STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155493	A. BUILDING 00 B. WING	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SCENIC HILLS AT THE MONASTERY	710 SUNRISE DRIVE FERDINAND, IN 47532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00409650. Complaint IN00409650 - Federal/state deficiencies related to the allegations are cited at F689 and F880. Survey dates: June 27, 28, 29, 2023 Facility number: 000534 Provider number: 155493 AIM number: 100267220 Census Bed Type: SNF/NF: 68 SNF: 12 Residential: 40 Total: 120 Census Payor Type: Medicare: 9 Medicaid: 51 Private: 15 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 5, 2023	F 0000	The submission of this plan of correction does not indicate an admission by Scenic Hills at the Monastery that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Scenic Hills at the Monastery. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bailey Sherman	Executive Director	07/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision of residents environment and to prevent falls for 2 of 6 residents reviewed for accidents. Fall interventions were not in place or updated when interventions were ineffective for residents with multiple falls. Neurological (neuro) assessments were not completed for an unwitnessed fall. A random observation of a medication cart left unlocked on the locked dementia unit. (Resident D, Resident G) Findings include: 1. During an observation on 6/27/23 at 9:31 A.M., Resident G was sitting in her wheelchair in the common area of the locked dementia unit. The wheelchair lacked foot pedals. Observation on 6/29/23 at 12:12 P.M., Resident G was sitting in her wheelchair at the dining room table of the locked dementia unit eating. The wheelchair lacked foot pedals. On 6/28/23 at 1:35 P.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, dementia, and depression. The most recent quarterly MDS (minimum data set) Assessment, dated 5/19/23, indicated Resident G was severely cognitively impaired and	F 0689	1. Residents D and G were affected by the alleged deficient practice. No adverse effects noted. Licensed nursing staff were immediately educated on locking the medication cart when left unattended. Licensed nursing staff were immediately educated on completing neurological assessments on residents with unwitnessed falls. Licensed nursing staff were educated on ensuring fall interventions are in place and updated when interventions are ineffective. 2. All residents have the potential to be affected. Licensed nursing staff to be educated on ensuring carts are locked when unattended. Licensed nursing staff to be educated on completing neurological assessments on residents with unwitnessed falls. Licensed nursing staff to be educated on ensuring fall interventions are in place and updated when interventions are ineffective. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 med carts to ensure they are locked when left unattended weekly x4 weeks, then every other week x2 months, then monthly x3 months.	07/28/2023

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	required extensive assistance of 1 staff with bed mobility, transfers, and toileting. Resident G required physical help in part of bathing with 1 staff member. The MDS indicated Resident G sustained a fall with major injury. Resident G's care plan included, but was not limited to, "Resident is at risk for falling r/t [related to]: recent fall with fracture, debility, medications" dated 3/13/23. Interventions included, but were not limited to "Pressure alarm to bed/chair, check placement and function every shift," dated 3/13/23. "Dycem to w/c [wheelchair]. Monitor placement every shift. Ensure pad alarm to chair and foot pedals in place," dated 5/30/23. Resident G's fall history included the following: Fall 1 On 3/6/23 at 6:10 A.M., Resident G was found sitting on her buttocks on the bathroom floor with legs outward facing the toilet. Her walker and wheelchair were not in reach. Resident G indicated she had pain from her hip to her knee. Resident G was transferred to the Emergency Room for further evaluation. Hospital records were reviewed and included, but were not limited to, "Patient sustained a fall from mechanical height earlier this morning while going to the bathroom without her walker...she was evaluated with physical exam and imaging confirming right femoral neck fracture." The fall with fracture required Resident G to have a partial right hip replacement on 3/6/23 at 2:04 P.M. The record lacked a new intervention put into place after that fall. Fall 2 On 3/29/23 at 10:11 P.M., Staff responded to a chair alarm to find resident walking from the recliner to the bed. Resident G picked her pajamas		The DHS or designee will audit 5 fall events to ensure neurological assessments are completed for unwitnessed falls weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will audit 5 residents to ensure fall interventions are in place and updated if interventions are ineffective weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	up off of the bed and lost her balance and fell when she turned around while staff was in the room. The new intervention at that time was "Offer HS [bedtime] care after supper, between 6-8." Fall 3 On 3/30/23 at 2:00 P.M., Staff was in the bathroom assisting resident and Resident G stood up to wipe herself. Resident G lost her balance and fell on her knees. The new intervention at that time was to put non-skid strips in front of the toilet. Fall 4 On 5/12/23 at 7:25 A.M., Staff heard a loud noise and found Resident G's walker standing upright and Resident G was laying on the floor in the hallway. Prior to that fall, the bed/chair alarm failed to sound. The new intervention at that time was to monitor Resident G's blood pressure per MD [medical doctor] order. That was an existing intervention, already in place with the neurological (neuro) assessments. Fall 5 On 5/12/23 at 10:30 A.M., Staff responded to a chair alarm that sounded and found Resident G on the bathroom floor laying on the right side of her back. At that time, Resident G indicated she was going to put her teeth in. A skin tear to her right forearm was noted. After lunch, Resident G complained of pain in her upper back and left rib area. An X-ray of her ribs was obtained and indicated "There are displaced fractures involving the left seventh and eighth ribs." The new intervention, dated 5/15/23, indicated to assist resident with putting dentures in when morning care was performed. Fall 6			

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	On 5/24/23 at 7:00 A.M., Resident G was found sitting on the floor in the bathroom barefoot. The bed/chair alarm failed to sound when Resident G got up. The new intervention, dated 5/25/23, indicated "Offer toileting at beginning of shift. Encourage activities in between meals." Fall 7 On 5/29/23 at 1:00 P.M., another resident's family member notified staff that they witnessed Resident G fall from her wheelchair to the floor. Neuro assessments were completed at 1:00 P.M., 1:15 P.M., 1:30 P.M., and 1:45 P.M. The clinical record lacked neuro checks after that time. The new intervention, dated 5/30/23, indicated "Dycem to w/c [wheelchair]. Monitor placement every shift. Ensure pad alarm to chair and foot pedals in place." Interview on 6/29/23 at 12:30 P.M., CNA (Certified Nurse Aide) 6 indicated that the bed alarm and chair alarm were the only interventions used to keep Resident G from falling, and all staff should check both alarms daily. Interview on 6/29/23 at 2:25 P.M., LPN (Licensed Practical Nurse) 14 indicated the following interventions are put into place to prevent Resident G from falling: bed alarm, chair alarm, call light enhancement device, call don't fall signs to her walker and placed in her room, toilet resident every 2 hours, and that Resident G did not utilize foot pedals on her wheelchair. At that time, LPN 14 indicated that the bed and chair alarms should be checked daily, and there are times that the alarms do not work properly due to the batteries going dead. She further indicated that a new intervention should be put into place after each fall.			

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	Interview on 3/30/23 at 3:13 P.M., the DON (Director of Nursing) indicated on the 3/30/23 fall, she was unsure if a gait belt was used at the time of the fall, and that staff was moving the wheelchair back to the resident when she fell. At that time, the DON indicated that she was unsure why the alarm wasn't sounding for all the falls and staff should check to make sure the alarms are working every time they go in the room. The DON indicated that Resident G should have foot pedals on her wheelchair at all times when she is in it. On 6/29/23 at 4:00 P.M., the CNA sheet was reviewed for 6/28/23 and 6/29/23. The sheet indicated Resident G should have foot pedals in place on the wheelchair. On 6/29/23 at 5:40 P.M., the Administrator, DON, and Regional Consultant provided a summary of Resident G's falls and the Regional consultant indicated "They don't know what else they could have done to keep her from falling." 2. On 6/27/23 at 2:19 P.M., Resident D was seated in a recliner in the commons area of the locked dementia unit. On 6/27/23 at 2:00 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors, unsteady gait, repeated falls, and weakness. The most recent quarterly MDS Assessment, dated 5/9/23, indicated Resident D was severely cognitively impaired and an extensive assist of 1 for bed mobility, transfers, and toileting. Current physician orders included, but were not limited to, the following: Offer routine toileting through the night, offer to toilet after supper and at HS, check every 2 hours			

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	through night if dry offer to toilet, dated 7/23/20, and discontinued 6/28/23 Activity: up independently in room and supervision in common areas, dated 10/30/20 Staff to set out outfit for the next day during HS care and hang on closet door as visual for resident, dated 11/7/22 Staff to offer resident toileting at least every two hours, dated 4/6/23 A current risk to fall care plan, dated 2/25/20, included, but was not limited to, the following interventions: Offer toileting at least every every 2 hours, initiated 4/8/2020 Provide non-skid footwear, initiated 2/25/20 Resident D's fall history included the following: Fall #1 On 4/1/23 at 4:30 A.M., Resident D was found sitting on the floor on her bottom beside her bed. Resident indicated to staff she didn't know what happened. No injuries were noted. The new intervention, dated 4/6/23, indicated staff was to encourage resident to use the bathroom every 2 hours or so. The intervention was already listed on the care plan dated 4/8/20. Fall #2 On 5/2/23 at 12:01 A.M., Resident D was seen reaching for an incontinence pad while on the commode as staff entered the resident's room. Resident D fell onto her knees and laid on the floor. No injuries were noted, other than redness to bilateral knees. "Nonskid socks placed on			

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	resident as safety measure". The new intervention at that time, was placing nonskid socks on resident and anti slip strips in front of toilet in efforts to decrease risk of sliding. Provide non-skid footwear was listed as an intervention, dated 2/25/20. Resident D experienced three falls from 5/2/23 at 3:30 P.M. to 5/25/23 at 5:30 P.M. without injuries. On 6/29/23 at 11:27 A.M., the bathroom floor in Resident D's room was observed to have puddles of water and wetness over the entire floor. No one was present in the room and no caution signs were posted. Interview on 6/29/23 at 11:52 A.M., CNA 8 and LPN 14 observed the puddles of water and wet floor and LPN 14 indicated housekeeping must have cleaned the floor and there should have been a sign placed on the door that told the resident not to enter because of the wet floor. At that time, she indicated the resident did well with signs and would comply with that. She further indicated 1 staff was supposed to assist the resident if she was going to her room. Interview on 6/29/23 at 3:14 P.M., CNA 10 indicated that the 6/29/23, the CNA sheet indicated the resident was independent in her room and supervision in the commons area, but that wasn't right. The resident was supposed to be an assist of 1 in her room and supervision in the commons area. LPN 14 indicated Resident D was an assist of 1 even though the current order says independent in room. CNA 8 indicated that she wouldn't feel comfortable letting Resident D walk to her room or go to the bathroom by herself because she has fallen too many times. At that time, CNA 10 indicated that staff get out Resident			

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	D's clothes including socks and shoes for her to wear and help her get dressed. 3. During a random observation on 6/29/23 at 11:25 A.M., the medication cart on the locked dementia unit was unlocked and resident information was visible on computer screen. At 11:30 A.M., the DON walked past the cart walking down the hall and again when she came back up the hall at 11:33 A.M. The Maintenance Man and a construction worker walked down and up hall at 11:35 AM. CNA 6 walked down and up the hall past the cart at 11:36 A.M. LPN 14 walked down and up the hall past the cart at 11:37 A.M. A resident on the locked unit walked down and up the hall past the cart at 11:39 A.M. At 11:42 A.M., a housekeeper went up and down the hall past the cart. At 11:57 A.M., the cart was locked and resident info was off the screen. Interview on 6/29/23 at 3:15 P.M., the DON indicated they have identified falls as a concern and have discussed it in the QAPI (Quality Assurance and Performance Improvement) meetings. She indicated there are a variety of reasons for falls. Some residents were impulsive and got up on their own and some don't utilize their call lights. At that time, the DON indicated the medication cart should be locked any time there was not a nurse in front of it. On 6/29/23 at 1:00 P.M., the Administrator provided the Falls Management Program Guidelines policy, reviewed, 3/16/22. The policy indicated "[name of company] strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...The resident care plan should be updated to reflect any new or change in interventions ... "			

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	On 6/29/23 at 4:28 P.M., the Administrator provided the Guidelines for Neurological Checks policy, revised 3/16/22. The policy indicated "Neuro-checks for 24 hours should be completed within the Fall Event Form...Obtain vital signs with each assessment..." At that time, the DON indicated neuro checks are completed when a fall was unwitnessed for the following duration: every 15 minutes times 4, every 30 minutes times 4, every 60 minutes times 4, and every 4 hours times 4. On 6/29/23 at 4:28 P.M., the Administrator provided a current Medication Administration policy, revised November 2018. The policy indicated " ... 15. During administration of medications, the medication cart is kept closed and locked when out of sight of the facility medication administration personnel ... In addition, privacy is maintained at all times for all resident information (e.g., MAR [medication administration record]) when not in use ... " This Federal tag relates to Complaint IN00409650. 3.1-45(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to ensure infection control practices were in place for 4 of 5 residents observed during perineal/incontinence care. Staff failed to sanitize hands and change gloves between dirty to clean tasks. Staff failed to lather for at least 20 seconds when washing hands. (Resident B, Resident C, Resident D, Resident E) Findings include: 1. On 6/28/23 at 8:26 A.M., Resident B was observed for perineal care. CNA (Certified Nurse Aide) 4 and CNA 6 entered the residents room with the resident in her wheelchair. Once in the bathroom, CNA 4 and CNA 6 washed their hands. CNA 6 washed using a 15 second lather. Both CNAs put on gloves. Resident B stood using the grab bar on the wall for assistance. CNA 4 pulled down the resident's pants and incontinence pad	F 0880	1. Residents B, C, D, and E suffered no ill effects from the deficient practice. CNA #4, CNA #6, and QMA #20 were educated on proper handwashing procedures. QMA #20 was educated on changing gloves between dirty and clean tasks. CNA #18 and QMA #20 were educated on hand sanitation between glove changes. 2. All residents have the potential to be affected. Handwashing education with nursing staff to ensure return demonstration meets requirements. Education with nursing staff to ensure infection control practices of hand sanitation and changing of gloves	07/28/2023

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	while CNA 6 pulled the wheelchair out from behind the resident. CNA 4 transferred resident to the toilet. When resident was finished, CNA 4 stood in front of the resident, wiped perineal area from front to back, folded the same wipe and wiped front to back again. She then grabbed a new wipe and wiped the resident's backside. CNA 4 grabbed another wipe and wiped the backside again. She then removed her gloves. CNA 6 pulled up Resident B's pants then transferred her to the wheelchair and took off the gait belt. CNA 4 washed hands with an 18 second lather and CNA 6 with a 10 second lather. 2. On 6/28/23 at 8:56 A.M., Resident C was observed for perineal care. CNA 18 entered the resident's room and sanitized her hands with ABHR (alcohol-based hand rub). CNA 18 put on gloves and pulled Resident C's pants and incontinence pad down then assisted Resident C down to the toilet. When resident was finished, CNA 18 stood behind the resident and wiped the resident from front to back, folded the same wipe and wiped again. CNA 18 applied cream to buttocks with the same gloves. CNA 18 took off her gloves and put on new gloves without sanitizing her hands. CNA 18 pulled up Resident B's incontinence pad and pants and then pulled the resident's shirt down. 3. On 6/28/23 at 8:37 A.M., CNA 4 and CNA 6 were observed performing perineal care on Resident D. Upon entering the room, CNA 6 washed hands with an 11 second lather. Both CNAs put on gloves. CNA 6 transferred resident to the front of the toilet and then pulled residents pants and soiled incontinence pad down. Once resident was seated, CNA 6 grabbed a new incontinence pad from the shelf. CNA 6 then noticed a wet area on the floor and wiped the floor		between dirty to clean tasks occur. 3. As a measure of ongoing compliance: The DHS or designee will observe 1 random nursing staff for proper handwashing daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks, then monthly x3 months. The DHS/designee will observe 1 random nursing staff for glove change between dirty and clean tasks daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks, then monthly x3 months. The DHS/designee will observe 1 random nursing staff daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks, then monthly x3 months to ensure proper hand sanitation occurs between glove changes. 4. As a quality measure, the DHS or designee will review any findings and corrective action weekly in QAPI meetings until achieved compliance, then at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	155493	A. BUILDING 00 B. WING	06/29/2023

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	with a paper towel. CNA 4 put Resident D's pants and new incontinence pad on. CNA 6 took off gloves and washed hands with a 15 second lather before putting on new gloves. CNA 4 grabbed the package of the wipes, set them on back of toilet, picked up resident's shoes, and touched the bottom of the shoes while she put them on. CNA 4 took those gloves off, washed hands with a 23 second lather and put new gloves on. CNA 6 stood in front of the resident and helped her stand from the toilet. CNA 4 stood in front of the resident and wiped resident from front to back, folded the wipe and wiped again. She grabbed a new wipe, stood behind the resident, and wiped front to back again then folded it and did backside only. CNA 4 took off her gloves. CNA 6 pulled up Resident D's incontinence pad and pants. CNA 4 washed her hands with a 22 second lather and CNA 6 removed her gloves and washed her hands with a 12 second lather. 4. On 6/28/23 at 10:31 A.M., QMA (Qualified Medication Aide) 20 was observed performing incontinence care on Resident E. QMA 20 washed her hands with a 16 second lather, put on gloves, used controller to raise Resident E's bed, and uncovered the resident. The DON sanitized hands using ABHR and went to the left side of the bed. QMA 20 stood on the right side of the bed and pulled down the resident's pants and unfastened the soiled incontinence pad. QMA 20 grabbed a wipe and wiped the resident's front, grabbed another wipe, and wiped the front again. Then rolled the resident to his left side. QMA 20 took off soiled incontinence pad and put it into trash. She grabbed a new wipe and wiped the backside of Resident E from front to back. She grabbed a new wipe, wiped the backside from front to back and then took off her gloves. She put new gloves on and wiped front to back with a new wipe. She			

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	placed the new incontinence pad under the resident and rolled the resident to the right side. The DON pulled out the incontinence brief from the left side. QMA 20 took her gloves off and put on new gloves without sanitizing her hands then transferred resident from his bed into his high back wheelchair using a lift. Interview on 6/29/23 at 3:15 P.M., the DON indicated when doing incontinence care, staff should change gloves between performing dirty and clean tasks and should be sanitizing hands or performing washing hands when they take gloves off and before putting new gloves on. Brainwashing should include 20 seconds of scrubbing all parts of the hands. A current handwashing policy, revised 2/9/17, was provided by the Administrator on 6/29/23 at 4:28 P.M., and indicated " ... health care workers shall use hand hygiene at times such as ... a. Before/after having direct physical contact with residents ... d. After removing gloves, worn per standard precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc ... Procedures: 1. Handwashing a. Turn water on to a comfortable temperature b. Wet hands with running water. Apply liquid soap and work into a lather. c. Wash well for at least 20 seconds, using a rotary motion and friction. d. Rinse hands well under running water, allowing water to flush from wrist to fingertips. e. Dry hands with paper towel(s). f. Turn off faucet with paper towel to avoid recontamination hands from the faucet ... " This Federal tag relates to Complaint IN00409650. 3.1-18(l)			

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