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	04/20/2023

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00404115, IN00401456, IN00397288, IN00391267, IN00391324, IN00389222 and IN00385467. Complaint IN00404115- No deficiencies related to the allegations are cited. Complaint IN00401456- State deficiencies related to the allegations are cited at R273. Complaint IN00397288 - No deficiencies related to the allegations are cited. Complaint IN00391267 - No deficiencies related to the allegations are cited. Complaint IN00391324 - No deficiencies related to the allegations are cited. Complaint IN00389222 - No deficiencies related to the allegations are cited. Complaint IN00385467 - No deficiencies related to the allegations are cited. Survey dates: April 17,18, 19 and 20, 2023 Facility number: 002656 Residential Census: 54 These State Residential Findings are cited in accordance 410 IAC 16.2-5. Quality review completed 5/9/2023.	R 0000	The following is the Plan of Correction for Brookdale Granger regarding the Statement of Deficiencies dated April 20, 2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Carney	Executive Director	05/22/2023

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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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 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 interview and record review, the facility failed to ensure a fire and disaster drill was attempted every six months in conjunction with the local fire department. This had the potential to affect 54 of 54 residents residing at the facility. Finding includes: On 4/18/2023 at 9:47 A.M., the Executive Director indicated that they did not contact the local fire department last year to conduct a fire and disaster drill.	R 0092	**R092-Based on interview and record review, the facility failed to ensure a fire and disaster drill was attempted every six months in conjunction with the local fire department. This had the potential to affect 54 of 54 residents residing at the facility.**	05/11/2023

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	On 4/18/2023 at 9:52 A.M., the Executive Director provided a policy titled, "Fire Drill", revised 4/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Fire drills shall be conducted on a monthly basis with every shift participating at least once per quarter, or as per state regulation...."		· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected by the alleged deficient practice. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Alleged deficient practice has the potential to affect all residents. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Maintenance Manager in serviced on state regulation that fire drills must be conducted in conjunction with local fire department every 6 months. Fire drill with local fire department conducted on 5.11.23. Maintenance manager will schedule fire drill with fire department every 6 months going forward. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance Manager will schedule and hold fire drill with the fire department every 6 months. Maintenance Manager will document fire drills with fire department in work order documentation system. ED to	

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			monitor work order system 1x monthly for 12 months to verify monthly fire drill occurs including fire drill with the fire department every 6 months. · By what date the systemic changes will be completed. 5.11.23	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of			

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	the services to be provided. Based on observation, record review and interview, the facility failed to ensure the service plan regarding fall risk was implemented and revised as needed for 1 of 5 residents reviewed. (Resident E) In addition, the facility failed to ensure 2 of 7 service plans were signed and dated by either the resident and/or the residents' representatives. (Residents F and H) Findings include: 1. During an observation on 4/17/2023 at 10:00 AM., Resident E was seated in his wheelchair in the doorway to his bathroom, receiving facial shaving assistance from a nursing staff member. CNA 8 indicated the resident required total staff for all daily living except eating needs. A large recliner and a regular twin bed, were observed in his room. During an observation of Resident E on 4/20/2023 at 11:00 A.M., he was sleeping in a smaller power recliner in his room. The resident was noted to be wearing regular socks and his shoes had been removed. At 11:30 A.M., CNA 8 was observed to use the lift mechanism of the recliner chair, assist Resident E with putting on his shoes and cue and physically assist the resident to transfer from the recliner to his wheelchair. The resident transferred and pivoted with one assist but kept his knees bent during the transfer. The record for Resident E was reviewed on 4/18/2023 at 10:30 A.M. Resident E was admitted to the facility on 5/12/2022. His initial service plan, completed on 5/15/2022 indicated Resident E required assistance for transportation to and from the dining room, and	R 0217	**R 217 Evaluation Deficiency-Service Plans** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Clinical Specialist or designee to review service plans with residents by 5.26.23. Residents will be offered opportunity to sign service plans by 5.26.23. Fall intervention addendum to care plan put into place for residents affected on 5.9.23 · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Clinical Specialist completed audit of service plans for residents on 5.16.23. Clinical Specialist or designee will review service plans with 8 identified residents by 5.26.23. Residents will be offered opportunity to sign service plans by 5.26.23. Fall intervention addendum to care plan put into place for 8 residents identified on 5.9.23 · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Clinical Specialist or designee to review service plans with resident or responsible party 2x annually and with change in	05/19/2023

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	staff were to be alert to heightened risk for falling. The resident utilized a wheelchair as a mobility aid. The plan also mentioned the following "Universal Fall Precautions" for Resident E: "Familiarize resident to the environment and routine of the community as needed, Familiarize resident with the call system and have him/her demonstrate use, Be alert to placing resident's personal items within reach, Educate resident on reducing environmental clutter and arrange furniture for adequate walkways, Familiarize resident with handrail in bathrooms, Bed should be kept in locked position if applicable, Bed should be in the low position when resident is resting in bed, bed should be raised, if possible , to a comfortable height when assisting the resident with transfer, resident wheelchair should be in the locked position if stationary, Floor should be clean and dry. Clean spills promptly, Educate resident on use of comfortable properly flitting non slip footwear, Educate resident on supplemental lighting, nightlights and Follow safe handling practice....In addition the following was included: "...Additional Personalization of Falls Management is considered based on the resident's history while balancing independence dignity and choice....Potential Interventions - sometimes interventions that may be utilized for Falls Management are declined by Resident and/or their legal representatives after weighing the benefits to the resident versus the impact to their independence, lifestyle willingness to engage in change and/or cost. Potential interventions specifically chosen by the Resident and/or Legal representative not to be used: Encourage use of furniture corners or removal of sharp edged furniture in apartment if needed, Encourage use of contrasting wall color behind toilet for visual cue to aid in defining toilet boundaries, Encourage use of hip protectors to		condition as per community policy. Resident/responsible party will be given the opportunity to sign service plans going forward. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and; ED or designee to review and sign ~~all~~ service plans for compliance 1x monthly for 6 months and until alleged deficient practice is corrected. · By what date the systemic changes will be completed. 5.19.23	

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	reduce risk of injury related to falls, especially re. osteoporosis, Encourage use of low bed, Encourage use of scoop mattress to prompt resident to call for help and to define bed boundaries and reduce the risk of sliding from bed, Encourage use of bedside fall cushion mat to reduce impact if at risk for falls from bed, Encourage use of high-rise toilet seat for easier sit to stand movements, Fall intervention(s) not listed above...." The most recent service plan for Resident E, completed on 12/9/2022 had the exact same verbage regarding fall risk and interventions. . The Progress Notes from January 2023 through April 20, 2023 for Resident E indicated he had fallen 10 times. The resident slid off the toilet once, fell out of his wheelchair once but other times was found beside his bed. The resident did incur a laceration above his eye as a result of one of his falls. During an interview with CNAs 6 and 7, on 4/18/2023 at 9:50 A.M., they indicated they were not aware of any specific fall intervention in place for Resident E. Both CNAs indicated the resident required two person assist for transfers and toileting needs. During an interview with the Executive Director, on 4/20/2023 at 9:48 A.M., she indicated the facility had a fall management policy and an "addendum" was to be completed after resident falls with any new and/or personalized intervention denoted on the form. After looking for any such "addendum" completed for any of Resident E's falls, the ED indicated she could not find any.2. The record review for Resident H was reviewed on 4/17/2023 at 2:00 P.M. The diagnoses			

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	included, but were not limited to: chronic kidney disease, Alzheimer's disease, and hypertension. During an interview on 4/18/2023 at 10:15 A.M., the Clinical Specialist indicated that Resident H did not have a signed and dated service plan. The policy and procedure, titled....and provided by the ED on 4/20/2023 at 11:10 A.M., included the following: ..."Residents have the potential to fall and therefore has identified universal fall precautions applicable to residents. A fall risk evaluation is completed at the time of move in/admission. A witnessed or reported unwitnessed fall, with or without injury, is reported in the facility reporting system. Resident who sustain a fall should have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury...4. A post fall evaluation is completed after a resident fall, individualized interventions are considered, and the evaluation is a part of the resident record. 5. When a fall occurs: a. In Assisted Living:...v. Document the resident fall/injuries, resident response, and interventions taken in the Point Click Care (PCC) Progress Notes. vi. Service Plan is reviewed for potential fall interventions and updated as necessary. See Fall Interventions Clinical guideline....." The facility policy and procedure, titled...., "Service Plan Process Policy" provided by the Executive Director on 4/20/2023 at 10:52 A.M., included the following: "...6. Upon initial review and subsequent changes, members of the community care team that contributed to the service plan, including the ED or designee, or nurse and the resident/legally responsible party should sign the service plan...."			

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R 0271 Bldg. 00	410 IAC 16.2-5-5.1(d) Food and Nutritional Services - Deficiency (d) All modified diets shall be prescribed by the attending physician. Based on observation, record review and interview, the facility failed to prepare and serve modified diets for 8 of 40 residents with physician orders for modified diets. (Resident E, H, L, M, N, O, P and Q) Findings include: 1. During an observation of the noon meal service, on 4/17/2023 at 12:00 P.M., the FSS (Food Service Supervisor) was serving residents a bar-b-que pork rib, baked beans, Italian style green beans and apple crisp. There were a few residents served a grilled chicken breast, if they did not like pork. The FSS was observed to remove the pork from the bone and chop the meat into bite sized pieces for residents. Cook 5 indicated she had misread the menu and accidentally prepared the green beans instead of the southern style greens. The menu for the noon meal on 4/17/2023 indicated the carbohydrate controlled diets were to be offered reduced sugar strawberry cream pie, the low fat/low cholesterol were to be served 3 ounces of roast beef instead of the ribs and reduced sugar strawberry cream pie instead of the apple crisp, the modified texture, ground meat was to be served two 1/2 scoops of deboned ground pork rib meat with 2 ounces of gravy, and the 2 gram sodium diets were to be served steamed green beans and steamed spinach instead of the baked beans and the Southern style greens. 2. During an observation of the noon meal service, conducted on 4/18/2023 at 12:00 P.M., Cook 5 was observed to serve breaded cod filets,	R 0271	**R-271 Based on observation, record review and interview, the facility failed to prepare and serve modified diets for 8 of 40 residents with physician orders for modified diets. (Resident E, H, L, M, N, O, P and Q)** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident service plans were audited for diet accuracy. Diet orders were confirmed and communicated with dining service director for the 8 residents identified. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; audit of diet orders completed on xx/xx/xxxx. 8 residents on modified diets could potentially be affected by alleged deficient practice. These residents will be offered proper diet going forward. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice	05/24/2023

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	herbed rice and Southern style greens and yellow cake with chocolate icing. The Cook indicated she did not make the m Baked Sole Almondine and had prepared breaded chicken fingers for the residents that did not like fish. The cook was observed to chop either chicken fingers or fish fillets into bite sized pieces. The menu for the noon meal, on 4/18/2023 indicated the carbohydrate controlled diets and low cholesterol/low fat diets were to be served reduced sugar frosted apple cake instead of the Bavarian Apple Tart. The texture modified ground meat was to be served baked sole with 2 ounces of Velpute (sic) sauce or other sauce. The 2 gram sodium were to be served low sodium applesauce spice bars instead of the Bavarian tart. During an interview with the FSS (Food Service Supervisor), during the serving of the noon meal, on 4/18/2023 at 12:00 P.M., he indicated the facility sometimes prepared the sugar free desserts. He indicated all the food was prepared without seasonings and salt as residents had salt and pepper at the table. He indicated he prepared specific foods for the one resident requiring a renal diet but she currently was hospitalized. 3. Review of the physician orders for diets, on 4/20/2023 at 10:00 A.M., indicated the following residents had orders for modified diets: Resident N had an order for carbohydrate controlled Resident O had an order for low fat/low cholesterol Residents E, H, L, M and Q had an order for 2 gram sodium (low sodium diet) Resident P had an order for modified texture, ground meat/mechanical soft		does not recur; Dining manager to be retrained on how to read physician sheets, review of menu manager program, how to properly read nutrition tracker and match dining orders, and how to read and properly use daily modification sheets for special diets. Dining manager will verify there is an accurate list of residents who are on a modified diet available to dining associates. Dining manager will verify diet modification recipes are available. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and HWD will verify diets on all new admissions and changes on current residents, diet order sheet will be completed and copies given to dietary manager and ED. ED or designee will monitor that modified diets are offered per menu 5x weekly on rotating meal periods for 4 weeks; then 1x weekly on rotating meal periods for 4 weeks; and then 1x monthly for 3 months . · By what date the systemic changes will be completed 5.24.23 !--[if !supportAnnotations]-->	

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	The policy and procedure, titled, "Diet Manual/Menu" provided by the Executive Director on 4/20/2023 at 10:30 A.M. included the following: "...4. The diet manual is to be used as a reference to assure that the Regular Diet and all therapeutic diets are planned and prepared as ordered by the physician...." The Executive Director also provided a copy of the complete diet manual which included specific instructions and guidelines for preparing each type of modified diet.			
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, record review and interview, the facility failed to ensure food was stored, prepared and served in a sanitary manner for 1 of 1 kitchen observed. This deficient practice had the potential to affect 40 of 40 residents who consumed food. Findings include: 1.During an tour of the kitchen, conducted on 4/17/2023 between 9:20 A.M. - 9:50 A.M., the following observed: The floor underneath the shelving, in the dry storage room had a heavy accumulation of grime, food crumbs and miscellaneous paper products. There was an open bag of salt with the top of the bag rolled, half hazardously up and no date on the bag to indicate with it had been opened. There was an opened container of peanut butter with no date to indicate when it had been opened. The floors underneath the food preparation	R 0273	**R 273 Based on observation, record review and interview, the facility failed to ensure food was stored, prepared and served in a sanitary manner for 1 of 1 kitchen observed. This deficient practice had the potential to affect 40 of 40 residents who consumed food.** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All outdated food has been disposed of. No residents affected by alleged deficient practice. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what	05/24/2023

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	counters were noted to be heavily soiled with grime, food crumbs and miscellaneous paper products. There was a cart, stored in the dry storage room, with a cookie oven on the top shelf of the cart. The cart was heavily soiled with food crumbs and yellow grime. The refrigerator in the kitchen had opened bags of sliced meat, hot dogs, cheeses and mixed vegetables, none of the bags were labeled or dated and the hot dog bag was opened to air. There were were also spilled red liquid on the rim of the bottom of the refrigerator. There were also plastic pitchers of tomato juice, yellow liquid, dark brown liquid and red liquid without labels or dates. There were silicone molds with frozen pureed food, unlabeled in the freezer. In addition, the bottom of the refrigerator had approximately an inch of standing water than ran all over the floor with the lower crisper drawers were pulled out. The floor underneath the ice machine and the floor mat underneath the ice machine had a heavy accumulation of grime. In addition, ice scoop was lying on top of the ice machine. There was a thin layer of dust on the top of the ice machine. The shelving on the open shelving unit, beside the ice machine, used to store bread and bread type products, had a heavy accumulation of crumbs. 2. During the noon meal service, conducted on 4/17/2023 at 12:00 P.M., the FSS (Food Service Supervisor) had donned gloves and was observed to touch plates, his glasses, handles of large serving spoons and utensils, the outside of a bread bag and then reached into the bag and touched the bread slices with his contaminated gloved hand. He then proceeded to obtain packaged meat slices from the refrigerator and		corrective action will be taken; Alleged deficient practice had the potential to affect all residents. Deep clean of the kitchen including completed on 4.24.23. Community audited food in fridges, freezers and dry pantry on 4.23.23. Food is dated labeled and appropriately stored per community policy. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DSM to be retrained on dating and labeling foods, handwashing, creating a cleaning list for community, sanitation walk through and general sanitation of dining department. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED or designee will monitor kitchen 5x weekly for 4 weeks; then 1xweekly for 4 weeks then 1x monthly for 3 months to verify that foods are properly dated and labeled, proper handwashing techniques are utilized and that a cleaning/sanitation list in the kitchen is implemented and utilized. · By what date the systemic changes will be completed. 5.24.23	

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		A. BUILDING 00 B. WING	04/20/2023

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	used the same contaminated gloved hands and handled meat slices to place them onto the bread. 3. During the noon meal service, conducted on 4/18/2023 at 12:00 P.M., the FSS was observed serving resident plates with gloved hands. He was observed to put a fish fillet to the side of the plates with his gloved hands so he could place a spoonful of tartar sauce onto the plate. Cook 5, who was serving the food, who was wearing gloves, had touched handles of serving utensils, plates and then touched fish filets with her contaminated gloved hands to arrange other food items on the plate. The facility policy and procedure, titled "Cleaning Schedule" provided by the Executive Director on 4/18/2023 at 9:48 A.M. included the following: "...In order to serve food in a safe and sanitary manner, a cleaning schedule must b posted and initiated to ensure that all cleaning tasks are completed....The Dining Services Management reviews the cleaning schedule to be certain that the cleaning is thoroughly completed...." The facility policy and procedure, titled "Labeling" provided by the Executive Director on 4/18/2023 at 9:48 A.M., included the following: "...1. All food items...upon receipt from food vendors must have a date marked before putting in any storage (dry, refrigerator, freezer, pantry). This should be done even if the food items has a "use by" or "sell by" date marked by the manufacturer. 2. All prepared items (i.e. leftovers or prepared for next meal) must have a label with the name of item, date prepared, by whom, and date of discard...." The facility policy and procedure, titled, "Serving Food" provided by the Executive Director on		!--[if="" !supportannotations]--="">	

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	4/18/2023 at 9:48 A.M., included the following: "The Dining Services Management should ensure foods are served using clean and sanitized utensils. When utensils are not practical, certain foods may be served by first washing hands and then wearing approved food handling gloves...3. When gloves become soiled by touching soiled or dirty items,, gloves must be removed ,,, hands washed and new gloves put on...." 410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.			
R 0356 Bldg. 00	Based on observation, record review and interview, the facility failed to ensure the emergency file for Residents included a hospital preference for 3 of 7 records reviewed. (Resident E, B and D) Findings include:	R 0356	**R-356 Clinical Records Hospital Preference** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Hospital preference will be noted	05/19/2023

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	1. The record for Resident E was reviewed on 4/17/2023 at 2:00 P.M. The emergency file information form, also utilized in the facility Emergency Binder did not denote hospital preference. 2. The record for Resident B was reviewed on 4/19/2023 at 10:00 A.M. During an interview on 4/19/2023 at 11:57 A.M., the Clinical Specialist indicated that Resident B did not have a hospital preference listed on his emergency information file. 3. The record for Resident D was reviewed on 4/19/2023 at 11:00 A.M. The emergency file information form, also utilized in the facility Emergency Binder, did not denote hospital preference. On 4/19/2023 at 1:45 P.M. an interview with the Executive Director indicated the facility did not have a policy for the Emergency Information and should have identified a hospital preference on the clinical records.		on face sheets for 3 residents identified. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; audit of emergency files for residents completed on 4.24.23.Resident records found to have hospital preferences noted. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Clinical Specialist or designee will verify hospital preference is documented on each resident face sheet upon move in to the community. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Executive Director or designee will review face sheets of resident move ins 1x monthly for 6 months and then randomly to verify hospital preference is noted on face sheet. · By what date the systemic changes will be completed. 5.19.23	
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: (1) A system that enables the facility to			

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	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 record review and interview, the facility failed to establish an infection control program that included, but not limited to, a system that enables the facility to analyze patterns of known infection symptoms and ongoing analysis of surveillance data and review of data and documentation of follow-up activity. This had the potential to affect 54 of 54 residents who reside in the facility. Finding includes: During an interview on 4/19/2023 at 2:30 P.M., the Clinical Specialist provided a blank infection control log and indicated she did not see any of them filled out. The facility did have a section in electronic charting program called clinical overview where you can see urinary tract and respiratory infections. They did not have a staff member assigned to monitor and carry out an infection control program. On 4/19/2023 at 2:50 P.M., the Clinical Specialist provided a policy titled, "Communicable Disease Control", revised 4/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy Overview: The community nurse leader (Health and Wellness Director (HWD)/Director of Clinical Services (DCS)/designee is responsible for monitoring	R 0407	**R407 Infection Control –Infection control tracker** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Infection control binder was immediately put in place; No residents affected by alleged deficient practice. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Alleged deficient practice had the potential to affect all residents. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Health and Wellness Director will be infection control designee. Community has implemented infection control tracker. Clinical Specialist or designee to review infection control tracker on a monthly basis to analyze patterns of known	04/24/2023

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	infections on an ongoing basis to assist in the prevention, transmission, and mitigation of communicable disease and infection. B. Infectious or Contagious Disease Identified: 6. Separate confidential lists of residents and associates with symptoms of the disease should be maintained and tracked to monitor the course of the disease and outcomes...."		infectious symptoms · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ED or designee to meet with HWD 1x monthly for 6 months to verify the accuracy of infection control log. · By what date the systemic changes will be completed. 4.24.23 !--[if !supportAnnotations]-->	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure an annual health statement was in place for 2 out of 7 resident charts reviewed. (Resident H & E) Findings include: 1. The record for Resident H was reviewed on 4/17/2023 at 2:00 P.M. Diagnoses included, but were not limited to: chronic kidney disease, Alzheimer's disease, and hypertension. During an interview on 4/18/2023 at 10:43 A.M., the Clinical Specialist indicated that Resident H did not have an annual health statement.2. The	R 0409	**R409- Infection Control- Health Statement** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; MD notified that resident did not have health statement. TB surveillance completed for 2 identified residents. MD notified of results. Verbal order given/received that resident is free from communicable disease including tuberculosis.	05/16/2023

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	clinical record for Resident E was reviewed on 4/17/2023 at 2:00 P.M. The Physician's Orders for Resident E did not contain a health statement indicating Resident E was free from any communicable diseases including Tuberculosis. On 4/19/2023 at 11:26 A.M., the Clinical Specialist provided a policy titled, "Tuberculosis Screening/Testing", revised 1/2023, and indicated the policy is the one currently used by the facility. The policy indicated "...A statement that the resident shows no evidence of tuberculosis in an infectious stage is verified upon admission and yearly...."		· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Audit of health assessments for ~~all~~ residents completed on 5.16.24. Resident's health assessments found to be in compliance. · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Health and Wellness Director or designee to review health statement for each prospective resident prior to admission to community. Health statements to be received prior to move in per community policy. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ED or designee to review admission paperwork 1x monthly for 6 months to verify health statement has been received and reviewed by HWD . · By what date the systemic changes will be completed. 5.16.24	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to			

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	admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to ensure Tuberculin Test on, or prior to admission and second step were completed for 2 out of 7 resident charts reviewed . (Resident B & E) Findings include: 1. The record review for Resident B was reviewed on 4/19/2023 at 10:00 A.M. During an interview on 4/19/2023 at 11:00 A.M., the Clinical Specialist indicated that Resident B did not have an admission Tuberculin Test and 2nd step and should have.2. The record for Resident E was reviewed on 4/17/2023 at 2:00 P.M. Resident E was admitted to the facility on 5/12/2022. The resident had a Mantoux Tuberculin skin test completed on 6/21/2022. During an interview with the Executive Director,	R 0410	**R410- Infection Control- TB administration resdidents** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 2 residents identified received first step of two step PPD on 5.15.24. Second step PPD to be administered by 5.24.23. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A review of resident records were reviewed. Twelve residents identified- and received first step of two step PPD test on 5.15.23.	05/24/2023

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	completed on 4/20/23 at 10:50 A.M., she confirmed there was no other Tuberculin skin testing documentation located for Resident E. On 4/19/2023 at 11:26 A.M., the Clinical Specialist provided a policy titled, "Tuberculosis Screening/Testing", revised 1/2023, and indicated the policy is the one currently used by the facility. The policy indicated "...A TB skin test shall be completed within 3 months prior to admission and read at 48-72 hrs. For residents who have not had a documented negative TB skin test during the preceding 12 months, the baseline TB shall employ the 2-step method. If the 1st step is negative, a 2nd step shall be performed within 1-3 weeks after the 1st test. The frequency of repeat testing will depend on the risk of infection...."		These residents will receive second step of PPD test by 5.24.23 · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Clinical Specialist or designee to create tracker for residents. Residents to be added to tracker upon admission to community. Clinical specialist or designee to verify through emar system that two steb tb process is completed for each resident. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and ED or designee to review tracker 1x monthly for 6 months to verify new residents receive two step tb upon admission. · By what date the systemic changes will be completed. 5.24.23	