STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155611	A. BUILDING 00 B. WING	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 24, 25, 28, 29, and 30, 2024. Facility number: 000277 Provider number: 155611 AIM number: 100290530 Census Bed Type: SNF: 9 SNF/NF: 81 Total: 90 Census Payor Type: Medicare: 4 Medicaid: 65 Other: 21 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 1, 2024.	F 0000	Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure survey event ID 2LTV11.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure a resident that self-administered medications was appropriately assessed for self-administration for 1 of 17 residents reviewed for self administration of medications. (Resident 18) Findings include:	F 0554	Hoosier Christian Village does ensure residents self-administered medications are appropriately assessed for self-administration of medication. During an interview with RN 7, she indicated she did not see the cough syrup on resident's bedside table when assisting him prior. On	10/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Garrison	Administrator	11/15/2024

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	During and observation on 10/28/24 at 10:23 A.M., Resident 18 was sitting in his recliner in his room. His over the bed table was in front of him and he was finishing his breakfast. On the left side of the table sat a bottle of severe cold and cough syrup. During an observation on 10/28/24 at 1:06 P.M., Resident 18 was sitting in his recliner in his room. His over the bed table was in front of him. On the left side of table was a bottle of severe cold and cough syrup. During an observation and interview on 10/29/24 at 9:35 A.M., Resident 18 was sitting in his recliner in his room. His over the bed table was in front of him. There was a bottle of severe cold and cough syrup sitting on the table. The resident indicated he only took the medication when he had something caught in his throat. During an interview on 10/29/24 at 11:44 A.M., RN 7 indicated if a resident self-administered medications a fax would be sent to the resident's physician to get an order to have the medication at the bedside and the resident had to be mentally competent to have them at the bedside. Resident 18 did not self-administer any medications. She was unaware the resident had any cough syrup at his bedside. She went into the resident's room and removed the cough syrup. The clinical record for the resident was reviewed on 10/28/24 at 10:33 A.M. An Admission Minimum Data Set (MDS) assessment, dated 08/09/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, fractures, anemia, hypertension, atrial fibrillation, anxiety, and depression.		10/29/2024, RN removed medication from resident bedside. On 10/29/2024, ADON spoke with resident and resident family member to remind them of community's policy on bringing meds in from home. Residents have the potential to be affected by this alleged deficient practice. 0n 10/29/2024, the DON, ADON, and SSD completed a thorough round to ensure no medications were in resident rooms that were not ordered and approved per policy for self-administration of medication. No residents were found to be affected by this alleged deficient practice. Resident was re-educated on requesting any medication with nursing instead of visitors. Upon admission, residents and loved ones will receive education on appropriate policy regarding self-administration of medication and medication brought from home. On 10/29/2024, nursing and environmental services staff were re-educated on monitoring resident rooms to ensure no medications are placed at bedside without a physician order and self-administration assessment completed. Any medication found at bedside will be reported to the charge nurse for further assessment and evaluation. SSD will provide re-education to residents and loved ones during	

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	The clinical record lacked an assessment or a physician's order for the resident to self-administer medications. The resident lacked a physician's order for cough syrup. The current facility policy titled, "Self-Administration of Medications" with a review date of 02/07/11, was provided by the Director of Nursing (DON) on 10/29/24 at 1:52 P.M. The policy indicated, "...The interdisciplinary team is responsible for ensuring the resident is capable and all required documentation is completed...If the resident chooses to self-administer drugs, the interdisciplinary team must assess the resident's cognitive, physical, and visual abilities to carry out this responsibility...A physician's order will be obtained and recorded in the chart. The order will also include if specific medications may be stored at the resident's bedside..." The current facility policy titled, "Bedside Medication Storage", with an effective date of 09/01/23, was provided by the DON on 10/29/24 at 1:52 P.M. The policy indicated, "...Bedside medications storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team..." 3.1-11(a)		routine care plan meetings, as well as during resident council meeting on 11/12/2024, to include self-administration policy. On 10/29/2024, an audit was conducted by Environmental services, SSD, IP, DON, and ADON that included observation of all resident rooms to ensure any medication at bedside contains an order and assessment per policy. These audits will continue to be conducted weekly for four weeks, then monthly, ongoing. Any concerns will be brought to the Quality Assurance team for further review and recommendations.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	Based on observation, interview, and record review, the facility failed to maintain oxygen therapy equipment in a clean and safe manner and assess a resident during breathing treatments for 1 of 2 residents reviewed for oxygen therapy. (Resident 69) Findings include: During an observation and interview on 10/24/24 at 1:07 P.M., Resident 69 had a breathing treatment nebulizer machine sitting on her nightstand. The face mask was attached to the side of the machine and open to air. The face mask and the attached tubing were not dated as to when the equipment was put into use. No plastic bag or other breathing treatment equipment was visible in the general vicinity. The resident indicated they received breathing treatments for Chronic Obstructive Pulmonary Disease (COPD). During an observation on 10/28/24 at 10:17 A.M., the breathing treatment nebulizer machine was sitting on the resident's nightstand. The face mask was attached to the side of the machine and open to air. The face mask and the attached tubing were not dated as to when the equipment was put into use. No plastic bag or other breathing treatment equipment was visible in the general vicinity. A small amount of fluid was visible in the reservoir of the breathing treatment apparatus. During an observation and interview on 10/28/24 at 3:17 P.M., the breathing treatment nebulizer machine was sitting on the resident's nightstand. The face mask was attached to the side of the machine and open to air. The face mask and the attached tubing were not dated as to when the equipment was put into use. No plastic bag or other breathing treatment equipment was visible	F 0695	Hoosier Christian Village does maintain oxygen therapy equipment in a clean and safe manner and residents' assessments are completed after breathing treatments per policy. On October 28, 2024, the ADON changed the tubing and mask and labeled with date and initials. During the weeks of November 3, 2024, and November 10, 2024, the nursing team was re-educated on the respiratory equipment policy that included changing the tubing, the mask, weekly, dating it, and bagging the mask when not in use. On November 7, 2024, a physician's order was received for resident 69 to include changing the resident's breathing treatment equipment per policy, the duration of the treatment in minutes, the resident's pulse, number of respirations, and oxygen saturation values with each treatment. Residents who have orders for nebulizer treatments have the potential to be affected by this alleged deficient practice. On October 28, 2024, the DON and ADON conducted an audit of residents who receive nebulizer treatments to ensure tubing is changed and labeled per policy and masks placed in plastic bags. No residents were found to be affected by this alleged deficient practice. During the week of November 3,	11/15/2024

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	in the general vicinity. A small amount of fluid was visible in the reservoir of the breathing treatment apparatus. The resident indicated there was no plastic bag and the staff did not use a bag for her equipment. She had not been on an antibiotic recently, but she did have COPD. During an observation and interview on 10/28/24 at 3:19 P.M., the Assistant Director of Nursing (ADON), while looking at the resident's uncovered breathing treatment nebulizer machine with undated tubing and mask, indicated oxygen tubing was changed every Sunday night. There was usually a plastic bag on top of the mask. The residents had a physician's order to have the mask and tubing changed on the Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR). The staff dated the equipment with a marker when it was put into use, including the tubing, the mask, and the plastic bag. During an interview on 10/28/24 at 3:33 P.M., Qualified Medication Aide (QMA) 9 indicated oxygen tubing was changed weekly. The clinical record was reviewed on 10/25/24 at 1:50 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 09/11/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anxiety and COPD. The EMAR/ETAR for September and October 2024, were provided by the Director of Nursing (DON) on 10/29/24 at 10:59 A.M. The records lacked a physician's order to change the resident's breathing treatment equipment. The records included, but were not limited to, the following current physician's order:		2024, the IP started a weekly audit to ensure nebulizer tubing is changed weekly and labeled with date and initials. During the week of November 3, 2024, the IP began a daily audit to ensure the nebulizer mask is contained in a bag when not in use. These audits will continue weekly for three months, then monthly, ongoing. On November 7, 2024, the DON, or designee, began a daily audit to ensure documentation is completed per policy after nebulizer treatment. These audits will continue daily for three months, then weekly for six months, then monthly, ongoing. Any findings will be brought to the Quality assurance committee and be addressed with further review and recommendations as needed.	

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- Albuterol Sulfate Nebulization Solution, 3 milliliters, inhale orally via nebulizer two times a day related to COPD, with a start date of 06/27/24.

The duration of the treatment in minutes, the resident's pulse, number of respirations, and oxygen saturation values were to be documented with each treatment. The records lacked documentation of the values on the following dates:

- September 1, through September 30, 2024 (no values were documented for the entire month of September), and
- October 1, through October 27, 2024.

The Progress Notes for September and October 2024, were provided by the DON on 10/29/24 at 10:59 A.M. The records lacked any indication the resident's breathing treatment equipment had been change or that the resident had been monitored during their breathing treatments.

During an interview on 10/29/24 at 2:13 P.M., QMA 6 indicated the vital signs should be taken at the time of the medication administration.

The current "Oxygen Administration" policy, with a reviewed date of 12/21/11, was provided by the Administrator on 10/29/24 at 3:39 P.M. The policy indicated, "...Tubing must be changed weekly and must be labeled with date and initials of the individual who changed the tubing..."

The current "Nebulizer" policy, with a revised date of 12/21/11, was provided by the DON on 10/29/24 at 10:59 A.M. The policy indicated, "...nursing staff will administer and monitor the effectiveness of nebulizer treatments as ordered

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	by the resident's physician...Auscultate lung sounds and assess respiratory rate...assess heart rate..." 3.1-47(a)(6)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails Based on observation, interview, and record review, the facility failed to assess a resident for bedrails for 1 of 1 resident reviewed for bedrails. (Resident 78) Findings include: During an observation on 10/24/24 at 12:54 P.M., Resident 78 had a half bedrail up on the side of her bed. During an observation on 10/28/24 at 10:15 A.M., Resident 78 was sitting in a chair in her room. There were half bedrails in place on both sides of the resident's bed. During an observation on 10/28/24 at 1:16 P.M., Resident 78 was sitting in a chair in her room. There were half bedrails in place on both sides of the resident's bed. During an observation on 10/29/24 at 9:40 A.M., Resident 78 was sitting in a chair in her room. There were half bedrails in place on both sides of the resident's bed. During an observation and interview on 10/29/24 at 2:13 P.M., Certified Nurse Aide (CNA) 8 indicated the resident had half bed rails on both sides of her bed.	F 0700	Hoosier Christian Village does assess residents for bed rails. On October 29, 2024, the ADON received a physician order for ¼ side rail as an enabler for mobility for resident 78. On October 29, 2024, a side rail assessment for resident 78 was completed per policy and plan of care was updated. On October 30, 2024, the DON and ADON conducted a thorough round to ensure residents with side rails had physician orders and side rail assessments completed per policy. No residents were found to be affected by this alleged deficient practice. On October 29, 2024, the Environmental Services Director was re-educated by the Administrator on the side rail policy to ensure side rails are removed from beds upon resident discharge of community. During the week of November 3, 2024, environmental services and nursing designee conducted a weekly audit of residents' beds to ensure residents with siderails had physician orders and a siderail	11/15/2024

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	During an interview on 10/29/24 at 2:16 P.M., the Assistant Director of Nursing (ADON) indicated if a resident had an enabler bar on their bed, then they should have a physician's order for the bar. The clinical record for the resident was reviewed on 10/28/24 at 2:32 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 09/19/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, unspecified dementia, hypertension, anxiety. The resident had used a bedrail less than daily. The clinical record lacked a physician's order for bedrails or an assessment for bedrails prior to 10/29/24. During an interview on 10/29/24 at 3:40 P.M., the ADON indicated the resident should have had an order and an assessment prior to the bedrails being placed on her bed. During an interview on 10/29/24 at 3:57 P.M., the Maintenance Director indicated the nurses would let him know when a resident had an order for bedrails to be on their bed and then he would put them on. He was unsure when Resident 78's bedrails were placed on her bed. They were not placed that day. He would inspect resident bedrails once a month. The current facility policy titled, "Use of Rails (Side Rails, Bed Rails, Grab Bars, Assist Bars)" with a revision date of 12/12/17, was provided by the Director of Nursing (DON) on 10/30/24 at 9:41 A.M. The policy indicated, "...After proper assessment, side rails/bed rails/grab bars/assist bars may be used...If alternatives were considered but deemed inappropriate to attempt for a		assessment completed per policy. These audits will be completed weekly, ongoing. Any concerns will be brought to the quality assurance committee fur further review and recommendations.	

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	resident, the resident will be assessed for rail use...A physician order will be obtained for the type of rail(s) to be utilized and when the rail is to be utilized (i.e. when in bed)..." 3.1-45(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to follow physician's orders related to hold parameters and gave medications without adequate need for use for 2 of 5 residents reviewed for unnecessary medications. (Residents 18 and 5) Findings include: 1. The clinical record for Resident 18 was reviewed on 10/28/24 at 10:33 A.M. An Admission Minimum Data Set (MDS) assessment, dated 08/09/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, fractures, anemia, hypertension, atrial fibrillation, anxiety, and depression. A current physician's order, dated 09/07/24, indicated the resident was to be administered Digoxin 125 (micrograms) MCG, once a day for atrial fibrillation. The staff were to hold the medication if the resident's heart rate was less than 60. The September and October 2024, Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) indicated the resident had received the medication on the following dates when the heart rate was	F 0757	Hoosier Christian Village does follow physician's orders related to hold parameters and giving medications without adequate need. On November 7, 2024, the DON reviewed Resident 18's MAR with the Medical Director, including the digoxin administration and heart rate. There were no new orders received. On November 7, 2024, the DON reviewed Resident 5's MAR with the Medical Director, including midodrine administration and blood pressures. No new orders were received. Residents who receive medications that have parameters could have the potential to be affected by this alleged deficient practice. During the week of November 4, 2024, the DON reviewed all resident orders to identify residents who have medication orders with parameters. No other residents were found to be affected by this alleged deficient practice. During the week of November 3, 2024, the DON initiated an audit to be	11/15/2024

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	less than 60: - 09/08/24, when the heart rate was 49, - 09/17/24, when the heart rate was 58, - 09/25/24, when the heart rate was 51, - 10/08/24, when the heart rate was 56, - 10/15/24, when the heart rate was 56, and - 10/18/24, when the heart rate was 51. 2. The clinical record for Resident 5 was reviewed on 10/25/24 at 12:56 P.M. A Quarterly MDS assessment, dated 07/23/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, end stage renal disease, and hypertension. An open-ended physician's order, with a start date of 08/22/24, indicated the resident was to take Midodrine (a blood pressure medication) 5 milligrams three times a day. The staff were to hold the medication if the resident's systolic blood pressure (top number) was greater than 105. The August and September 2024 EMAR indicated the resident received the medication on the following dates and times when the systolic blood pressure was greater than 105: - 08/23/24 at 8:00 A.M., when the blood pressure was 114/56, - 08/24/24 at 4:00 P.M. when the blood pressure was 109/60, - 08/25/24 at 8:00 A.M. when the blood pressure was 138/64, - 08/25/24 at 12:00 P.M. when the blood pressure was 107/58, - 08/26/24 at 8:00 A.M. when the blood pressure was 119/55, - 08/27/24 at 8:00 A.M. when the blood pressure was 112/58,		completed every shift by assigned qualified medication aide and/or nurse to ensure residents who have orders for medication with parameters received medication per provider orders. During the weeks of November 4, and November 11, 2024, nurse managers and/or designee completed med pass skills checkoff and reviewed the medication administration policy with medication passers that included monitoring vital signs and administering medication per provider's orders which have parameters with medication. Upon completion every shift of the medication parameter audit, it will be submitted to the DON for further review and recommendations. These audits will be completed ongoing, with any findings brought to the monthly QAPI meeting for further review and recommendations.	

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	- 08/27/24 at 12:00 P.M. when the blood pressure was 138/64, - 08/27/24 at 4:00 P.M. when the blood pressure was 138/64, - 08/29/24 at 8:00 A.M. when the blood pressure was 120/51 - 08/30/24 at 12:00 P.M. when the blood pressure was 112/74, - 09/06/24 at 4:00 P.M. when the blood pressure was 110/65. - 09/07/24 at 4:00 P.M. when the blood pressure was 128/62, - 09/13 24 at 4:00 P.M. when the blood pressure was 117/51, - 09/16/24 at 8:00 A.M. when the blood pressure was 147/68, - 09/16/24 at 12:00 P.M. when the blood pressure was 135/65, - 09/16/24 at 4:00 P.M. when the blood pressure was 110/65, - 09/19/24 at 8:00 A.M. when the blood pressure was 116/63, - 09/20/24 at 4:00 P.M. when the blood pressure was 118/60, - 09/21/24 at 4:00 P.M. when the blood pressure was 116/56, - 09/24/24 at 8:00 A.M. when the blood pressure was 121/57, - 09/24/24 at 12:00 P.M. when the blood pressure was 115/56, and - 09/28/24 at 12:00 P.M. when the blood pressure was 116/53. During an interview on 10/29/24 at 2:13 P.M., Qualified Medication Aide (QMA) 6 indicated she would obtain residents vital signs at the time she was going to administer the medications. If the vital sign was outside of the parameter per the physician order, then she wouldn't administer the medication. If there was a check on the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

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	EMAR/ETAR then that meant the resident was given the medication. The current facility policy titled, "MEDICATION ADMINISTRATION-GENERAL GUIDELINES" with an effective date of September 01, 2023, was provided by the Director of Nursing (DON) on 10/29/24 at 4:01 P.M. The policy indicated "...Medications are administered in accordance with written orders of the prescriber..." 3.1-48(a)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, interview, and record review, the facility failed to ensure resident skin assessments accurately reflected the condition of a resident's skin/nails for 1 of 2 residents reviewed for skin conditions. (Resident 80). Findings include: On 10/29/24 at 10:46 A.M., Resident 80's bare feet were observed. The resident's toenails were long. The toenails on the resident's big toes were thick, yellow, and curved in on the sides. The skin under the third toe on the resident's right foot was black in color under the toenail. The toenail appeared raised from the nail bed but was attached to the skin. The resident's toes were observed with the Director of Nursing (DON) on 10/29/24 at 3:19 P.M. The DON indicated the resident's toe was black and it looked like the nail was coming off. The nails were pretty thick. Nursing staff would normally document a skin condition in the resident's record. The weekly skin assessments	F 0842	Hoosier Christian Village does ensure resident skin assessments accurately reflect the condition of a resident's skin/nails. On October 29, 2924, the ADON updated the provider on the skin assessment of Resident 80's toe. New order was received, and treatment start with skin prep BID to toe. Residents have the potential to be affected by this alleged deficient practice. During the weeks of 11/4/2024, and 11/7/2024, the wound nurse, the DON, and the ADON assessed all residents to ensure skin assessments accurately reflected the condition of residents' skin/nails. No other residents were found to be affected by this alleged deficient practice. During the weeks of 11/4/2024 and 11/7/2024, nursing was	11/15/2024

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	included a place to document on the resident's toes and toenails. During an interview on 10/29/24 at 3:44 P.M., Certified Nurse Aide (CNA) 2 indicated the resident had been treated for a wound on her bottom but it had healed. She gave the resident a bed bath yesterday and didn't see any skin impairments. She did have an area on one of her toes that looked like the toe had been caught on something. The toe was discolored. The resident moved to this unit of the facility at the beginning of this month and the toe looked like that when the resident came to the unit. If she identified a skin impairment, she would go straight to the charge nurse and tell them. She thought the nurses knew about the resident's toe. During an interview on 10/30/24 at 11:38 A.M., Licensed Practical Nurse (LPN) 3 indicated she was familiar with the resident and cared for her routinely until she moved to another unit in the beginning of October. There were no wounds on the resident's feet that she could recall, and no injuries to the resident's toes. She was not sure how the resident would have injured her toe. She was dependent for all care and the staff used a mechanical lift to transfer her. During an interview on 10/30/24 at 1:36 P.M., CNA 4 indicated she routinely cared for the resident until she moved to another unit at the beginning of October. She had trimmed and filed the resident's nails before. She would notify the nurse if there was a skin issue. The resident's toe was discolored. She had not seen an open area, but she would consider the condition of the toe to be a skin impairment. They were supposed to document skin impairments in the resident's record. She had told a few nurses about the		re-educated on the skin check policy that included completion of the head-to-toe assessment weekly as scheduled or when deemed necessary, examination status of toenails and fingernails, and documentation of the findings. The wound nurse will conduct random weekly audits, ongoing, of residents on their scheduled shower days to ensure skin assessments and documentation are completed per policy. The wound nurse will continue random weekly audits, ongoing, of residents on their scheduled shower days and bring any concerns to the monthly QAPI committee for further review and recommendations.	

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	toenail. She was not sure when she first saw the skin impairment, who she told, or when she told them. She was not sure if there was any documentation about the toenail. The resident's clinical record was reviewed on 10/29/24 at 2:41 P.M. An Admission Minimum Data Set (MDS) assessment, dated 07/29/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hemiplegia, hypertension, and aphasia. The resident was impaired on one side of their upper and lower extremities and used a wheelchair. The resident required substantial to maximal staff assistance with eating and was dependent on staff for all other Activities of Daily Living (ADLs). A Progress Note, dated 10/29/2024 at 6:04 P.M., indicated the nurse was notified about a discoloration to the third toe on the right foot. The area under the third toenail was black in color but did not appear to be causing any pain or discomfort. The toenails were very thick and long. The nurse completed the assessment and updated the physician and the family of the new area. They updated the Social Services Director on the need for a podiatry visit if consent was in place. The resident's clinical record lacked documentation of an identified skin impairment prior to the progress note dated 10/29/24. During an interview on 10/29/24 at 3:27 P.M., the Administrator indicated residents were offered ancillary services, including podiatry services, on admission. Additionally, ancillary services were discussed during quarterly Care Plan meetings and on an "as needed" basis. The podiatrist was in the building at least monthly and would come			

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	sooner if there was an urgent need. The resident's family declined podiatry services when the resident was admitted to the facility in July of 2024. She spoke to the family, and they now wanted podiatry services. The current facility policy, titled "Skin Check Policy", effective 02/23/21, was provided by the DON on 10/30/24 at 2:42 P.M. The policy indicated, "...Complete the head to toe assessment weekly as scheduled or when deemed necessary...Examine status of toenails and fingernails...Document the findings..." 3.1-50(a)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on interview, observation, and record review, the facility failed to provide safe water temperatures for 10 of 18 resident rooms observed. (Rooms 114, 141, 142, 143, 310, 324, 325, 329, 330, and 343) Findings include: 1. During an interview and observation in Resident Room 143 on 10/24/24 at 12:20 P.M., The resident indicated the water in his bathroom got hot. "You couldn't keep your hand under it for very long". The water in the resident's bathroom sink was felt and found to be hot. The water stream was too hot to keep a hand under the water flow without discomfort. The water temperature was tested with a probe thermometer and was found to be 126.5 degrees Fahrenheit. The resident indicated he had not been burned by the water.	F 0921	Hoosier Christian Village does provide safe water temperature for residents. No residents were found to be affected by this alleged deficient practice. Residents have the potential to be affected by this alleged deficient practice. On October 24, 2024, the Environmental Services Director reset the water temperature and ran water at the farthest end of the building to flush out all lines to ensure all rooms had water temperatures of 100 to 120 degrees. On October 24, 2024, the Administrator and nurse managers rounded to ensure that residents had no concerns with water temperatures. On October 24, 2024, the	11/15/2024

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	On 10/24/24 at 12:49 P.M., the water in the Resident Room next door to Room 143 (Room 141) was checked with a probe thermometer and the water temperature was found to be 126.9 degrees Fahrenheit. The following water temperatures were observed on 10/24/24, with the Maintenance Director using the facility's probe thermometer: - At 1:04 P.M., Resident Room 141 the water temperature was 126.5 degrees Fahrenheit, - At 1:06 P.M., Resident Room 142 the water temperature was 125.3 degrees Fahrenheit, - At 1:07 P.M., Resident Room 143 the water temperature was 124.5 degrees Fahrenheit, and - At 1:10 P.M., Resident Room 114 the water temperature was 122.7 degrees Fahrenheit. During an interview on 10/24/24 at 1:33 P.M., the Maintenance Director indicated he did random checks of the water temperatures in the resident rooms, but he did not document the actual temperatures of the water from the individual sinks. He documented the temperature reading he obtained from the water heater gauge in his office. The water heater temperature reading was 120 degrees Fahrenheit. 2. On 10/24/24, the following water temperatures were checked using a probe thermometer: - At 12:52 P.M., Resident Room 142 the water temperature was 125.2 degrees Fahrenheit, and - At 12:54 P.M., Resident Room 114 the water temperature was 124 degrees Fahrenheit. Resident 69, who resided in the room, was able to get up and use the bathroom on their own. They indicated they had not been burned by the water.		Administrator re-educated the Environmental services director on the water temperature inspection policy that indicated water temperatures in resident area will range from 100 to 120 degrees Fahrenheit. During the week of November 4, 2024, the Environmental Services Director started a random weekly audit, ongoing, using a probe thermometer to ensure water temperatures in resident areas were maintained between 100 and 120 degrees. The weekly audits, ongoing, will be brought to the Administrator weekly to ensure compliance, and the QAPI committee monthly for further review and recommendations.	

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	During an interview on 10/24/24 at 1:35 P.M., the Administrator indicated if they had a policy related to water temperatures in resident rooms, it probably stated the state regulation of between 100 degrees and 120 degrees Fahrenheit. During an interview on 10/24/24 at 2:17 P.M., the Administrator indicated the staff had rounded with the residents and no residents had any concerns related to the hot water. The Maintenance Director indicated he had turned down the water temperature and was running water at the farthest ends of the building to flush out the lines. 3. During an observation on 10/24/24 the following water temperatures were observed using a probe thermometer: - At 12:29 P.M., Resident Room 324, the water temperature was 122.9 degrees Fahrenheit, - At 12:30 P.M., Resident Room 325, the water temperature was 122.0 degrees Fahrenheit, - At 12:32 P.M., Resident Room 329, the water temperature was 121.0 degrees Fahrenheit, the resident indicated the water would get pretty warm, - At 12:37 P.M., Resident Room 330, the water temperature was 122.7 degrees Fahrenheit, - At 12:39 P.M., Resident Room 343, the water temperature was 122.9, degrees Fahrenheit, and - At 12:41 P.M., Resident Room 310, the water temperature was 122.7 degrees Fahrenheit. During an observation on 10/24/24 the following water temperatures were observed with the Maintenance Director: - At 1:14 P.M., Resident Room 310, the water temperature was 122.5 degrees Fahrenheit, - At 1:16 P.M., Resident Room 343, the water			

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	temperature was 119.5 degrees Fahrenheit, - At 1:23 P.M., Resident Room 325, the water temperature was 122.5 degrees Fahrenheit, - At 1:23 P.M., Resident Room 324, the water temperature was 120.5 degrees Fahrenheit, and - At 1:24 P.M., Resident Room 329, the water temperature was 121.0 degrees Fahrenheit. During an interview on 10/24/24 at 1:09 P.M., the Maintenance Director indicated he would try to keep the hot water temperatures between 120 to 125 degrees Fahrenheit. During an interview on 10/24/24 at 2:18 P.M., the Maintenance Director indicated he had turned the water heater down and was flushing the tanks at that time. The current facility policy titled, "Water Temperature Inspection" with a review date of 03/02/22, was provided by the Administrator on 10/24/24 at 2:18 P.M. The policy indicated, "...Hot water in resident area will range from 100-120 degrees Fahrenheit..." 3.1-19(r)(1) 3.1-19(r)(2)			