STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155587	A. BUILDING 00 B. WING	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE SUMMERFIELD	34 SOUTH MAIN STREET CLOVERDALE, IN 46120

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00427902. Complaint IN00427902 - No deficiencies related to the allegations are cited. Survey dates: April 24, 25, 26, 29, and 30, 2024 Facility number: 000415 Provider number: 155587 AIM number: 100291250 Census Bed Type: SNF/NF: 40 Total: 40 Census Payor Type: Medicare: 1 Medicaid: 35 Other: 4 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 8, 2024.	F 0000	Plan of Correction 2024 Summerfield Health Center Cloverdale, IN Facility Number:000415 Provider:155587 AIM number100291250 F 0000 Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective, to the Annual State Survey conducted 4-30-24. The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would			

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

Tasheena Duncan | HFA | 05/10/2024

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	endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a call light was kept within the resident's reach for 1 of 16 residents reviewed for call lights (Resident 39). Finding includes: On 4/25/24 at 9:22 a.m., Resident 39 was observed sitting on his bed watching television. The resident's call light was observed on the floor underneath two plastic storage containers, out of the resident's reach. On 4/26/24 at 8:55 a.m., Resident 39 was observed sitting on his bed watching television. The resident's call light was observed on the floor underneath two plastic storage containers, out of the resident's reach. On 4/29/24 at 9:02 a.m., Resident 39 was observed sitting on his bed watching television. The resident's call light was observed on the floor underneath two plastic storage containers, out of the resident's reach. On 4/29/24 at 3:15 p.m., the Director of Nursing (DON) observed the call light under the two storage containers and indicated, Resident 39's call light should be within reach and not on the floor under the two storage containers. Resident 39's record was reviewed on 4/30/24 at 9:48 a.m. Resident 39 was admitted to the facility, on 2/26/24, with diagnoses included, but were not limited to, Huntington's disease (A condition that damages nerve cells in the brain causing them to stop working properly. The damage to the brain	F 0558	F-558 The facility has, and had at the time of survey, policy, and procedures to ensure all residents call lights are in reach to ensure reasonable accommodations and needs/preferences See (Exhibit A). Was updated and facility was in compliance on 5-1-24. As a pro-active measure, all members of the staff were in-serviced see (Exhibit B) two audits plans put in place see (Exhibit C). As well as a resident council meeting was held with all residents willing to attend including but not limited to resident 39. They were education on the importance of not putting call lights under beds, behind curtains and or under mattress. The resident were reminded that this is their form of asking for help and in an emergency, they need to be able to always obtain call light. See (Exhibit D) resident council min with survey result education. To ensure compliance, DON will put out call light audits for nursing and CNA's DON is responsible for the completion and delegation of the call light audit. Audit to be completed 7 days a week am and pm shift, housekeeping has also	05/01/2024

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	gets worse over time. It can affect movement, cognition, and mental health), unspecified lack of coordination, unsteadiness of feet, reduced mobility, and repeated falls. An admission Minimum Data Set (MDS) assessment, dated 3/4/24, indicated the resident had a severe cognitive impairment and required supervision or assistance from staff for activities of daily living (ADL) (daily tasks related to resident care and hygiene). A care plan, goal target, dated 5/26/24, indicated the resident was at risk for falls due to Huntington's disease. Interventions included, but were not limited to, keep all light within reach. On 4/30/24 at 8:45 a.m., the Administrator (ADM) indicated the residents' call lights should be within their reach. The ADM provided and identified a document as a current facility policy titled, "Call Light," revision dated 2/2/18. The policy indicated, "...Purpose: To respond to residents' requests and needs in a timely and courteous manner...1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location...." 3.1-3(v)(1)		added call light in place to the daily room cleaning sheets see (exhibit C) The DON will audit to ensure call lights are being monitored checking 5 days a week for first month, then 3 times a week for 6 months , the checking audits weekly. Housekeeping will keep the check for call light from this point forward. The result of these audits will be reviewed by the QAPI committee monthly. If 100% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.			

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	§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide Registered Nurse (RN) coverage 8 hours per day 7 days per week for 7 of 28 days reviewed for staffing. This had the potential to affect 40 of 40 residents who resided in the facility. Findings include: On 4/30/24 at 11:00 a.m., review of RN staffing schedules for 4/1/24 to 4/27/24 indicated the Director of Nursing was scheduled as the RN Monday through Friday. An RN was not scheduled for the weekends of 4/6/24, 4/7/24, 4/12/24, 4/13/24, 4/19/24, 4/20/24, or 4/28/24. The Administrator indicated the Director of Nursing was available for calls during the weekends. On 4/30/24 at 11:45 a.m., the Administrator provided a document titled, "Staffing," dated 2001, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Statement ...Our facility provides adequate staffing to meet needed care and services for our resident population ...1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed staff are available to provide and monitor the	F 0727	F-727 The facility has, and had at the time of survey, policy, and procedures to ensure all residents are properly cared for in a safe manner See (Exhibits E). Was updated and in compliance on 5-1-24. As a pro-active measure, we are using RN agency nursing sat and sun. We are also actively recruiting RN's see (Exhibit F) RN agency schedule. DON was also educated on ensuring we have RN coverage on the weekend. We also have 3 staff in school to obtain an RN license. To ensure compliance DON is on call. Admin and DON are responsible for recruiting RN's we have worked with our Corp team to get ads out as well as make wage adjustments to entice RNs to apply to work at Summerfield. We had and will continue to ensure we have adequate staff to ensure all resident needs are taken care of by running an LPN in place of an	05/01/2024

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	delivery of resident care services ...." 3.1-17(b)(3)		RN in event we don't have an RN. Staff will be reviewed weekly in Agency call with Corp, admin, and RVP.The result of staffing challenges will be reviewed by the QAPI committee monthly. If 100% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	Based on observation, interview, and record review, the facility failed to ensure staff wore a hairnet restraint when in the kitchen, hand hygiene was completed appropriately, food items were labeled and dated, expired foods were discarded, dented cans were not stocked for usage for the residents' meals, and food was not stored directly onto the storeroom floor for 1 of 2 kitchen observations. This deficiency had the potential to affect 40 of 40 residents who received food from the kitchen. Findings include: During an initial tour of the kitchen with the Dietary Manager (DM), on 4/24/24 at 9:50 a.m., the following was observed: a. While in the kitchen, the DM had her hair in a ponytail without a hairnet and failed to wash her hands prior to beginning the kitchen tour and handling food items. b. The kitchen freezers contained an undated bag of biscuits, 2 undated bags of frozen French fries, 3 undated lemon pies, 2 undated bulk sausage tubes, 6 undated packages of waffles, 2 packages of puree peas labeled with a use by date of 11/9/23, 6 undated bags of tator tots, a large bag of frozen hamburger patties undated, an undated package of fish pollock, 6 undated apple pies, 3 undated hamburger rolls, undated package of pizza crusts, 8 undated rolls of ground pork shoulder, undated package of chicken and dumplings seasoning, undated package of donuts, undated bag of chicken tenders, 2 undated packages of hashbrown, 2 undated bags of diced chicken, and 2 undated packages of chicken tender.	F 0812	F-812 The facility has, and had at the time of survey, policy, and procedures to ensure all residents food is stored at safe and properly with proper labels, proper storage location, proper hair restraint, proper hand washing (Exhibit G). Was updated and in compliance 5-1-24. As a pro-active measure, all members of the dietary department were in-serviced 5-1-24 see (Exhibit H) . Attached is a copy of the Pre and Posttest To ensure compliance the Dietary manger or persons designated by Administrator will monitor and has been educated and will do audits on hand hygiene/hair net usage see (Exhibit I). An audit was developed and implemented to ensure proper labels on food in freezers and fridge see (Exhibit J). An audit was developed and implemented for storage of dry and dented can’s see (Exhibit K). Audits will be completed 5 days a week for 6 months. Date audit 5 days a week for six months and 3 times a week for 6 months. Then daily spot check to continue indefinite. All Fridges and freezers have been gone through to ensure that no expired items	05/01/2024

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	c. The dry storage area contained 3 dented cans of 106-ounce (oz) tomato sauce and a large cardboard box of ice cream cones stored directly on the stockroom floor without a barrier. On 4/24/24 at 10:30 a.m., the DM wiped her brawl with her bare hand and tucked her hair behind her ear, then touched more food items. She indicated no food items should be stored directly on the floor, all dented cans including the dented cans of tomato sauce should be discarded. All food items should be dated when received and stocked in the kitchen, but it was not getting done. On 4/24/24 at 10:37 a.m., the DM washed her hands, turned off the water faucet with her bare hand, indicated there were no paper towels in the dispenser, shook out her wet hands onto the floor, wiped her wet hands onto her pants, and then continued the tour of the kitchen and dry storage area. On 4/25/24 at 11:00 a.m., the Administrator (ADM) indicated staff were required to wear hairnet restraints when in the kitchen. Staff were required to wash their hands and turn off the water faucet with a paper towel when entering the kitchen and before and after touching food items. All food items should be labeled and dated when received, food items should not be stored directly on the floor, and canned goods with a compromised seal (dented) should be returned to the vendor. The ADM provided and identified a document as a current facility policy titled, "Hand Washing," dated 06/2018. The policy indicated, "...Policy: It is the policy of the Dietary Department to prevent the spread of infection through proper handwashing...Procedure: ...1. Hands are washed: ...a When entering and before starting work in the		are in the freezer or fridge. Also, to ensure all items are date appropriately. All food storage areas have been gone through to ensure no food is on floor or no dented can's as well as everything is labeled correctly. This will take place every food delivery day Tue and Fri so we will check Wed and Mon. A proper hand washing hair net audit is to be completed 5 days a week for 6 months 3 times a week for 6 months then daily spot checks . /p>	

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	Dietary Department...d. Before and after handling foods...e. After using the bathroom, sneezing, coughing, touching face or hair, scratching and using a handkerchief...2. Handwashing Procedure: ...e. Hands must be washed for a minimum of 20 seconds...f. Rinse thoroughly...g. Wipe dry with disposable paper towels...h. Turn off water faucet with paper towels...." The ADM, on 4/25/24 at 11:00 a.m., provided and identified a document as a current facility policy titled, "Food Storage (Dry, Refrigerated, and Frozen)," dated 2020. The policy indicated, "...Procedure: ...General storage guidelines to be followed: ...a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded...f. Dented cans are set aside in a separate labeled area of the storeroom to avoid using them and discarded according to vendor procedure...." The ADM, on 4/25/24 at 11:00 a.m., provided and identified a document as a current facility policy titled, "Storage of Dry Foods," dated 06/2018. The policy indicated, "...7. Food should not be exposed to splash, dust or other contamination and at least six inches above the floor...." 3.1-21(i)(1) 3.1-21(i)(3)			