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	02/01/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00405881. Complaint IN00405881 - No deficiencies related to the allegations are cited. Survey dates: January 31 and February 1, 2024. Facility number: 004392 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 16, 2024.	R 0000		
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			

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

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	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 record review and interview, the facility failed to attempt to hold a fire drill in conjunction with the local fire department at least every 6 months. Finding includes: During a record review of the facility fire drills, on 2/1/2024 at 4:48 p.m., the facility failed to contact the local fire department to hold a fire drill in conjunction with the local fire department at least every 6 months in the 12-month period. During an interview, on 2/1/2024 at 5:05 p.m., the Executive Director indicated she could not locate any fire drill records for December 2023 and January 2024. She indicated the facility did not contact the local fire department from January 2023 through January 2024 regarding any fire drills conducted at the facility. She indicated the facility did not have a policy and procedure for this activity.	R 0092	Plan of Correction Deficiency ID: R_0092 Completion Date: 3/1/2024 1. The Executive Director held a fire drill on 2/6/2024 at 2:15pm with 1st and 2nd shift. The inspector from the Lafayette Fire Department, Richard Dehahn was contacted requesting information on who to contact to invite for future drills 2. The Facility Operations Assistant or the ED will conduct monthly fire drills on rotating shifts throughout the year. LFD will be invited every March and September. 3.The ED was retrained by the Regional Director of Facility Operations on the regulations regarding fire safety on 2/28/2024. 4. A monthly audit of fire drills and invitation of the fire department will be conducted by the ED and discussed in the QI meeting	03/01/2024

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			monthly to ensure compliance. Audits will continue monthly for 12 months. QI committee will discuss ongoing audits after 12 months of 100% compliance. 5. Monitoring will be ongoing. Request IDR due to having completed required drills and request LFD attendance	
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 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 record review and interview, the facility	R 0117	Plan of Correction	03/01/2024

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	failed to ensure the staff on duty met the requirements of first aid training certification for 5 of 21 shifts reviewed for first aid qualification. (5 of 21 shifts) Finding includes: A record review of the employee worked schedule, on 1/31/2024 at 3:50 p.m., indicated during the week of 1/21/2024 through 1/27/2024, the facility had 5 out of 21 shifts without a first aid certified staff member in the facility. During an interview, on 1/31/2024 at 4:08 p.m., the Executive Director indicated first aid trained certified staff members were not on duty at the facility for the 5 shifts indicated on the staffing schedule reviewed for 1/21/2024 through 1/27/2024. She indicated the facility did not have a policy and procedure for this activity.		Deficiency ID: R_0117 Completion Date:3/1/2024 On 2/2/2024 The Executive Director (ED) and Director of Health and Wellness (DHW) audited current staff files for CPR certification and basic first aid certificates. Staff identified through audit of CPR and first aid certifications, were recertified by 3/1/2024 On 2/2/2024 ED conducted audit of current staff schedule to ensure a minimum of one (1) awake staff with current CPR and first aid certificates were assigned onsite. No additional shifts were noted without required minimum staff certified. The ED and/or designee will coordinate training certification for CPR and first aid for newly hired staff during basic orientation to meet the minimum requirements. On 2/1/2024, the Regional Director of Care Services (RDCS) in-serviced the ED and DHW the requirements to have a minimum of one (1) awake person with current CPR and first aid certification on site. Effective 3/1/2024, the ED and/or designee will provide biannual CPR and first aid certification trainings for current staff and add training for newly hired staff. ED and/or designee will review staff schedules prior to implementation	

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			to ensure a minimum of one (1) awake staff is assigned on site with current CPR and first aid certificates. ED and/or designee is responsible for compliance. ED and/or designee will audit 5 staff personnel records weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure current CPR and first certification. ED and/or designee will audit staff schedules weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure a minimum of one (1) awake person is assigned on site with current CPR and first aid certificates. Results will be reviewed monthly during QI meeting. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. If 100% compliance after 3 months, audits will be done every other month ongoing. Requesting an IDR due to all staff in question has been recertified in CPR and first aid	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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			

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	and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (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. (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. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure staff received in service education and training for residents' rights, abuse, and dementia for 9 of 10 staff members reviewed for staff training. (Staff Members 3, 4, 5, 6, 7, 8, 10, 11 and 12) Findings include:	R 0120	Plan of Correction Deficiency ID: R0120 Completion Date: 3/1/2024 1. On 2/6/2024 the ED audited all	03/08/2024

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	1. The employee record for Staff Member 3 was reviewed on 1/31/2024 at 3:33 p.m. The employee residents' rights and abuse training were not in the employee record file. 2. The employee record for Staff Member 4 was reviewed on 1/31/2024 at 3:35 p.m. The employee residents' rights, dementia and abuse training were not in the employee record file. 3. The employee record for Staff Member 5 was reviewed on 1/31/2024 at 3:38 p.m. The employee residents' rights and abuse training were not in the employee record file. 4. The employee record for Staff Member 6 was reviewed on 1/31/2024 at 3:42 p.m. The employee residents' rights, dementia and abuse training were not in the employee record file. 5. The employee record for Staff Member 7 was reviewed on 1/31/2024 at 3:45 p.m. The employee residents' rights, dementia and abuse training were not in the employee record file. 6. The employee record for Staff Member 8 was reviewed on 1/31/2024 at 3:48 p.m. The employee residents' rights, dementia and abuse training were not in the employee record file. 7. The employee record for Staff Member 10 was reviewed on 1/31/2024 at 3:52 p.m. The employee residents' rights, dementia and abuse training were not in the employee record file. 8. The employee record for Staff Member 11 was reviewed on 1/31/2024 at 3:56 p.m. The employee residents' rights, dementia and abuse training were not in the employee record file.		current employee files to identify those not in compliance with state required inservices on Abuse/neglect, resident rights and dementia. Those employees found non compliant will complete required in services no later than 3/8/2024. 2. All newly onboarding employees will complete Resident Rights, Abuse and dementia training with the DHW while in orientation. Current employee files will be audited by the ED or designee monthly to maintain compliance. 3. The Executive Director was re trained by the Regional Director of Care on the requirements for staff in services on 2/22/2024 4. The ED is responsible to maintain compliance. Employee files will be audited and discussed monthly in QI for 6 months. If compliance is at 100%, employee files will be audited quarterly ongoing. 5. Monitoring will be ongoing.	

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	9. The employee record for Staff Member 12 was reviewed on 1/31/2024 at 3:59 p.m. The employee residents' rights and abuse training were not in the employee record file. During an interview, on 2/1/2024 at 12:02 p.m., the Executive Director indicated Staff Members 3, 4, 5, 6, 7, 8, 10, 11 and 12 did not have a resident's rights or abuse training record in their files. She indicated Staff Members 4, 6, 7, 8, 10 and 11 did not have dementia training in their files. She indicated the facility did not have a policy and procedure for this activity.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on record review and interview, the facility failed to inspect the heating and ventilating system at least yearly. (2023) Finding includes:	R 0148	Plan of Correction Deficiency ID: R_0148 Completion Date: 3/1/2024	03/01/2024

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	During a record review of the facility maintenance records, on 2/1/2024 at 10:30 a.m., the facility failed to have a yearly maintenance check for the heating and ventilation system. During an interview, on 2/1/2024 at 11:19 a.m., the Executive Director indicated there were no records found for the heating and ventilation system maintenance for 2023 and the facility did not have a policy and procedure for this activity.		1. The Executive Director contacted Schomers Heating and Cooling to request an inspection of the community's heating and ventillation system on 2/29/2024. 2. The Facility Operations Assistant will conduct visual inspections of the heating and ventillation system every month and coordinate yearly inspections by an outside HVAC company. 3. The Regional Director of Facility Operations re trained the ED on regulations regarding HVAC inspection on 2/28/2024. 4. The inspection of the HVAC system will be discussed in monthly QI to ensure compliance. Visual inspections will be ongoing monthly to maintain 100% compliance	
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, interview and record review, the facility failed to ensure food was labeled and dated in the main kitchen area, the kitchen overhead lights were not damaged, and kitchen utensils were clean for 1 of 1 kitchen reviewed. This deficient practice had the potential	R 0273	Plan of Correction Deficiency ID: R_0273 1. Undated food was disposed of, kitchen was thoroughly cleaned and totes containing utensils were	03/01/2024

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	to affect 32 of 32 residents who received food from the kitchen. Findings include: During the tour of the kitchen, on 1/31/2024 at 2:30 p.m., the following observations were made: 1. The main kitchen area was observed to have the following opened, not sealed, and not dated items: a. Three (3) large bags of hoagie buns. b. Two (2) large bags of hot dog buns. c. One (1) large bag of hamburger buns. d. Two (2) loaves of bread. 2. The main kitchen area had 5 of 8 overhead lights chipped, cracked, and broken. 3. The main kitchen area had multiple utensils (5) located on dirty surfaces. 4. The main kitchen area had multiple containers (3) with clean utensils and debris in the containers. 5. The main kitchen area had clean containers stored on the dirty kitchen floor. During an interview, on 1/31/2024 at 2:55 p.m., the Cook indicated all items should be sealed, labeled, and dated when opened. Clean utensils and containers should be stored in clean areas. She indicated containers should be free of debris. During an interview, on 1/31/2024 at 2:58 p.m., the Executive Director indicated all items should be sealed, labeled, and dated when opened. Clean utensils and containers should be stored in clean areas. She indicated the containers should be free of debris, and the overhead lights needed repair.		sanitized, new light covers were ordered to replace the broken covers, new totes with lids were purchased to prevent debris from entering, a riser was purchased to keep clean dish racks off the floor. 2. The ED conducted an observational audit of the kitchen to establish a cleaning and repair list. 3.. The chef and the cook were in serviced on proper storage and dating/labeling of food and sanitation practices in the kitchen. 4. Effective 2/6/2024, observational audits of the kitchen will be conducted by the ED or designee 3x/week for 4 weeks, then 2x/week for 4 weeks, then weekly x 4 weeks. The findings will be discussed in QI meeting monthly and the QI committee will determine frequency of ongoing audits based on 3 consecutive months of compliance. If compliance is >95% after 3 consecutive months, spot audits by the ED or designee will be ongoing to maintain compliance 5. Systemic changes will be completed by 3/1/2024.	

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	A current facility policy, titled "Food Service Sanitation," not dated and received from the Executive Director on 2/1/2023 at 5:10 p.m., indicated "...All utensils, countertops, shelves and equipment shall be kept clean, maintained in good repair and shall be free from dust, grease, dirt, breaks, corrosions, open seams, cracks and chipped areas...." A current facility policy, titled "Food Service Protection from Contamination," not dated and received from the Executive Director on 2/1/2023 at 5:10 p.m., indicated "...Label and date all left over foods with a used date which is no more than 3 days from the date the food was prepared. Use or discard by the use by date...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (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. Based on observation, interview and record review, the facility failed to refrigerate 3 insulin pens, dispose of an outdated insulin medication pen, and date an opened and used insulin pen for 3 of 3 residents reviewed for insulin medication storage. (Residents K, L and O) Finding includes: 1. During an observation of medication storage for insulin pens, on 1/31/2024 at 1:10 p.m., a Novolin 70/30 FlexPen and a Tresiba FlexTouch 100U/ml flex pen were not opened and not refrigerated for Resident K. The medication label indicated	R 0300	Plan of Correction Deficiency ID: R_0300 Completion Date: 3/1/2024 1. Insulin pens found undated/unrefrigerated were destroyed. 2. The Director of Health and Wellness (DHW) conducted an audit to identify improperly stored or dated medications. Nurses were in-serviced on proper	03/01/2024

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	refrigerate until opened. 2. During an observation of medication storage for insulin pens, on 1/31/2024 at 1:10 p.m., a Novolin 70/30 FlexPen was opened and not dated and a Novolin 70/30 flex pen was not opened and not refrigerated for resident L. The medication label indicated refrigerate until opened and discharge 28 days after opening. 3. During an observation of medication storage for insulin pens, on 1/31/2024 at 1:10 p.m., a Novolog 100 U/ml FlexPen was found, dated as opened on 12/22/2024, and should have been discarded on 1/18/2024. The flex pen was not empty and was still being used by the staff for Resident O. Resident O had received 18 doses of Novolog 100/U FlexPen per her sliding scale prescription on the dates 1/19, 1/20, 1/21, 1/22, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30/2024 with the outdated medication. During an interview, on 1/31/2024 at 1:20 p.m., Staff Member 10 indicated she was not aware of an outdated insulin medication in the medication cart. She was not aware the medication cart had insulin pens which were not opened and should have been refrigerated. The staff were to date a FlexPen when they were opened and were to discard the pens after the expiration date. During an interview, on 1/31/2024 at 1:25 p.m., Staff Member 2 indicated she was not aware of an outdated insulin medication in the medication cart. She was not aware the medication cart had insulin pens which were not opened and should have been refrigerated. The staff were to date a FlexPen when they were opened and were to discard the pens after the expiration date.		medication storage and dating. 3. The DHW and ED were retrained by the Regional Director of Care on proper medication storage. 4. Effective 2/6/2024, the DHW will audit each med cart and the medication room for proper storage and dating of medications 3x/week for 4 weeks then 2x weekly for 4 weeks then weekly for 4 weeks. These findings will be reviewed in monthly QI meeting and frequency of ongoing auditing will be determined by the QI committee based on 3 consecutive months of compliance. If compliance is greater than 95% after 3 months, audits will be monthly ongoing. 5. Systemic changes will be completed by 3/1/2024	

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	A current facility policy, titled "Medication Storage," not dated received from the Executive Director on 2/1/2024 at 5:10 p.m., indicated "...Medication and medical equipment will be properly stored, accessed and secured...Medical equipment will be stored in a safe manner, and/or as recommended by the manufacturer...."			
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 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 ensure there was system which enabled the facility to track, trace and analyze patterns of known infectious symptoms and infections in the facility for 11 of 12 months reviewed. (1/2023 through 11/2023) Finding includes: During a record review of the facility infection control records, on 2/1/2024 at 11:30 a.m., the facility failed to have a documented program to track, trace and analyze infections throughout the facility for the months of 1/2023 through 11/2023. During an interview, on 2/1/2024 at 11:38 a.m., the	R 0407	Plan of Correction Deficiency ID: R_0407 Completed Date: 3/1/2024 1. The DHW began an infection control log for January and February moving forward. 2. DHW to review resident charts daily for new orders 3. DHW and ED were retrained by the Regional Director of Care regarding infection control tracking guidelines	03/01/2024

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	02/01/2024

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

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	Executive Director indicated there were no records found for the infection control monitoring of residents from 1/2023 through 11/2023. The facility should have had a system to track and trace infections as they occurred throughout the facility. She indicated the facility did not have a policy and procedure for this activity.		4. ED and DHW to audit the infection control log 2x/week for 4 weeks, then weekly x 4 weeks, then monthly to ensure compliance with tracking. Findings will be discussed in QI meeting and QI committee is to determine need for ongoing auditing based on 3 months of compliance. Monthly monitoring will be ongoing. 5. Systemic changes to be complete by 3/1/2024	