| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RESIDENCES AT DEER CREEK | 401 EAST US 30<br>SCHERERVILLE, IN 46375 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: November 8 and 9, 2021<br><br>Facility number: 013069<br><br>Residential Census: 80<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 11/12/21. | R 0000 | Residences at Deer Creek (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on | |

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

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| | | | that basis.<br>We are requesting paper compliance for this survey. | |
| R 0120<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(e)(1-3)<br>Personnel - Noncompliance<br>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments 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:<br>(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.<br>(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.<br>(3) Inservice records shall be maintained and shall indicate the following:<br>(A) The time, date, and location.<br>(B) The name of the instructor.<br>(C) The title of the instructor.<br>(D) The names of the participants. | | | |

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| | (E) The program content of inservice.<br>The employee will acknowledge attendance by written signature.<br>Based on record review and interview, the facility failed to ensure the required personnel annual inservices for non-nursing and nursing staff were completed, which included Resident Rights and Dementia training for 3 of 5 staff members reviewed. (CNA 1, LPN 1, and Executive Chef 1)<br><br>Findings include:<br><br>Review of the employee records was completed on 11/9/21 at 9:46 a.m.<br><br>1. CNA 1 was hired on 8/15/17. The CNA did not complete the required yearly Resident Rights and Dementia training for the 2020 calendar year. The CNA completed 1 hour of infection control training for 2020. No other inservices were completed.<br><br>2. LPN 1 was hired on 5/7/14. The LPN did not complete the required yearly Resident Rights and Dementia training for the 2020 calendar year. The LPN completed 2 hours of infection control training for 2020. No other inservices were completed.<br><br>3. Executive Chef 1 was hired on 12/3/12. The Executive Chef did not complete the required yearly hours of Dementia or Resident Rights training for the 2020 calendar year. The Executive Chef completed 1 hour of infection control training for 2020. No other inservices were completed.<br><br>The above staff did not complete their annual inservice training for safety, accident prevention, | R 0120 | No residents were affected by this citation.<br>Director of nursing or designee will have an organized in-service annual education and training program for all personnel in all departments. All staff who have contact with residents will have six hours of dementia training within 6 months and three hours annually after that. Director of Human Resources will audit employee files monthly to ensure staff is in compliance with the requirement. HR Director will ensure all staff are signed up to complete annual inservice training as well as dementia training and keep an updated list of staff that have attended the training. | 02/22/2022 |

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| | needs of specialized population served, medication administration, and nursing care.<br><br>Interview with the Human Resource Director on 11/8/21 at 1:45 p.m., indicated the above employees had not completed the required yearly hours of Dementia and/or Resident Rights training for the 2020 calendar year.<br><br>Interview with the Director of Nursing on 11/9/21 at 9:45 a.m., indicated the required annual inservice training had not been completed. | | | |
| R 0300<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(4)<br>Pharmaceutical Services - Deficiency<br>(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.<br>Based on observation, and interview, the facility failed to ensure multi-dose vials of insulin were labeled when opened for 1 of 5 residents observed during medication pass. (Resident 9)<br><br>Finding includes:<br><br>During medication pass on 11/8/21 at 11:30 a.m., LPN 3 was preparing an insulin injection for Resident 9. She removed a multi-dose vial of Novolog Insulin and drew up 4 units into the syringe. Neither the container the insulin was in, nor the vial, was labeled with a date opened.<br><br>Interview with LPN 3 at that time, indicated the vial was to be dated after opening.<br><br>Interview with the Director of Nursing on | R 0300 | No residents were impacted by this finding.<br>Weekly medication audits will be done by staff nurse on each unit to ensure all residents medications are labeled with name of drug, MD, dosage , and expiration date.<br>Weekly audit will be performed by staff nurses weekly and will be submitted to DON for review.<br>DON will ensure weekly audits are being completed. | 11/30/2021 |

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| | 11/8/21 at 2:00 p.m., indicated vial of insulin was to be dated after opened. | | | |
| R 0356<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(i)(1-8)<br>Clinical Records - Noncompliance<br>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:<br>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.<br>(2) The resident ' s hospital preference.<br>(3) The name and phone number of any legally authorized representative.<br>(4) The name and phone number of the resident ' s physician of record.<br>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.<br>(6) Information on any known allergies.<br>(7) A photograph (for identification of the resident).<br>(8) Copy of advance directives, if available.<br>Based on record review and interview, the facility failed to ensure each resident's emergency information file was updated related to the resident's hospital preference and physician information for 2 of 5 residents reviewed for emergency information files. (Residents 4 and 5)<br><br>Findings include:<br><br>1. The record for Resident 4 was reviewed on 11/8/21 at 12:56 p.m. The resident was admitted to the facility on 6/30/21.<br><br>The resident's emergency information indicated | R 0356 | No residents were impacted by this finding. All resident records have been reviewed and updated. Upon admission, resident's emergency profile information will be printed and given to admitting personnel. weekly audits will be conducted to ensure for accuracy. | 12/15/2021 |

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| | hospital preference, physician's name, address, and telephone number were not completed.<br><br>Interview with the Director of Nursing on 11/9/21 at 10:00 a.m., indicated the resident's emergency information was incomplete.<br><br>2. The record for Resident 5 was reviewed on 11/8/21 at 2:00 p.m. The resident was admitted to the facility on 4/9/21.<br><br>The resident's emergency information indicated her hospital preference was not completed.<br><br>Interview with the Director of Nursing on 11/9/21 at 10:00 a.m., indicated the resident's emergency information was incomplete. | | | |
| R 0407<br><br>Bldg. 00 | 410 IAC 16.2-5-12(b)(1-4)<br>Infection Control - Noncompliance<br>(b) The facility must establish an infection control program that includes the following:<br>(1) A system that enables the facility to analyze patterns of known infectious symptoms.<br>(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.<br>(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.<br>(4) Reporting communicable disease to public health authorities.<br>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 not wearing the appropriate eye protection and all health care professionals were not screened for COVID-19 | R 0407 | There were no residents impacted by this finding. DON and/or designee in-serviced staff on PPE protocol in reference to protective eyewear or face shields.<br>Each Department Leader or designee will monitor daily for four | 11/30/2021 |

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| | prior to working for 2 of 3 unvaccinated staff reviewed for infection control. (CNA 2 and LPN 2)<br><br>Findings include:<br><br>1. During a random observation on 11/8/21 at 11:30 a.m., on the memory support unit, Agency CNA 1 was observed standing behind the counter in the dining room area wearing a face mask and gloves to both hands. She was not wearing any eye protection. There were residents in the area and within 6 feet of her.<br><br>At 11:32 a.m., CNA 3 was observed to enter the memory care unit, wearing a face mask over her mouth and nose, but no eye protection. She walked by several residents and was within 6 feet of them.<br><br>Interview with both CNAs at that time, indicated that was not the information they were told regarding eye protection.<br><br>2. During a random observation on 11/9/21 at 8:32 a.m., the Director of Marketing and Sales was observed standing outside of the dining room talking with 2 residents and within 6 feet of them. She was wearing a face mask over her mouth and nose, however, was not wearing eye protection.<br><br>Interview with the Director of Marketing and Sales at that time, indicated she was unaware she was supposed to wear eye protection while speaking to residents.<br><br>3. During a random observation on 11/9/21 at 8:34 a.m., the Administrator was observed standing in the lobby area on the second floor. At | | weeks for three months. Inservice plan in place on importance of eyewear or face shields. | |

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| | that time, there were 2 residents getting out of the elevator and the Administrator walked over to them and started talking. She was not wearing any eye protection.<br><br>Interview with the Nurse Practitioner on 11/9/21 at 8:15 a.m., indicated she was unaware she needed to wear eye protection when seeing residents.<br><br>Interview with the Director of Nursing on 11/9/21 at 9:15 a.m., indicated she was aware of the changes for eye protection and had instructed staff to wear eye protection when residents were present.<br><br>The updated 9/28/21, "COVID-19 Infection Control Guidance in Long-term Care Facilities," indicated all HCP were to use eye protection for resident care and encounters when community transmission was substantial or high.<br><br>4. The Employee screening sheets were reviewed for unvaccinated staff on 11/8/21 at 1:44 p.m.<br><br>- CNA 2 had worked 7 shifts in a 2 week pay period and only screened herself 1 time.<br><br>- LPN 2 had worked 9 shifts in a 2 week pay period and did not screen herself at all.<br><br>Interview with Human Resource Director on 11/8/21 at 2:25 p.m., indicated the above staff did not self screen themselves for COVID-19 prior to working.<br><br>Interview with the Director of Nursing on 11/9/21 at 1:00 p.m., indicated all staff were to self screen themselves at the front desk prior to | | | |

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| | working. No one was monitoring or looking at the sheets to see if the staff were screening themselves.<br><br>The updated 9/28/21, "COVID-19 Infection Control Guidance in Long-term Care Facilities," indicated to screen all persons who enter the facility; (e. g. visitors, vendors and HCP) for signs and symptoms of COVID-19 (e.g., questions about and observations of signs or symptoms) and deny entry to those with COVID-19 diagnosis, signs or symptoms, or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status). | | | |