>1. During an interview on 4/13/23 at 1:13 P.M., Resident C indicated they wore disposable contacts and staff was aware they needed an appointment with an optometrist to get more contact lenses but they hadn't heard back from social services about it.<br><br>On 4/14/23 at 9:00 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, and hemiplegia, unspecified affecting right dominant side. Resident C was admitted 11/18/20.<br><br>The most recent quarterly MDS (Minimum Data Set) Assessment, dated 2/22/23, indicated the resident was cognitively intact, an extensive assist of 1 staff for bed mobility and supervision of 1 staff for transfers, eating and toileting. It also indicated Resident C's vision was adequate and corrective lenses were not worn.<br><br>Current physician's orders included, but were not limited to, may follow up with optometrist as needed, dated 11/18/20.<br><br>A current "I wear contacts" care plan, dated | F 0685 | *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C now has another eye doctor appointment scheduled for an eye exam and for the purpose of obtaining additional contacts. The facility is providing transportation to and from the appointment. It should be noted however, that a previous appointment had been made for the resident and the resident had canceled the appointment themselves.<br>*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B now has an eye doctor appointment scheduled for an eye exam. Social services will follow up to ensure that new glasses are obtained if warranted by the examination.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A house wide audit will be completed to determine if there are any additional residents that are in need of vision or hearing services and appointments will be scheduled as needed. Social | 05/05/2023 |

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| | 10/1/21, included, but was not limited to, the following intervention:<br>Arrange consultation with eye care practitioner as required, initiated 10/1/21.<br><br>During an interview on 4/14/23 at 11:09 A.M., Resident C indicated they had been wearing daily disposable contacts in both eyes for months because they needed an appointment with an eye doctor to get more contacts. They indicated they had a discussion with the Social Services Designee (SSD) about getting an appointment with an eye doctor for this reason several times and hadn't heard back about one being scheduled.<br><br>During an interview on 4/14/23 at 11:18 A.M., LPN (Licensed Practical Nurse) 12 indicated it came to staff's attention that resident was ordering contacts from an online company and at that time, staff tried to get them into an eye doctor, but they weren't sure if they went.<br><br>During an interview on 4/14/23 at 11:24 A.M., CNA (Certified Nurse Aide) 8 indicated they were not sure if Resident C wore contacts.<br><br>During an interview on 4/14/23 at 11:26 A.M., the SSD indicated they were not sure if Resident C wore contacts and wasn't sure if they had seen an eye doctor and was not aware of any visual concerns. She indicated resident had an appointment to see (doctor's name) in January 2023, it was canceled for an unknown reason, and the resident would have had to have transportation provided by the facility.<br><br>On 4/14/23 at 11:41 A.M., progress notes, appointment information, doctor notes, assessments, and any other documents related to contact lenses usage were requested from the | | services will continue to audit residents for the need of any ancillary services and schedule appointments as needed.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the social service director on their responsibility to ensure that the residents in need of any ancillary services such as vision, dental, hearing, podiatry are provided in a timely manner.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the provision of ancillary services for the residents in a timely manner. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |

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| | DON (Director of Nursing) and SSD and not provided.<br><br>On 4/14/23 at 12:00 P.M., (doctor's office) was contacted and staff indicated resident had an appointment scheduled with (doctor name) on 1/24/23 and it was canceled but staff could not tell who canceled the appointment or the reason why.<br><br>During an interview on 4/14/23 at 12:10 P.M., the SSD indicated she just spoke with Resident C and they reminded her that she took an empty contact box with the prescription on it from Resident C, went to her personal eye doctor, and got a pair of contacts for the resident to use until they could get her in for an appointment as a new patient. The appointment was scheduled for 1/2023 and the resident canceled but couldn't remember why. She confirmed Resident C was ordering contacts online in the past. The SSD indicated none of that was documented in the resident's clinical record but she did remember the situation.<br>2. During an interview on 4/12/23 at 10:52 A.M., Resident B indicated they wore glasses, but needed new ones, as they could not see well out of the current ones. Resident B indicated they had told staff, but did not remember who or when they were told. Resident B indicated after telling staff, nothing had been done or said related to getting new glasses or seeing an eye doctor.<br><br>On 4/12/23 at 11:20 A.M., Resident B's clinical record was reviewed. Resident B was admitted 7/29/21. Diagnosis included, but were not limited to, cerebral infarction and spinal stenosis. The most recent significant change MDS Assessment, dated 3/2/23, indicated Resident B was cognitively intact, was totally dependent of 2 staff for bed mobility, transfers, and bathing, and had adequate vision with no corrective lenses. | | | |

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Current physician orders included, but were not limited to: May follow up with ... optometrist ... as needed, dated 7/29/21.

A current vision care plan, revised 8/7/22, indicated the following intervention:
Arrange consultation with eye care practitioner as required. Monitor/document/report any signs or symptoms of acute eye problems as needed. Remind resident to wear glasses when up, and ensure glasses are free from scratches and in good repair, dated 10/5/21.

During an interview on 4/13/23 at 12:32 P.M., the SSD indicated an optometrist came to the facility every other month. She indicated she filled out a form for each resident, and sent the forms to the optometrist who then use that information to determine which residents they would see during their visit. Concerns related to vision would be added to the form to ensure those residents would be placed on the list to be seen. She further indicated that if a resident were to voice concerns with vision, staff should have told either her or the scheduler to have their name put on the list. She indicated she was unaware that Resident B had a concern related to glasses, and was not on the list to be seen on the 18th of the current month.

On 4/13/23 at 1:15 P.M., a request for services/consultation form was provided for Resident B, dated 12/9/22. The form was filled out with the resident's name, date of birth, the box beside "eye care"
was checked, and was signed by the DON. At that time, the DON indicated a new company was adopted in December of 2022 for eye care, podiatry, and audiology. That month, a form was

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| | filled out for all residents. If the box next to the service was checked, it meant that service needed to be provided for the visit on 1/20/23. She indicated the optometrist missed Resident B on that date. She indicated prior to December 2022, all residents had their own physicians for eye care, but did not have any documentation that Resident B had seen anyone.<br><br>On 4/14/23 at 10:41 A.M., a current Ancillary Services policy, revised 6/16/22, was provided and indicated "Each resident will be provided ancillary services of their choice such as dental, vision, hearing, podiatry, etc ... The facility will assist the resident in making appointment [sic] with ancillary services providers of their choice"<br><br>This Federal tag relates to Complaint IN00401287.<br><br>3.1-39(a)(1) | | | |
| F 0880 SS=E Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and | | | |

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| | controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155801 | A. BUILDING 00<br>B. WING | 04/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH | 305 E NORTH ST<br>BOONVILLE, IN 47601 |

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|---|---|---|---|---|
| | incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, interview, and record review, the facility failed to properly contain COVID-19 for 1 of 3 COVID positive rooms observed, and failed to ensure infection control practices and standards were maintained for 1 of 2 dining service observations, and 1 of 3 residents observed for care. Dinner trays were not disposed of from the night before, tables were not cleaned in between meals, an ice scoop was not covered, used PPE (personal protective equipment) was brought outside of a COVID positive room to be disposed of, and staff did not lather hands during handwashing per policy. (main dining room, Room 4, Resident E, Resident J, Resident K)<br><br>Findings include:<br><br>The Centers for Disease Control and Prevention (CDC) COVID Data Tracker (https://covid.cdc.gov/covid-data-tracker/#datatracker-home <https://covid.cdc.gov/covid-data-tracker/>), accessed on 4/10/23, indicated the county transmission level was moderate.<br><br>1. On 4/13/23 at 6:30 A.M., CNA (Certified Nurse | F 0880 | *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the CNA identified as CNA 8 has been re-educated on the proper donning and doffing of personal protective equipment as well as the proper placement of the trash can/linen bins and disposal of used PPE inside the resident's room. CNA 8 is now donning and doffing PPE and disposing of PPE in accordance with facility policy and acceptable standards of infection control practices.<br>*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E is now receiving wound care by staff members who are demonstrating proper hand hygiene in accordance with facility policy. The LPN identified as LPN 18 has been re-educated on proper hand | 05/05/2023 |

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|---|---|---|---|---|
| | Aide) 8 was observed donning (putting on) PPE before going into Room 4 to care for a resident on droplet/contact precautions. When CNA 8 came out of room 4, they were holding a plastic gown wadded up in their bare right hand and discarded it into a trash can placed outside of the resident's room in the hallway. CNA 8 continued doffing (taking off) the rest of their PPE, including their mask and goggles, in the hallway and also discarded them in the same trash can outside the resident's room in the hallway.<br><br>During an anonymous interview on 4/14/23, it was indicated PPE should be taken off before leaving the room and disposed of in the room. The trash can and linens bin should be located inside the room.<br><br>2. On 4/14/23 at 9:30 A.M., LPN (Licensed Practical Nurse) 18 was observed doing wound care on Resident E. At 10:31 A.M., LPN 18 washed their hands with a 10 second lather. After the wound care was complete, LPN 18 washed their hands with an 8 second lather.<br><br>During an anonymous interview on 4/14/23, it was indicated when washing hands, staff should turn water on, use soap, scrub for 45-60 seconds, rinse, use paper towel to dry hands and then turn water off.<br>3. On 4/13/23 at 6:00 A.M., two tables in the main dining room were observed with meal trays on them. The contents of the trays were observed to be remnants of the previous night's dinner (mashed potatoes, tuna casserole, and peas).<br><br>On 4/13/23 at 7:11 A.M., CNA (Certified Nurse Aide) 5 indicated the trays should have been disposed of the night before. | | hygiene. LPN 18 is now performing hand hygiene in accordance with facility policy and acceptable standards of infection control practices.<br>*3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the dining room tables are now being cleaned in between each meal service and/or between each resident usage. The residents identified as resident K and L are now being served their meals at a dining room table that has been cleaned in between each resident usage.<br>*4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the ice cart, ice cooler and scoop have all been thoroughly cleaned and disinfected and have been placed on a routine cleaning schedule. The ice scoop is now being placed in a zip lock bag in between usage. In addition, the resident identified as resident J was instructed to request assistance of the staff when needing ice for their drinks.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All staff members are now performing hand hygiene in accordance with facility policy and | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | On 4/13/23 at 7:17 A.M., the Activities Director put the trays in a garbage bag, and disposed of the bag. One of the two tables cleared had visible crumbs left on the surface. The tables were not wiped or disinfected.<br><br>On 4/13/23 at 7:20 A.M., Resident J and Resident K sat at the table with the crumbs, and at 7:49 A.M., Resident K was brought a tray that staff placed on the soiled table in front of him.<br><br>On 4/13/23 at 8:12 A.M., Therapy Staff 7 picked up Resident K's empty tray, put it on a cart just outside the kitchen door, then assisted Resident L to sit in the same place at the table without wiping it off in between residents.<br><br>4. On 4/13/23 at 6:00 A.M., an ice cooler was observed sitting in the main dining room by the closed kitchen window. The cooler was sitting in the top of a cart with an ice scoop sitting uncovered on the handle of the cart. The handle of the cart was observed with brown and black spots of an unknown substance covering it.<br><br>On 4/13/23 at 8:06 A.M., Resident J was observed to pick up the ice scoop on the handle of the ice cooler cart, and used it to obtain ice to place in their cup. Resident J then returned to the table with the ice, poured a drink into it, and drank it. At that time, there were two staff members observed in the main dining room.<br><br>During an anonymous interview on 4/13/23, it was indicated that kitchen staff should be cleaning off the tables after meals, then housekeeping should come in and clean the floor. It was also indicated that the ice cooler carts should have had a mesh bag that held the ice scoop, but one was missing, and if staff were to observe residents getting into | | acceptable standards of infection control practices. All staff members are now donning and doffing PPE and disposing of PPE in accordance with facility policies and acceptable standards of infection control practices. The dining room tables are now being cleaned and disinfected prior to each meal service and in between each resident usage. The facility ice cart is now clean and the ice scoop is being stored properly in accordance with facility policy. Staff members are providing residents with ice from the ice cart and residents are prohibited from accessing the ice cart.<br><br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on hand hygiene and the proper donning and doffing of PPE as well as the proper discarding of used PPE in the appropriate receptacles inside the resident's rooms. In addition, all nursing and dietary staff was re-educated on the proper cleaning of the dining room tables and ice cart in accordance with facility policy and infection control practices.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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|---|---|---|---|---|
| | the ice coolers, they should intervene and assist them.<br><br>On 4/14/23 at 12:13 P.M., a current "Donning and Doffing Personal Protective Equipment" policy, dated 6/16/22, was provided by the Regional Consultant and indicated " ... Remove all PPE before exiting the resident's room"<br><br>On 4/14/23 at 12:13 P.M., a current "Handwashing" policy, dated 8/4/22, was provided by the Regional Consultant and indicated " ... Vigorously lather hands with soap and rub them together creating friction to all surfaces, for at least forty-sixty (40-60) seconds under a moderate stream of running water"<br><br>On 4/14/23 at 12:13 P.M., a current Dietary Sanitization policy, revised 6/16/22, indicated "All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects ... Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime"<br><br>On 4/14/23 at 12:13 P.M., a current Ice Machines and Ice Storage Chests policy, revised 8/4/22, indicated "Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice ... Keep the ice scoop/bin in a covered container when not in use"<br><br>3.1-18(b)<br>3.1-18(b)(4)<br>3.1-18(l) | | monitor the staff's performance related to proper hand hygiene, proper donning and doffing of PPE as well as the proper discarding of used PPE inside the resident's rooms. The tool will also monitor the cleaning of the dining room tables in between each resident usage and the cleanliness of the ice cart and proper storage of the ice scoop. This tool will be completed by the Infection Preventionist and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 9999<br><br>Bldg. 00 | 1.<br><br>3.1-17 Nursing services<br><br>(b) The facility must provide services by sufficient number of each of the following types of personnel on a twenty-four (24) hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(1) Except when waived under subsection (f), the facility shall provide a licensed nurse hour-to-resident ratio of five-tenths (.5) licensed nurse hour per resident per day, averaged over a one (1) week period. The hours worked by the director of nursing shall not be counted in the staffing hours.<br><br>Based on interview and record review, the facility failed to ensure a sufficient number of nursing hours based on an hour to census ratio. The average nurse hours to census ratio was less than five-tenths averaged over a 7 day period.<br><br>Finding includes:<br><br>On 4/12/23 at 9:25 A.M., nursing hours as worked for the previous two weeks were requested and provided 4/12/23 at 1:00 P.M. At that time, the DON (Director of Nursing) indicated if a nurse's name was listed in two separate shifts, that nurse was here for 12 hours. If a nurse's name was listed for one shift, that nurse could be counted for eight hours, unless otherwise specified on the form. The staffing sheets from 4/2/23 through 4/8/23 were reviewed with the following information: | F 9999 | 9999 Nursing Services<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The facility is now providing at least five-tenths nurse hours to census daily.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the director of nursing on the required nurse hours that are to be provided for the resident's care daily as well as their responsibility to ensure that this standard is met or exceeded daily.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the nursing hours to ensure that the required five-tenths nurse hours to census is | 05/05/2023 |

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|---|---|
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|---|---|---|---|---|
| | 4/2/23: Total nursing hours 24<br>4/3/23: Total nursing hours 24<br>4/4/23: Total nursing hours 24<br>4/5/23: Total nursing hours 20<br>4/6/23: Total nursing hours 24<br>4/7/23: Total nursing hours 24<br>4/8/23: Total nursing hours 24<br><br>Total hours averaged over the 7 day period: 23.42<br><br>On 4/12/23 at 1:15 P.M., census hours from 4/2/23 through 4/8/23 were provided with the following information:<br><br>4/2/23: Census 52<br>4/3/23: Census 50<br>4/4/23: Census 49<br>4/5/23: Census 51<br>4/6/23: Census 52<br>4/7/23: Census 52<br>4/8/23: Census 50<br><br>Total census averaged over the 7 day period: 50.85<br><br>Total hours divided by total census averaged over the 7 day period: 0.46<br><br>During an interview on 4/14/23 at 9:35 A.M., the Regional Consultant (a Registered Nurse) indicated she had been in the building a couple of times per week, and helped on the floor as needed, but did not have documentation of days or hours spent working the floor.<br><br>On 4/14/23 at 12:41 P.M., a current Staffing Patterns policy, revised 9/5/22, was provided and indicated "Our facility provides adequate staffing to meet needed care and services for our resident | | maintained or exceeded daily. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.<br>9999 Social Services<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The facility has now retained the services of a qualified social service director who is providing at least fifteen minutes of social service for each resident weekly.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility has now retained the services of a qualified social service director who is providing at least fifteen minutes of social service for each resident weekly.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | population ... Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services"<br>2.<br><br>3.1-34 SOCIAL SERVICES<br><br>(d) In facilities of one hundred twenty (120) beds or less, a person who provides social services is an individual with one (1) of the following qualifications:<br>(1) Indiana board certification in social work under IC 25-23.6-5-1 with at least one (1) year's experience in a health care setting working directly with individuals.<br>(2) A bachelor's or advanced degree, or both, in social work or a degree in the human services fields, including, but not limited to:<br>(A) sociology;<br>(B) special education;<br>(C) rehabilitation counseling;<br>(D) psychology; and<br>(E) gerontology;<br>and one (1) year of supervised social service experience under the supervision of a qualified social worker in a health care setting working directly with individuals.<br>(3) A high school diploma or its equivalent who has satisfactorily completed, or will complete within six (6) months, a forty-eight (48) hour social service course approved by the division.<br>Consultation must be provided by a person who meets the qualifications under subdivision (1) or (2). Consultation by a person who meets the qualifications under subdivision (1) or (2) must occur no less than an average of four (4) hours per month. | | been provided with the social service designee related to the requirements of the position. The Executive Director has also been educated on the social service requirements as well as their responsibility to ensure that this service is consistently being provided by a qualified social service director.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the education requirements related to a social service director and is monitoring the number of hours that are being provided for the residents by social services to ensure compliance. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |

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|---|---|---|---|
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|---|---|---|---|---|
| | (4) Ordained minister, priest, rabbi, or sister or brother of religious institutes who has satisfactorily completed a forty-eight (48) hour social service course approved by the division. A person who has not completed a course must have consultation of no less than an average of four (4) hours per month from a person who meets the qualifications of subdivision (1) or (2) until the person has satisfactorily completed the division approved course.<br><br>This State Rule is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure requirements were met for 1 of 1 social service designee (SSD) employed by the facility. The completion of the SSD course by the SSD employee and the provision of monthly consultation by a qualified person was not made available to the facility. (SSD employee)<br><br>Findings include:<br><br>On 4/13/23 at 12:50 P.M., employee records were reviewed and indicated the SSD's start date as 8/15/22. At that time, the Regional Consultant indicated the SSD started in that role at the facility on 8/15/22.<br><br>During an interview on 4/13/23 at 2:48 P.M., the SSD indicated she started at the facility as the social service designee on 8/15/22 and had started the required course for that position in November of 2022. She indicated once she was finished with the course content, she would be tested for certification.<br><br>On 4/14/23 at 12:45 P.M., the DON (Director of Nursing) indicated there was not a formal policy | | | |

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| | for social service designee requirements, but provided a "social service designee" job description and indicated it was used as their policy. This form lacked information about the state requirements of a social service designee.<br><br>4/14/23 at 2:48pm the Previous Administrator and Regional Consultant indicated prior to previous administrator leaving the facility, the current SSD had consulted with her r/t (related to) SSD information ... after she left (several weeks ago), the current SSD still did consultation with her over the phone, but previous administrator was not staffed with them or contracted with them to do consultation ... The previous administrator did not hold the position of SSD, only consulted with current SSD on how to perform SSD responsibilities.<br><br>This state finding relates to complaint IN00401287. | | | |