STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155754	A. BUILDING 00 B. WING	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUBBARD HILL ESTATES INC	28070 CR 24 ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 6, 7, 8, 11, 12 and 13, 2023 Facility number: 001131 Provider number: 155754 AIM number: 200823940 Census Bed Type: SNF/NF: 12 SNF: 48 Residential: 131 Total: 191 Census Payor Type: Medicare: 17 Medicaid: 12 Other: 31 Total: 60 This deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 9/21/2023.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a			

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

Terry Schollmeier 10/06/2023

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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	resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and			

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	trauma-informed. Based on interview and record review the facility failed to have a care plan for a skin issue for 1 of 3 residents reviewed for skin. (Resident 18) Finding includes: During an interview, on 9/6/2023 at 1:27 P.M., Resident 18 indicated he had an area to his right toe. A record review was completed on 9/07/2023 at 11:34 A.M. Resident 18's diagnoses included, but were not limited to: fractured left leg, dysphagia, hypertension, diabetes, obstructive and reflux uropathy. A 5-day MDS (Minimum Data Set) assessment, dated 8/17/2023, indicated the resident required extensive assist of one staff for bed mobility, toilet use, dressing and two assist for transfers. A Nurses Note, dated 6/13/2023, indicated a scab was found during weekly skin assessment. Measured 1.2 x 2 cm (centimeters). Family notified and MD notified. No new orders to care for this site. A Nurse's Note, dated 6/16/2023, indicated Resident 18 was receiving therapy when the therapist found the wound to his toe. New order received for skin prep to resident's skin area on the Right 2nd toe. Area is scabbed over and there are no signs/symptoms of infection to this area. A Physician's order, dated 6/27/2023, included skin prep to the right 2nd toe three times a day, and notify the wound nurse if the area worsens or open.	F 0656	What corrective action will be done by the facility? Resident #18 has had his care plan revised to include right second toe infection with appropriate goals and interventions effective 9/7/23. Resident's toe is improving with current treatment. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have had skin assessments completed effective 10/4/23. A "New Wound Process" has been initiated on all new skin areas which includes initiating an event report, a new skin sheet, and updating the care plan. Care Plans have been completed on all new skin areas with appropriate goals and interventions. What measures will be put into place to ensure this practice does not recur? 1.Hubbard Hill Care Plan policy reviewed with nurses effective 10/5/23. 2.Wound Care/Treatment Guidelines policy reviewed with nurses effective 10/5/23. 3.New Wound Process in EMR reviewed with nurses effective 10/5/23. 4.Unit managers will review new event reports daily on scheduled	10/06/2023

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	A Nurse's Note, dated 8/30/2023, indicated Resident 18 received doxycycline hyalite (antibiotic) 100 mg (milligram) capsule 2 times daily for right 2nd toe infection. A Physician's order, dated 8/30/2023, indicated to cleanse area to the toe with NS (normal saline), apply bacitracin (antibiotic ointment) and a dry dressing every day. The record lacked a care plan for the skin issue to the toe. During an interview, on 9/07/2023 at 2:17 P.M., the Infection Preventionist indicated there should have been a care plan. On 9/11/2023 at 12:45 P.M., the Director of Nursing provided the policy titled, "Care Plan", dated November 2017, and indicated the policy was the one currently used by the facility. The policy indicated"... 3. Each resident's Comprehensive Person Centered Care Plan has been designed to: a. Incorporate identified problem areas... 6. Care plans are revised as changes in the resident's condition dictate...." On 9/11/2023 a 12:45 P.M., the Director of Nursing provided the policy titled "Wound Care/Treatment Guidelines", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... XIV. The care plan should reflect the current status of the wound and appropriate goals...." 3.1-35(a)		days of work to ensure Care Plans have been initiated on all new skin areas and updated. 5.The MDS nurse will audit event reports related to skin issues to assure care plans are updated. The MDS audits will be weekly. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of the Unit Managers audits and the MDS nurse audits will be reviewed bi-weekly at the Case Management meeting and quarterly at the QA meeting x 2. At that time, will review for continued need for auditing.	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§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. 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:			

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	(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 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, interview and record review, the facility failed to ensure proper infection control practices were implemented related to fanning dry skin after cleansed with alcohol for 1 of 1 Accucheck (blood glucose level) observed and not wearing gloves for 1 of 1 insulin injections observed. (RN 4) Finding includes:	F 0880	What corrective action will be done by the facility? RN 4 has been educated on Specific Medication Administration Procedures specifically Injectable Medication Administration and Blood Glucose Monitoring procedure Effective 10-5-23. RN 4 has completed return	10/06/2023

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	During an observation of an Accucheck, on 9/11/2023 at 11:08 A.M., RN 4 put on gloves and cleansed Resident 49's right middle finger with an alcohol wipe. After cleaning the area, RN 4 used an open hand to fan the area she had just cleansed and then used a lancet to poke the skin that had been fanned dried. During an observation of an insulin injection, on 9/11/2023 at 11:12 A.M., RN 4 cleaned the left lower quadrant of Resident 49's abdomen and administered insulin without wearing gloves. During an interview, on 9/11/23 at 11:17 A.M., RN 4 indicated that she shouldn't have fanned the skin dry after cleaning and that she should have been wearing gloves while giving an injection. A policy titled "Specific Medication Administration Procedures", dated 7/31/2017 and updated on 11/1/2017, was provided by the Director of Nursing, on 9/11/2023 at 12:45 P.M., and indicated the policy was the one currently used by the facility. The policy indicated " ...To administer medications via subcutaneous, intradermal and intramuscular routines in a safe, accurate, and effective manner ...Equipment ...E. Examination gloves ...Gather supplies ...gloves, alcohol wipes ...Put on gloves ...Inject medication ...Remove & discard gloves. Clean hands by washing or using sanitizer ....". A 4/2019 policy titled, "Blood Glucose Monitoring", and identified as the policy currently used by the facility was provide by the Director of Nursing, on 9/11/2023 at 12:45 P.M. The policy indicated, " ...7. Clean the intended site with an alcohol pad and allow to dry completely ....". 3.1-18(a)		demonstration on blood glucose checks and insulin administration following procedures appropriately Effective 10-5-23. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents receiving insulin and/or blood glucose checks have been assessed for signs and symptoms of infection with none noted. Effective 10-5-23. What measures will be put into place to ensure this practice does not recur? 1.Blood Glucose Monitoring policy reviewed with nurses effective 10-5-23. 2.Specific Medication Administration Procedures specifically Injectable Medication Administration policy reviewed with nurses effective 10-5-23. 3.Nurses completed return demonstration on blood glucose monitoring and insulin administration effective 10-5-23. 4.Staff Development Coordinator or Evening Shift Supervisor will audit 3 blood glucose checks and 1 insulin administration to ensure proper technique weekly X 4 weeks, biweekly X 4 weeks, then monthly. How will corrective action be monitored to ensure the deficient	

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			practice does not recur and what QA will be put into place? Results of the Staff Development/Evening Shift Supervisor audits will be reviewed biweekly in the Case Management Meeting, and quarterly at the QA meeting. At that time, will review for continued need for auditing.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00413253. Complaint IN00413253 - No deficiencies related to the allegations are cited. Survey dates: September 6, 7, 8, 11, 12 and 13, 2023 Facility number: 001131 Residential Census: 131 Hubbard Hill Estates was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed 9/21/2023.	R 0000		