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	10/28/2022

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 a Recertification and State Licensure Survey and Investigation of Complaint IN00391007. This visit included a State Residential Licensure Survey. Complaint IN00391007 - Unsubstantiated due to lack of evidence. Survey dates: October 24, 25, 26, 27, 28, 2022 Facility number: 000534 Provider number: 155493 AIM number: 100267220 Census Bed Type: SNF/NF: 67 SNF: 9 Residential:36 Total: 112 Census Payor Type: Medicare: 16 Medicaid: 15 Private: 6 Other: 3 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review competed on November 9, 2022.	F 0000		
F 0583 SS=E Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bailey Sherman	Executive Director	11/29/2022

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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	and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview, and record review, the facility failed to maintain privacy for 6 of 8 for medication administration and 1 of 1 random interview. An insulin injection was given with the door open, staff did not knock before entering resident rooms, and complaint of staff	F 0583	1. Residents # 9, 21, 49, 50, 53, 69, 70 and 423 suffered no ill effects from the alleged deficient practice. Residents were assessed with no concerns. 2. All residents have the potential	11/29/2022

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	not closing resident doors. (Resident 423, Resident 70, Resident 21, Resident 69, Resident 50, Resident 9, Resident 49, Resident 53) Findings include: 1. On 10/27/22 at 6:30 A.M., RN 9 was observed to enter Resident 50's room. RN 9 lifted Resident 50's shirt, and administered an insulin injection into the resident's right abdomen. The door was left open during administration with the resident facing the door. 2. During a medication administration observation on 10/27/22, RN 5 was observed to leave the medication cart with Resident 9's name, date of birth, age, and medication list up on the computer screen to enter a resident's room across the hall from 6:45 A.M. until 7:12 A.M. A resident was observed during that time sitting in a wheelchair in front of the medication cart within eyesight of the computer screen. 3. On 10/24/22 at 10:43 A.M., RN (Registered Nurse) 3 was observed administering medications. RN 3 was observed to enter Resident 423's room without knocking. After leaving that room, RN 3 entered Resident 70's room without knocking. After leaving that room, RN 3 entered Resident 21's room without knocking. After leaving that room, RN 3 entered Resident 69's room without knocking. 4. On 10/28/22 at 9:00 A.M., the PTD (Physical Therapy Director) was observed to enter Resident 49's room without knocking. During an interview on 10/25/22 at 09:06 A.M., Resident 53 indicated staff did not always respect		to be affected. All staff will be educated on HIPPA, knocking on doors before entering resident rooms. All licensed staff will be educated on EMR usage and closing of doors when administering medication or providing care. 3. As a measure of ongoing compliance, the DHS or designee will complete rounding audits ensuring doors are being shut when providing direct care and knocked on prior to entry and EMR is not left open unattended 5x/week for 4 weeks, then 5x every other week for 2 months, then monthly for 3 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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	privacy. The staff did not always shut the door. On 10/28/22 at 11:30 A.M., a current preparation and general guidelines policy, revised November 2018, indicated "...privacy is maintained at all times for all resident information (e.g., MAR [medication administration record]) when not in use" On 10/28/22 at 11:13 A.M., a current nondated HIPAA (Health Insurance Portability and Accountability Act) violation guideline was provided and indicated "Use 'walk away' button on computers after charting. When passing meds, make sure the TAR (Treatment Administration Record) is turned over when going into a patient's room, or leaving the medication cart unattended. Ensure the eMAR (Electronic Medication Administration Record) is not able to be seen by people passing by" A non dated Resident Rights form obtained from Clinical Support 43 indicated when the residents come to stay, privacy and confidentiality are examples of rights each resident maintains. 3.1-3(o) 3.1-3(p)(2)			
F 0656 SS=E Bldg. 00	483.21(b)(1) 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 resident's medical, nursing, and mental and psychosocial needs that are identified in the			

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	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.			
	Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident in order to meet medical needs that are identified in the comprehensive assessment. Staff did not implement care plan interventions or	F 0656	1. Resident #68 was affected. Resident 68 was evaluated per the MD with no adverse effects noted. Resident 68 has discharged without concern. Resident 12 was affected. Call light was	11/29/2022

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	follow current physician orders for 5 of 7 residents reviewed for care planning to have call lights within reach, using gait belts, and administering ordered medications when indicated. (Resident 12, Resident 13, Resident 31, Resident 49, Resident 68) Findings include: 1. On 10/24/22 at 3:02 P.M., Resident 68 was observed sitting in a recliner with her legs elevated. At that time, both of her feet were observed to be swollen. On 10/26/22 at 10:45 A.M., Resident 68 was observed sitting in her recliner asleep with her legs elevated, both of her feet were observed to be swollen. On 10/26/22 at 10:51 A.M., Resident 68's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure, coronary artery disease, and hypertension. The most recent admission MDS (Minimum Data Set) Assessment, dated 10/2/22, indicated Resident 68 was cognitively intact and required extensive assistance of 2 (two) staff with bed mobility, transfers, and toileting. Current physician orders included, but were not limited to: Lasix (furosemide) tablet; 20 mg (milligrams); oral Special Instructions: PRN (as necessary) for weight gain, edema, or SOA (shortness of air) Give for weight gain of 2 lbs (pounds) in 24 hours or 3 lbs in 5 days. Once A Day - PRN, dated 10/04/2022. A current diuretic medication care plan, dated 10/21/22, included but was not limited to the following interventions:		immediately placed within reach and staff was immediately educated to assist with use of a gait belt. No adverse effects noted. Resident 13 was affected. Staff were immediately educated on transfers with gait belt. No adverse effects noted. Resident 31 was affected, and call light was immediately placed within reach. No adverse effects noted. Resident 49 was affected. The Physical Therapy Director was immediately educated on placing the call light within reach when leaving the resident's room. No adverse effects noted. 2. All residents have the potential to be affected. All staff to be educated on call lights being placed within reach. All clinical staff to be educated on the care plan policy, gait belt usage when transferring residents following plan of care. All licensed staff to be educated on administering PRN diuretics as ordered. 3. As a measure of ongoing compliance, the DHS or designee will monitor 5 transfers weekly to ensure proper transfer technique and gait belt use per care plan for 4 weeks, then every other week for 2 months, then monthly for 3 months. The DHS or designee will round 5 resident rooms to ensure call lights are within reach weekly x4 weeks, then every other week x2 months, then monthly x3 months. DHS or designee will	

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	administer medications per physician orders, started 10/21/22, and observe cardiovascular system and fluid status to determine effectiveness of diuretic therapy, started 10/21/22. Resident 68's weights from 10/04/22 to 10/25/22 included: 10/4/22 153.4 lbs 10/5/22 155.6 lbs --weight gain 2.2 lbs 10/6/22 155.0 lbs 10/7/22 156.4 lbs 10/8/22 155.4 lbs 10/10/22 153.4 lbs 10/11/22 151.4 lbs 10/12/22 154.0 lbs--weight gain 2.6 lbs 10/13/22 153.0 lbs 10/14/22 153.5 lbs 10/15/22 151.2 lbs 10/16/22 152.0 lbs 10/17/22 149.4 lbs 10/18/22 155.4 lbs--weight gain 6.0 lbs 10/19/22 150.0 lbs 10/21/22 151.8 lbs 10/24/22 150.2 lbs 10/25/22 152.0 lbs Resident 68's MAR (medication administration record) dated 10/4/22 to 10/26/22 was reviewed and showed Lasix had not been administered during those dates. During an interview on 10/27/22 at 1:19 P.M., LPN (Licensed Practical Nurse) 14 indicated Lasix was ordered as needed for a certain amount of weight gain. She was not sure exactly how many pounds it was. LPN 14 was not able to explain why the Lasix was not given when there was a weight gain of 2 (two) pounds in 24 hours, and further indicated she was not sure where to look to see if it had been given. After looking in the EMR		audit PRN diuretic administration daily for compliance with orders. 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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	(electronic medical record), LPN 14 indicated the last dose of Lasix was given on 9/27/22. 2. On 10/24/22 at 3:14 P.M., Resident 12 was observed asleep in bed. The call light was draped over the arm rest of the recliner out of the resident's reach. On 10/25/22 at 12:32 P.M., Resident 12 was observed laying back in bed with his head tilted to the right side against the wall. At that time, Resident 12 indicated he fell backwards while he was eating his meal from the bedside table on the side of the bed. He further indicated he could not get up. The call light was observed to be hanging over the arm rest of the recliner out of the resident's reach. On 10/27/22 at 7:04 A.M., CNA (Certified Nurse Aide) 24 brought Resident 12 to the dining room from his room at the end of the hall walking with his walker without using a gait belt. Their right hand was holding on to the back of pants and their left hand was on his left arm as he held onto a rolling walker. On 10/27/22 at 8:35 A.M., LPN 12 assisted resident 12 back to his room at the back of the hall from the dining room without using a gait belt. LPN 12 did not hold onto resident while walking down the hall. They remained on left side of resident and his rollator walker. On 10/26/22 at 2:05 P.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, unsteadiness on feet, unspecified fall, and weakness. The most recent annual MDS Assessment, dated 8/2/22, indicated Resident 12 had severe cognitive impairment and			

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	required extensive assistance of 1 (one) staff for bed mobility, transfers, and toileting. A current resident is at risk for falling care plan, dated 10/18/21, included but was not limited to the following intervention: "keep call light within reach", started 10/18/21. A current risk for decreased walking self performance care plan, dated 11/24/21, included but was not limited to the following intervention: "apply gait belt and provide necessary assistive devices prior to walking", started 11/24/21. Current physician orders included, but were not limited to: "gait belt to be used with all transfers Q [every] shift", started 1/12/22. A current profile care guide care plan, dated 3/16/22, included but was not limited to the following intervention: "transfers: assist x 1 use gait belt RW [Rollator walker]", started 3/16/22. On 10/25/22 at 12:34 P.M., LPN 17 was alerted that the resident needed assistance. At that time, LPN 17 indicated she asked Resident 12 if he wanted to sit in the recliner to eat but he wanted to sit on the bedside. She proceeded to transfer the resident from the bed to the recliner without using a gait belt. During an interview on 10/27/22 at 11:38 A.M., LPN 17 indicated Resident 12 was able to use the call light at times but he usually lifted his buttocks enough to set off the alarm on his chair or bed to get assistance. During an interview on 10/27/22 at 11:41 A.M.,			

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	LPN 17 indicated a gait belt should be used when transferring residents. 3. On 10/25/22 at 1:20 P.M., the ADON (Assistant Director of Nursing) and CNA 30, were transferring Resident 13 from her wheelchair to the couch. They each grabbed under the residents arms and used the other hand to grab the back of Resident 13's pants while transferring the resident. On 10/28/22 at 10:00 A.M., Resident 13's clinical record was viewed. Diagnoses included, but were not limited to, vascular dementia without behavioral disturbance, unspecified fall, and muscle weakness, generalized. The most recent quarterly MDS Assessment, dated 8/2/22, indicated Resident 13 had moderate cognitive impairment and required extensive assistance of 1 (one) staff for bed mobility, transfers, and toileting. A profile care guide care plan, dated 3/25/22, included but was not limited to the following intervention: "ensure assist of 1 [one] staff with ambulation with gait belt in place and [do] not to let go of gait belt -hands on assist with resident for ambulation and transfers', started 3/25/22. During an interview on 10/27/22 at 11:41 A.M., LPN 17 indicated a gait belt should be used when transferring resident. 4. On 10/24/22 at 3:17 P.M., Resident 31 was observed laying in bed resting. The call light was observed laying behind the resident attached to her blanket out of her reach. On 10/25/22 at 2:44 P.M., Resident 31 was observed laying in bed resting. The call light was			

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	observed laying behind the resident out of reach. On 10/27/22 at 8:40 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, age-related osteoporosis, and weakness. The most recent significant change MDS Assessment, dated 8/26/22, indicated Resident 31's cognitive status could not be assessed and required extensive assistance of 2 (two) staff for bed mobility and toileting. A current resident is at risk for falling care plan, dated 10/1/2020, included but was not limited to the following intervention: "Keep call light within reach", started 10/1/2020. 5. On 10/28/22 at 9:00 A.M., the PTD (Physical Therapy Director) was observed performing wound care on Resident 49. When finished, the PTD left the resident laying on her left side without the call light being placed within the resident's reach. On 10/27/22 at 10:17 A.M., Resident 49's clinical record was reviewed. Diagnoses included, but were not limited to, Rheumatoid Arthritis, unspecified, unspecified dementia without behavioral disturbance, and pressure ulcer of sacral region, stage 4 (four). The most recent quarterly MDS Assessment, dated 9/15/22, indicated Resident 49 had moderate cognitive impairment and required extensive assistance of 2 (two) staff for bed mobility, transfers, and toileting. A current resident is at risk for falling care plan, dated 9/6/22, included but was not limited to the following intervention: "Keep call light within reach", started 9/6/22.			

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	On 10/28/22 at 10:00 A.M., a current Guidelines for Gait Belt Use policy, dated 5/10/17, was provided and indicated gait belts should be used according to the plan of care for the individual resident. On 10/28/22 at 2:30 P.M., a current Care Plan Policy, dated 5/22/18, was provided and indicated the purpose of the policy was "To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability or disease in accordance with state and federal guidelines" 3.1-35(a) 3.1-35(g)(2)			
F 0689 SS=E 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 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 ensure adequate assistance was provided to ensure the safety of residents during 1 of 2 dining observations, and during 1 of 3 medication administrations observed. The medication cart on the 700 Hall (Dementia Unit) was left unlocked, medications were left in resident rooms, and loose pills were observed in 2 of 3 medication carts observed. (700 Hall medication cart, Resident 423, Resident	F 0689	1. Residents 423, 70, 21, and 69 were affected by the alleged deficient practice. No adverse effects noted. 100 hall medication cart has been cleaned of loose pills. 700 hall medication cart has been cleaned of loose pills. All licensed nursing staff were immediately educated on locking the medication cart when left	11/29/2022

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	70, Resident 21, Resident 69) Findings include: 1. On 10/24/22 at 10:43 A.M., RN (Registered Nurse) 3 was observed during a medication administration. RN 3 prepared Resident 70's medication and placed them into a medication cup. RN 3 then wrote the resident's name on a piece of tape, and taped it to the medication cup. The medication cup was then placed on top of the medication cart. RN 3 then prepared Resident 21's medication, placed into a medication cup, put a piece of tape with the resident's name on it on the cup, then placed the cup on top of Resident 70's medication cup. The same was observed with Resident 69's medications and Resident 423's medications. RN 3 then obtained all 4 (four) medication cups and entered Resident 423's room. RN 3 administered medications to Resident 423 with a spoonful of applesauce, then left the room. RN 3 then entered Resident 70's room, placed a medication cup on the bedside table, and yelled out to the resident in the bathroom that the medications were on the bedside table when they got done. RN 3 then left the room. RN 3 then entered Resident 21's room and sat down a medication cup with medications in it on the bedside table in front of the resident, and left the room before Resident 21 took the medications. RN 3 then entered Resident 69's room and left a medication cup with medications in it on a table out of the resident's reach, and left the room indicating to the resident what the cup was. 2. On 10/26/22 at 12:12 P.M., the 100 Hall medication cart was observed with the following loose pills in the drawers: 1 small white tablet with the marking "ep" 1 small white round tablet with no markings		unattended and medications not being left in resident rooms unattended unless care planned. 2. All residents have the potential to be affected. Licensed nursing staff to be educated on ensuring loose pills are removed from the drawers of the medication carts, carts are locked when unattended and medications are not left in resident rooms unless care planned. Licensed nursing staff educated on medication administration. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 random med passes and carts 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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	155493	A. BUILDING 00 B. WING	10/28/2022

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	1 yellow heart shaped tablet with no markings 1 round white tablet with the marking "g10" 1 light pink round tablet with no markings 2 small white round tablets with marking "ep 117" on one side, and "40" on the other 1 small white round tablet with marking "D" on one side, and "22" on the other 1 small white round tablet with no markings 1 small blue round tablet with marking "F5" 1 small brown triangle tablet with the marking "20" on one side, and "xa" on the other At that time, LPN (Licensed Practical Nurse) 14 indicated medication carts were usually cleaned out at least one time a week, and as needed by nursing staff. If loose pills were found in the cart, staff should dispose of them in the medication storage room. On 10/26/22 at 2:55 P.M., the 700 (Legacy) Hall medication cart was observed with the following loose pills in the drawers: 1 green capsule with marking "yh 126" 1 pink round tablet with the marking "g" on one side, and "o" on the other 1 white round tablet with the marking "ola 5" on one side, and "apo" on the other 1 white round tablet with the marking "tcl 340" 1 blue capsule with the marking "sg 146" 1 peach round tablet with the marking "ig 206" 1 very small light orange tablet with the marking "z" on one side, and "4" on the other At that time, LPN 21 indicated medication carts should have been cleaned out every Friday. 3. During a dining observation on 10/25/22 at 12:35 P.M., on the 700 (Legacy) Hall, the following was observed: At 12:35 P.M., the medication cart was observed unlocked. Staff and residents were observed in the dining area.			

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	LPN 17 walked past the cart CNA (Certified Nurse Aide) 16 walked past the cart 4 (four) times Therapy 10 walked past the cart LPN 17 walked to the cart, obtained a bottle of hand sanitizer, stood by the cart and rubbed the sanitizer into her hands, then obtained a cup from the top of the cart and walked to the dining area. CNA 16 walked to the cart, obtained a drinking straw from the top of the cart, then took it to a resident's room. Resident 223 stood across the hall from the cart in a doorway, walked out into the hall and past the cart 3 (three) times. Staff was not near cart. CNA 16 walked past the cart with Resident 37 2 (two) times Resident 43 walked past the cart while staff was out of sight of the cart. CNA 16 walked past the cart with Resident 49 2 (two) times Resident 24 walked past the cart without staff present 2 (two) times LPN 17 walked past the cart with Resident 49 2 (two) times Resident 24 walked past the cart, and played with the top 2 handles of the cart without staff present The ADON (Assistant Director of Nursing) walked past the cart 2 (two) times Resident 24 and Resident 43 walked past the cart without staff present At 1:32 P.M., RN (Registered Nurse) 22 was observed to enter the 700 Hall, walk to the medication cart, and locked it. During an interview on 10/28/22 at 1:17 P.M., the Regional Support Nurse indicated during medication administration, staff was not supposed to prepare more than one resident's medication at a time, and medications should not be left in a resident's room unattended. She further indicated			

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	medication carts were supposed to be locked at all times if staff were to walk away and resident information should not be left on the computer screen. On 10/28/22 at 11:30 A.M., a current medication administration policy, revised January 2018, indicated "Administer medication and remain with resident while medication is swallowed ... Do not leave medications at bedside, unless specifically ordered by prescriber" On 10/28/22 at 11:30 A.M., a current preparation and general guidelines policy, revised November 2018, indicated "Medications are not pre-poured either in advance of the med pass or for more than one resident at a time ... During administration of medications, the medication cart is kept closed and locked when out of sight of the facility medication administration personnel. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by ... The resident is always observed after administration to ensure that the dose was completely ingested" 3.1-45(a)(1)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly			

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	responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure completed staffing sheets were posted daily for 5 of 5 days during the survey. Findings include: On 10/24/22 at 11:00 A.M., a posted nurse staffing sheet was observed on the wall across the hall from the 300 Hall. Specific halls were not listed and specific hours for each staff were not listed	F 0732	1. No residents were affected by the deficient practice. Daily staffing sheet with counts was immediately posted. 2. No residents have the potential to be affected. Education will be provided to the leadership team on the requirements of posting the daily staffing sheet with counts. 3. As a measure of ongoing	11/29/2022

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	on the form. The same was observed for the duration of the survey from 10/24/22 through 10/28/22. During an interview on 10/25/22 at 12:38 P.M., LPN (Licensed Practical Nurse) 17 indicated the form by the 300 Hall was the only posted nurse staffing form in the facility and it was not posted on any other hall. During an interview on 10/28/22 at 1:35 P.M., the Executive Director indicated although there was no specific facility policy for posted nurse staffing, it was the policy to follow the federal and state regulation for posting.		compliance, the ED or designee will audit 5x/weekly for 4 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.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and			

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	serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure sanitary preparation and storage of food. A refrigerator and microwave were observed with debris, coffee mugs were observed with brown debris on the inside, and dry storage items were observed past the use by date for 2 of 3 dining halls. (700 Hall, Main Kitchen) Findings include: 1. On 10/24/22 at 10:01 A.M., the main kitchen was observed with a container of Rice Krispies sitting on the counter with a "use by" date of 8/30/22. A container of Corn Flakes was observed sitting on the counter as well with a "use by" date of 10/15/22. On 10/27/22 at 10:30 A.M., the main kitchen was observed with the same container of Corn Flakes with a "use by" date of 10/15/22. At that time, Cook 31 indicated items that were past the use by date should be disposed of. 2. On 10/25/22 at 10:00 A.M., a resident's family member indicated the refrigerator and microwave on the 700 Hall were dirty, as well as the blue coffee mugs used on that unit. On 10/27/22 at 6:41 A.M., the 700 Hall dining area was observed. The microwave was observed with food debris and a white substance on the bottom under the turntable. The refrigerator was observed with liquid spots throughout. 5 (five) blue coffee mugs that were in the kitchen area were observed with a brown substance on the inside of the mugs that was removable if rubbed with a finger. At that time, a CNA (Certified Nurse Aide) was observed	F 0812	1. 1. No residents were affected by the alleged deficient practice. Refrigerator, microwave, and coffee mugs were immediately cleaned. Expired items were disposed of immediately. 2. 2. All residents have the potential to be affected. All expired items have been discarded and equipment inspected to ensure of cleanliness. The dining services team to be educated on proper cleaning, storage, labeling, and disposal of expired items. 3. 3. As a measure of ongoing compliance, the ED or designee will round for cleanliness, labeling of items, and proper disposal of expired items five times weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. 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.	11/29/2022

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	taking a mug from the cabinet containing the blue mugs and used it to serve coffee to Resident 66. The same was observed for Resident 12. During an interview on 10/28/22 at 10:11 A.M., the Housekeeping Director indicated each day, a housekeeper was assigned to the 700 Hall. Responsibilities of that housekeeper included, but were not limited to, cleaning out the microwave and refrigerator. She further indicated staff on that unit were responsible for cleaning those areas when a housekeeper was not available. On 10/28/22 at 12:50 P.M., a current Food Labeling and Dating policy, revised 4/26/22, was provided but did not indicate anything related to using food by the use by date or disposing of such items. 3.1-21(i)(2) 3.1-21(i)(3)			
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. 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,			

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	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 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.			

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	§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 infection control practices were followed for 1 of 1 residents observed for wound care, 6 of 8 for infection control, and 1 of 1 for catheter use. Hands were not washed and gloves were not changed between dirty and clean tasks during wound care, medications were touched with bare hands and picked up from the top of a medication cart with bare hands before administering to residents, and a catheter bag was hanging on the trash can. (Resident 21, Resident 49, Resident 65, Resident 69, Resident 70, Resident 423) Findings include: 1. On 10/24/22 at 10:22 A.M., Resident 65 was observed laying in bed. Resident 65's catheter bag was hanging on the side of the trash can and the tubing was touching the floor. At that time, Resident 65 indicated the catheter bag is always hung on the side of the trash can. During an observation on 10/26/22 at 2:18 P.M., CNA (Certified Nurse Aide) 18 clipped Resident 65's catheter bag on the bed frame with his bare	F 0880	1. Residents #21, 49, 65, 69, 70, and 423 suffered no ill effects from the deficient practice. Resident #65's foley catheter bag was immediately removed from the side of the trash can, ensuring the tubing was not touching the floor. RN #3 was educated on infection control practices during med pass. PD was educated on infection control practices during wound care. 2. All residents have the potential to be affected. Handwashing education with all nursing and therapy staff to ensure return demonstration meets requirements. Education with therapy department on proper procedure for sanitizing equipment used for multiple residents. Education with therapy department on hand hygiene during wound care. Education with all nursing staff on catheter care and placement of drainage	11/29/2022

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	hands. During an interview on 10/27/22 at 1:23 P.M., the Assistant Director of Nursing (ADON) indicated she would use the bed frame to hang a catheter bag. On 10/28/22 at 11:14 A.M., a current Preserving Dignity With Indwelling Catheter policy, revised 5/11/2016, was provided and indicated "...Urinary drainage bags and catheter tubing should be kept from touching the floor surface." On 10/28/22 at 11:30 A.M., a current Standard Precautions policy, dated January 2007, was provided and indicated "Gloves shall be worn...for handling items or surfaces with blood or body fluids..." 2. On 10/26/22 at 2:22 P.M., Resident 65's bathroom was observed with a disposable syringe sitting on a paper towel on the right side of the sink under a hairbrush full of hair. The syringe had a liquid in the tip. At that time, RN (Registered Nurse) 14 indicated she was unsure why the syringe was in the bathroom, but assumed it was for the resident's urinary catheter irrigation. She further indicated since it was a disposable syringe, it should have been disposed of, and not been left sitting on the sink used for handwashing. 3. On 10/24/22 at 10:43 A.M., RN 3 was observed administering medications. RN 3 was observed to pop out Resident 70's medications from the medication cards into her bare hand, then place them into a medication cup. During the preparation for Resident 70, a tablet dropped onto the top of the medication cart, and RN 3 picked it up with a bare hand, and placed it into the medication cup. The same was observed with		bag and tubing. 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 ED/designee will observe 1 random therapist daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks, then monthly x3 months to ensure proper equipment sanitation is being completed. The DHS/designee will observe 1 random therapist daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks, then monthly x3 months to ensure proper hand hygiene during wound care. The DHS or designee will observe catheter bag and tubing placement daily x6 weeks, weekly x3 weeks, then every other week x3 weeks, then monthly x3 months to ensure proper infection control practices meet policy expectations. The DHS or designee will observe 1 random licensed staff daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks, then monthly x3 months to ensure proper infection control practices are being followed with med administration. The DHS/designee will observe 1 random licensed staff daily x6 weeks, then weekly x3 weeks, then every other week x3 weeks,	

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	Resident 21, Resident 69, and Resident 423. All off the medications were placed in individual cups, then the cups were stacked on top of one another, and taken to each room for administration. RN 3 entered Resident 423's room, then exited and entered Resident 70's room, then exited and entered Resident 21's room, then exited and entered Resident 69's room. RN 3 did not wash or sanitize her hands between rooms. During an interview on 10/27/22 at 1:23 P.M., the ADON (Assistant Director of Nursing) indicated medications should be placed directly from the medication cards to the medication cups, and should not be handled with bare hands. She further indicated if a medication were to drop on the cart, the nurse should dispose of it and obtain another one. 4. On 10/28/22 at 9:00 A.M., the PTD (Physical Therapy Director) was observed performing wound care on Resident 49's sacral pressure ulcer. At that time, the PTD indicated that they use the same machine for multiple residents. Upon entering the resident's room, the PTD greeted the resident, plugged in the E-stem machine (wound care machine), and got out supplies for the treatment. Without hand hygiene being preformed, the PTD put on her gloves, asked Resident 49 to roll over to her left side, and pulled the resident's pants down from behind. The PTD removed the dressing from the open sacral wound. She grabbed a 4" by 4" piece of gauze from the package and placed it on the resident's skin folded up and held it with her left hand to catch runoff from the Anasep spray. She sprayed the wound with Anasep spray, saturated another 4" x 4" piece of gauze with Anasep spray, wadded it up and placed it into the open sacral wound. As she held that in place with her left hand, she used her right hand to get 2 (two) electrode pads out of		then monthly x3 months for proper infection control practices with catheter care. 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	10/28/2022

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
	the package and grab tape. She placed the electrode pad onto the wound and taped it to the skin. The second electrode pad was placed on the resident's right hip. The PTD then took off her gloves and hooked the electrode pad up to the machine. She put a pillow under the residents side and between her legs to prop her up on her left side and covered up the resident. She used her bare hands to touch the screen to set the machine, threw the used supplies in the trash can, and on her way out of the room, she adjusted Resident 49's roommate's pillow under her head. She proceeded into the resident's bathroom to wash her hands using a 12 (twelve) second lather. On 10/28/22 at 10:09 A.M., the PTD was observed completing wound care on Resident 49's sacral wound. Upon entering the room, the PTD grabbed gloves from the bathroom and put them on. She greeted resident, pulled the pillow from under her side and legs, and pulled the resident's pants down from behind. She unhooked the electrode pads from the machine and grabbed supplies from the machine drawer. The PTD pulled off the electrode pads from the resident's skin and proceeded to pull the gauze out of Resident 49's open wound. She opened a bottle of packing gauze, touched it with her left glove, and cut it with a scissors from the machine drawer. Then she proceeded to put Anesep ointment on a sterile Q-tip, stuck the Q-tip into the wound to apply ointment, pulled out the Q-tip, and pushed in the piece of packing gauze. She wiped around the margins of the wound with an alcohol wipe and put supplies back into the machine drawer. She got the adhesive bandage out of the package and covered the wound. The PTD removed her gloves, grabbed a marker from the machine drawer, and labeled the dressing with the date and time. She put the marker back into the machine drawer,			

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	threw the used, disposable supplies away in the trash can, and then unplugged the machine from the wall. She moved the machine to the foot of the bed, assisted the resident to sit on the side of the bed, and transferred Resident 49 from her bed to her wheelchair. Then the PTD proceeded to push the resident's wheelchair and pull the E-stem machine out of the resident's room and down the hallway. During an interview on 10/28/22 at 10:19 A.M., the PTD indicated they don't have to clean the E-stem machine because it doesn't touch the residents. On 10/28/22 at 11:00 A.M., a current Infection Prevention and Control policy, dated November 2017, was provided and indicated hand washing is the most important method of infection prevention and control and hands should be washed between direct contact with any resident or any other task that provides an opportunity for infection. 3.1-18(b)(1) 3.1-18(l)			
F 9999 Bldg. 00	3.1-13 Administration and management (w) The facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of	F 9999	1. No residents were affected by the deficient practice. The facility designated a dementia care unit director with a required earned degree. 2. No residents have the potential to be affected. Education was provided to the leadership team on the requirements of the dementia care unit director. 3. As a measure of ongoing	10/28/2022

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	adoption of this rule are exempt from the degree and experience requirements. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to designate a dementia care unit director with a required earned degree for 1 of 1 dementia units. (700 Hall) Finding includes: On 10/26/22 at 10:00 A.M., the employee files were reviewed. The employee record list provided by the facility indicated the dementia care director was an LPN (Licensed Practical Nurse). At that time, the facility's dementia disclosure agreement was provided and indicated LPN 17 was the dementia unit director. During an interview on 10/27/22 at 8:58 A.M., LPN 17 indicated she was the unit director for the dementia unit. During an interview on 10/27/22 at 9:02 A.M., the Executive Director indicated LPN 17 was the only dementia care director, and was unaware at that time that the unit director needed to have a degree. During an interview on 10/28/22 at 1:35 P.M., the Executive Director indicated the facility did not have a policy specific to the requirements for the dementia care director, but it was the facility policy to follow the state regulation.		compliance, the ED or designee will audit to ensure the designated dementia care unit director has the required earned degree 5x/weekly for 4 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.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000		

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	Survey. This visit included the Investigation of Complaint IN00391007. Complaint IN00391007 - Unsubstantiated due to lack of evidence. Survey dates: October 24, 25, 26, 27, 28, 2022 Facility number: 000534 Residential Census: 36 Scenic Hills at the Monastery was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00391007.			