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	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT HOBART	1420 ST MARY'S CIRCLE HOBART, IN 46342

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 9 and 10, 2021 Facility number: 002627 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/13/21.	R 0000	This plan of correction is not to be construed a an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. The Administrator will ensure all corrective action in the following Plan of Correction has been completed.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview the facility failed to ensure fire drills were conducted quarterly on each shift. Finding includes: The fire drill logs were reviewed on 8/9/21 at 2:43 p.m. Fire drills were conducted from 8/2020 to 8/2021 as follows: 9/29/20 evening shift 9/30/20 midnight shift 11/20/20 midnight shift 3/26/21 day shift 3/26/21 evening shift 3/29/21 midnight shift 4/1/21 day shift 6/28/21 evening shift 6/30/21 day shift Fire drills were not completed at least quarterly on each shift. Interview with the Administrator on 8/10/21 at 9:51 a.m., indicated she was aware the fire drills were missing as they have had no Maintenance Director for some time. She indicated the fire department had been out and participated in a fire drill during the fire watch this past year, however, she did not have any record of that.	R 0092	1. What corrective actions will be a ccomplished for those residents found to have been affected by the deficient practice? Fire Drills will be conducted on each shift by the end of the month to ensure compliance with all regulations immediately. A disaster drill will be scheduled with the fire department and completed within 30 days. 2. How will the facility identify other resident having the potential to be affected by the sam deficient practice and what corrective action will be taken? All residents have the potential to be affected. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All scheduled fire drills will be entered into a calendar system for one shift per quarter per shift to ensure the drills take place. Disaster drills will also be scheduled with the fire department. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? Administrator will monitor and ensure all drills are done timely. 5. The systemic changes will be	09/16/2021

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			completed on September 16, 2021.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure annual dementia training was completed for 3 of 5 employee records reviewed. (Dietary Cook 1, LPN 1, and QMA 1) Finding includes:	R 0095	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All staff identified will complete dementia training in Relias by 09/15/2021.	09/15/2021

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	The employee records were reviewed on 8/10/21 at 8:45 a.m., and indicated the following: a. Dietary Cook 1, who was hired on 9/24/18, had no documentation indicating she had received her 3 hours of annual dementia training. b. LPN 1, who was hired on 4/4/16, had no documentation indicating she had received her 3 hours of annual dementia training. c. QMA 1, who was hired on 7/18/15, had no documentation indicating she had received her annual 3 hours of dementia training. Interview with the Human Resources Director on 8/10/21 at 9:00 a.m., indicated annual dementia training had not been completed for the above employees.		2. How will the facility identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken? all residents have the potential to be affected. All employee training records will be audited to determine which employees ned to complete required training. Training will be either in Relias or in person. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Department heads will incorporate one hour every two weeks of training on the department schedule at a designated day and time for each employee in their department. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? Each department head will monitor the schedule weekly to ensure all staff in their department have completed the required training. ED will monitor all employee training monthly to ensure it is completed. 5. The systemic changes will be completed on 09/15/2021	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments			

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	at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure annual resident rights training was completed for 3 of 5 employee records reviewed. (Dietary Cook 1, LPN 1, and QMA 1)	R 0120	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All staff identified will complete annual resident rights training by	09/15/2021

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	Finding includes: The employee records were reviewed on 8/10/21 at 8:45 a.m., and indicated the following: a. Dietary Cook 1, who was hired on 9/24/18, had no documentation indicating she had received her annual resident rights training. b. LPN 1, who was hired on 4/4/16, had no documentation indicating she had received her annual resident rights training. c. QMA 1, who was hired on 7/18/15, had no documentation indicating she had received her annual resident rights training. Interview with the Human Resources Director on 8/10/21 at 9:00 a.m., indicated annual resident rights training had not been completed for the above employees.		09/15/2021. 2. How will the facility identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken? all residents have the potential to be affected. All employee training records will be audited to determine which employees need to complete required training. Training will be completed in Relias or in person. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Department heads will incorporate one hour every two weeks of training on the department schedule at a designated day and time for each employee in their department. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? Each department head will monitor the schedule weekly to ensure all staff in their department have completed the required training. ED will monitor all employee training monthly to ensure it is completed. 5. The systemic changes will be completed on 09/15/2021	
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:			

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	(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. (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, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to residents not wearing face coverings when the county positivity rate was greater than 5% and staff not wearing the correct personal protective equipment (PPE). (Resident 11) Findings include: 1. During a random observation, on 8/9/21 at 9:50 a.m., 3 residents were seated in the lobby area. The residents were not wearing face coverings and were seated within 6 feet of each other. At 10:00 a.m., 5 residents were observed participating in an exercise activity on the Second floor. The residents were not wearing face coverings and were seated within 6 feet of each other. Interview with the Wellness Director on 8/9/21 at 11:30 a.m., indicated she was aware the county positivity rate was over 5%. She indicated she would inform the residents they needed to wear face coverings indoors regardless of their	R 0407	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident identified will be COVID tested. Employee involved will be in-serviced on PPE requirements. 2. How will the facility identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected so all residents will be COVID tested. All staff will be trained on the proper use of PPE to prevent and contain Covid-19. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? County COVID infection rates will be monitored daily and when county infection rates are higher than 5% staff will be required to use face shields whenever there is resident contact. The need to continue monitoring will be evaluated in	09/15/2021

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	vaccination status.2. On 8/9/21 at 10:13 a.m., Resident 11 was observed ambulating in the hallway with visibly soiled clothing. CNA 1 assisted the resident to his room and provided incontinence care. CNA 1 was wearing a surgical mask. She was not wearing any eye protection. On 8/9/21 at 11:30 a.m., the Wellness Director provided a list of facility staff who had not been fully vaccinated for COVID-19. CNA 1 was unvaccinated. Interview with the Wellness Director on 8/9/21 at 11:30 a.m., indicated she was aware the county positivity rate was over 5%. She would provide face shields for the staff to wear. The "Adjunct IDOH (Indiana Department of Health) Guidance: LTC Facilities Guidelines in Response to COVID-19 Vaccination," updated 7/29/21, indicated, "...CDC recommends that everyone wear a mask in public indoor settings in areas with substantial or high COVID-19 transmission, regardless of vaccination status, to help prevent the spread of the Delta variant of COVID-19...Masks are required for all when the county positivity rates are above 5%..." The IDOH "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure," updated 7/21/21, indicated "...Unvaccinated HCP must wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission...If the county positivity rates are > 5% with increase to moderate or high substantial		monthly quality assurance committee. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? Director of Wellness will monitor staff compliance daily. All department heads will be in-service on use of PPE to prevent the spread of covid-19. Department heads will monitor their staff daily for compliance with proper use of PPE. 5. The systemic changes will be completed on 8/31/2021	

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	community transmission then eye protection should be used by unvaccinated HCP for all residents within 6 feet when delivering essential direct care regardless of COVID 19 status..."			