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	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGBY PLACE	167 CR W 240 S LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 28 and 29, 2021 Facility number: 004392 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 3, 2021.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential			

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

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	nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to have CPR or first aid coverage for 3 out of 7 night shifts. This deficient practice had the potential to affect 31 of 31 residents who resided at the facility. Findings include: During a staffing review, on 4/29/21 at 2:20 p.m., there was no staff certified for CPR or first aid for the night shift on 4/18/21, 4/19/21 and 4/22/21. During an interview, on 4/29/21 at 3:33 p.m., the Executive Director indicated they did not have coverage for the night shift on 4/18/21, 4/19/21 and 4/22/21. The facility did not have a policy and followed the state regulations.	R 0117	1. On 5/12/2021, the Executive Director reviewed and updated staffing schedule to ensure minimum of one employee with current CPR and first aid certification was present on each shift. 2. An audit of employee first aid/CPR certification was completed on 05/06/20211 by the Executive Director. Employees without current first aid/CPR certification will obtain certification by 5/29/2021. Attachment 1 3. The Executive Director was re-trained by Regional Director of Care Services on 04/29/2021 regarding the first aid/CPR regulation requirement. Attachment 2 4. The Executive Director is responsible for sustained compliance. The Care Services Manager or designee will audit the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure a	05/29/2021

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			first aid/CPR certified employee is on site at all times. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date 5/29/2021	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview and record review, the facility failed to maintain clutter free hallways for 1 of 3 hallways (the left side hallway). Finding includes: During the walk through tour, on 4/28/2021 at 11:33 a.m., the left side hallway had the following items near the exit door: 1. One air conditioning unit on the floor with the front panel removed and the inner components exposed. 2. One closet door leaned against the wall. 3. One carpet cleaner/extractor next to the closet door. 4. One shampoo machine. 5. A metal cart with an air conditioning unit and boxes piled on top of the unit. 6. A large window blind leaned on the wall next to the closet door.	R 0144	The air conditioning unit, closet door, carpet cleaner, shampoo machine, metal cart, and blinds were removed from the hallway by the Maintenance Director on 04/28/2021. 2. The hallways were inspected on 5/10/2021 by the Executive Director to ensure they are clutter free. No issues identified. Attachment 3 3. The Maintenance Director was retrained by the Executive Director on 04/28/2021 on maintaining clutter free hallways. Attachment 4 4. The Executive Director is responsible for sustained compliance. The Executive Director or designee will inspect hallways 3 times per week for 4 weeks, then 2 times per week for	05/29/2021

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	During an interview, on 4/28/2021 at 11:40 a.m., the Maintenance Director indicated the facility did not have enough storage. The air conditioning units were removed from resident rooms on 4/27/2021 and needed to be discarded, the window blinds were broken, the closet door was removed from a room by resident request and the shampoo machine and the carpet cleaner/extractor were utilized daily. During an interview, on 4/28/2021 at 11:49 p.m., the Executive Director (ED) indicated the facility had to pay extra to have the air conditioning units removed and the closet door and the blinds should go into the storage room. A facility "Walkthrough Checklist/Guidelines," not dated and received from the ED on 4/29/2021 at 3:32 p.m., indicated "...Hallways/Alcoves...furniture organized...not cluttered...."		4 weeks, then weekly for 4 weeks to ensure they are clutter free. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date 5/29/2021	
R 0147 Bldg. 00	410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on observation, interview and record review, the facility failed to maintain the established smoke free policy. This deficient practice had the potential to affect 31 of 31 residents who resided at the facility. Finding includes: During an observation, on 4/28/2021 at 1:30 p.m., RCP (Resident Care Provider) 2 and RCP 3	R 0147	1. RCP 2 and RCP 3 were retrained by the Executive Director on 4/28/2021 on the community smoke free policy. Attachment 5 2. An inspection of outdoor areas was completed on 05/07/2021 by the Executive Director to ensure no evidence of smoking on community property. None noted.	05/29/2021

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	were sitting right outside the kitchen door on benches and both were smoking cigarettes. During an interview, on 4/28/2021 at 1:30 p.m., the Executive Director (ED) indicated the facility had a smoke free policy and the staff were aware they should not be smoking on the facility property. A current policy, not titled, dated September 2018 and received from the ED on 4/29/2021, indicated "...Smoke-Free Policy...In accordance with state law, the Residence has implemented a smoke-free policy...Guests and visitors are also required to observe this smoke free policy...." A current policy, not titled and not dated, received from the ED on 4/29/2021 at 3:04 p.m., indicated "...No Smoking Policy...You are not allowed to smoke on company property at any time...."		Attachment 6 3. Staff was retrained on 04/30/2021 by the Executive Director regarding community smoke free policy. Attachment 7 4. The Executive Director is responsible for sustained compliance. The Executive Director or designee will complete observational audits of outside community areas 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure smoke free. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date 5/29/2021	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to dispose of outdated food, to label and date food, to have covered trash cans, to ensure staff wore hairnets in the kitchen and to complete food temperatures according to safe food handling standards. This deficient practice had the potential to affect 31 of 31 residents who received food from the kitchen.	R 0273	1. The strawberries and ice cream were discarded on 04/29/2021 by Cook 4. The trash can by the handwashing sink was replaced with a covered trash can on 04/29/2021 and the trash can in dry storage was removed on 04/29/2021 by Cook 4. RCP 2 and RCP 3 were retrained on the	05/29/2021

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	Finding includes: 1. During an observation, on 4/28/2021 at 1:30 p.m., the following was observed: a. There was one 6.5 pound white plastic container of sliced strawberries in the reach in cooler with a manufacturer date of 1/2020 and an opened date of 3/22 with no year indicated. b. There was one plastic container of ice cream with chocolate sauce with no label and no date. c. The trash can by the handwashing sink did not have a cover and was filled with used paper towels. d. The trash can in the dry storage area did not have a cover and was filled with trash. 2. During an observation, on 4/28/2021 at 1:26 p.m., RCP (Resident Care Provider) 2 and RCP 3 walked through the kitchen, next to the food preparation area and through the kitchen exit door to the outside. RCP 2 and RCP 3 were not wearing hair nets. 3. During an observation, on 4/29/2021 at 11:35 a.m., Cook 4 put the thermometer in the pan of ham on the steam table, removed the thermometer and dipped it in the red sanitizer bucket with the quaternary sanitizer (a quaternary ammonium compound designed to kill germs), wiped the thermometer with her glove and put the thermometer in the macaroni and cheese pan without rinsing it. Cook 4 then took the thermometer and wiped it with a stained rag which was in the red sanitizing bucket. During an interview, on 4/29/2021 at 11:37 a.m., Cook 4 indicated she always cleaned the thermometer with the sanitizing bucket quaternary sanitizer because the facility did not have any of the individual wipes to clean the		kitchen dress code, including wearing hairnets in the kitchen, by the Executive Director on 04/29/2021. Cook 4 was retrained by the Executive Director on 04/29/2021 on the proper procedure for sanitizing food thermometer. Attachment 8 and 9 2. An audit of kitchen was done on 04/29/2021 by the Executive Director to ensure no outdated food present, food is labeled and dated, trash cans are covered, hair is contained, and food thermometers are being sanitized according to policy. No issues identified. Attachment 10 3. Staff was retrained on 05/10/2021 by the Executive Director regarding food storage, trash storage, dress code in the kitchen and thermometer sanitizing policy. Attachment 11 4. The Chef is responsible for sustained compliance. The Executive Director or designee will conduct observational audits of the kitchen 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure safe food handling and kitchen sanitation practices and procedures are maintained. Results of the spot checks will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be	

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	thermometer and was not aware the quaternary bucket was not appropriate to use to dip the thermometer in. During an interview, on 4/29/2021 at 11:53 p.m., the Executive Director (ED) indicated the facility did have alcohol wipes to clean the thermometers between food temperatures. During an interview, on 4/29/2021 at 2:46 p.m., the ED indicated Cook 4 did not have a ServSafe certification and would have been instructed on the procedure for food temperatures by the lead cook. The strawberries should have been discarded, the ice cream was from an outside source for an employee and should have been stored in the break room freezer and the trash cans should have lids on them. The facility did not have a policy for trash cans. A current policy, titled "Food Storage Guidelines," not dated and received from the ED on 4/29/2021 at 3:04 p.m., indicated "...All foods must be labeled using food storage labels...Prepared foods must be labeled with common name, prepared date and use by date...Guidelines to hold food...7 days-from opening...items like pudding, fruits, and vegetables...." A current policy, titled "Correct Use of Thermometers," dated as revised on 12/12/2019 and received from the ED on 4/29/2021 at 3:04 p.m., indicated "...Care of Thermometers...Wash with hot soapy water...Sanitize by using alcohol wipes or use three-compartment sink to wash, rinse and sanitize...."		on-going. 5. Completion date 5/29/2021	