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	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KEEPSAKE VILLAGE OF COLUMBUS	2564 FOXPOINTE DR COLUMBUS, IN 47203

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: October 25 and 26, 2022 Facility number: 010680 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 31, 2022.	R 0000	This plan of correction is submitted as required under State and Federal Law. The submission of this Plan of Correction does not constitute an admission on the part of Keepsake Village of Columbus as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedule and should be inadmissible in any proceeding on that basis.The Community submits this plan of correction with the intervention that it be inadmissible by any third party in any civil or criminal action against the Community or any employees, agent, officer, director, attorney or shareholder of the Community.	
R 0005 Bldg. 00	410 IAC 16.2-5-0.5(e) Scope of Residential Care - Deficiency (e) Notwithstanding subsection (f)(2), (f)(3), (f)(4), and (f)(5), a residential care facility that			

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

Heather Angel | Executive Director | 11/11/2022

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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	retains appropriate professional staff may provide comprehensive nursing care to residents needing care for a self-limiting condition. Based on observation, interview, and record review, the facility failed to provide appropriate professional staff to provide comprehensive nursing care for a resident needing care for a self-limiting condition and identify a pressure ulcer prior to being found at a Stage 4 for a resident on hospice with a decline in health for 1 of 7 residents reviewed for scope of residential care. (Resident 5) Findings include: During an observation and interview on 10/25/22 at 1:27 P.M., CNA (Certified Nurse Aide) 2 indicated Resident 5 was confused at times. Staff had to provide all care for the resident as she had a decline in her health recently. The resident was unable to turn and reposition herself in the bed. This had been going on for about three months. The resident had a geri-chair. The resident had a wound on her right heel and wore heel protector boots while in bed. The only way staff knew she had to wear the boots was because they had been told she had to wear them. CNA 2 removed the resident's right sock. There was no dressing covering the right heel. There was a wound to the right heel that was approximately dime sized with a black center. The clinical record for Resident 5 was reviewed on 10/25/22 at 12:25 P.M. The resident was admitted to the facility two years ago. The diagnoses included, but were not limited to, dementia, falls, and altered mental status. A Charting Note, dated 08/23/22 at 9:07 P.M.,	R 0005	* Resident 5 is receiving all care in accordance in their service plan. Service plan was updated on 11.09.2022 *The community reviewed each residents record to determine which residents if any could be affected by the deficient practice. *The Health Service Director has reviewed and confirmed all residents are receiving care as listed in their individual service plans. In addition, nursing staff were inserviced on proper wound care and documentation. *The HSD or designee will audit the weekly wound log for the next six months to ensure residents listed on the log are receiving proper wound care. *If compliance is not maintained during the six month period, the monitoring will extend until the community is found to be compliant for a three month period.	11/26/2022

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	indicated the staff were laying the resident down in bed when the CNA had noticed the resident had a wound on her right heel. It was open and black in some places. The staff would pass the information along to hospice. A Charting Note, dated 08/24/22 at 10:27 A.M., indicated the staff nurse had called hospice services related to the resident's right heel wound. The hospice staff would come and evaluate the resident. A Charting Note, dated 08/24/22 at 7:39 P.M., indicated the hospice staff did not make it into the facility to evaluate the resident's right heel. They would be called again the next morning and request for a visit. A Charting Note, dated 08/25/22 at 7:53 P.M., indicated the resident had a wound to her right heel. The hospice staff provided the resident with a heel protector boot to wear. There were no physician's orders or charting notes indicating the resident's heels were elevated while in bed prior to the wound appearing. Weekly Wound Reports, dated 08/05/22, 08/12/22, and 08/19/22, indicated there were no current wounds. A Weekly Wound Report, dated 08/23/22, indicated Resident 5 had a Stage 4 (Full thickness skin loss with exposed bone and tendon, or muscle, often including undermining or tunneling. Slough [yellow, tan, gray, green, or brown] or eschar [tan, brown, or black] may be present on some parts of the wound bed) pressure ulcer that was developed in the facility.			

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	The Shower Reports for August 2022 indicated the following: - 08/01/22, no new skin areas, - 08/03/22, no new skin areas, - 08/05/22, no new skin areas, - 08/08/22, no new skin areas, - 08/10/22, no new skin areas, - 08/13/22, no new skin areas, - 08/15/22, no new skin areas, - 08/17/22, no new skin areas, - 08/20/22, no new skin areas, - 08/22/22, no new skin areas, and - 08/24/22, the resident had an area on her right heel. A Hospice Visit Note, dated 08/22/22, indicated the resident had no new wounds. A Hospice Visit Note, dated 08/24/22, indicated the resident's right heel was black. A Hospice Visit Note, dated 09/08/22, indicated the resident's right heel wound measured 6 cm (centimeters) by 3 cm. A Hospice Visit Note, dated 09/16/22, indicated the resident's right heel wound measured 2 cm in diameter. The depth could not be determined due to black tissue. The wound had a scant amount of serosanguineous (yellowish with small amount of blood) drainage. A Hospice Visit Note, dated 10/03/22, indicated the resident had a wound to the right heel that measured 2.5 cm by 1.5 cm. The wound was covered with a dark eschar with a scant amount of serosanguineous drainage. A Hospice Visit Note, dated 10/10/22, indicated			

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	the resident had an Unstageable (full thickness tissue lose which the base of the ulcer is covered by slough and/or eschar in the wound bed) wound to the right heel. The wound measured 6.5 cm by 4 cm and the center measured 2 cm by 1 cm. There was a scant amount of serosanguineous drainage. A Hospice Visit Note, dated 10/21/22, indicated the resident had a wound to the right heel that measured 1.5 cm by 1.5 cm. The wound was covered with eschar. An open-ended physician's order, with a start date of 08/29/22, indicated the nursing staff were to cleanse the right heel with soap and water, pat dry, apply a non-stick dressing and wrap with rolled gauze. During an interview on 10/25/22 at 1:33 P.M., LPN (Licensed Practical Nurse) 3 indicated the resident required one or two staff for assistance with transfers. The resident would transport in a geri-chair and required hospice services. The resident had gone out to the hospital at the beginning of August and returned on hospice services. Once she returned, she was more dependent on staff for all care and had not been able to turn and reposition herself. If the resident's dressing came off the nurse working would be notified, and she would reapply the dressing. She was unaware that the resident's dressing had come off. The resident's pressure relieving boots started after the wound was present. During an interview on 10/25/22 at 1:48 P.M., the Administrator indicated she did not know anything about the resident's wound to the right heel. The wound developed at the facility. The facility staff would monitor the resident's skin			

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	while giving showers and assisting with dressing or undressing. If there were any new skin concerns such as redness or open areas the nurse would be notified. The facility staff should have noticed a change in the resident's skin on her right heel prior to the black spots being noticed. The current facility policy, titled "Skin Breakdown Prevention Program", with a revision date of 06/08/2017, was provided by the Business Office Manager on 10/25/22 at 2:45 P.M. The policy indicated, "...To ensure, to the extent possible, residents receive care that prevents the development of skin breakdown and that any skin breakdown or other alteration in skin integrity will be addressed promptly..."			
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 follow infection control guidelines in the kitchen related to storage areas for 2 of 2 observations. Findings include: 1. During the initial kitchen tour, conducted on 10/25/2022 at 10:30 A.M., with the DM (Dietary Manager) the following was observed: - The DM picked up two large black insulated bags, used to transport meals, off the floor, placed them on the top shelf of a white three shelf wheeled cart, she pushed the cart out into the hallway, returned the cart to the kitchen empty,	R 0273	All dietary staff have been coached on infection control in the dietary department. * The Environmental Service Director reviewed each shift and dietary employee to determine if any other residents could be affected by the alleged deficient practice. *The ESD has reviewed and confirmed each dietary department employee is aware of the infection control policy and the dietary deptartment cleaning schedule. In additional all dietary carts and therometers have been replaced. *The ESD or designee will audit the dietary	11/26/2022

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	and washed her hands. The cart was littered with black flecks of debris on each shelf. - A wire four shelf rack had clean dishes stacked on the shelves. A stack of small bowls had black flecks and a half inch black hair in the top bowl. The wire shelves and wheels had fuzzy dust clinging to every shelf and the wheels had food particles stuck to the caps covering the wheels and on the wheels themselves. - A wire three shelf wheeled cart had fuzzy dust clinging to every shelf and the wheels had clumps of dust built up and food particles on them. - The milk cooler had a thermometer that was not legible due to moisture build up inside the thermometer. A second thermometer, found underneath a box of products, read five degrees Fahrenheit and was sticky to the touch. The bottom of the cooler had a dinner plate size liquid puddle containing various colored small particles and a one inch by one inch black chunk of debris. 2. During an observation and interview in the kitchen with the Maintenance Director on 10/26/22 at 10:30 A.M., the following was observed: - A wire four shelf rack had clean dishes stacked on the shelves. A staff's cell phone was laying on the second shelf, at eye level, next to the clean dishes. The wire shelves and wheels had fuzzy dust clinging to every shelf and the wheels had food particles stuck to the caps covering the wheels and on the wheels themselves. The Maintenance Director indicated the racks were cleaned monthly, the phone should not have been on the racks and he handed the phone to the DM. - The milk cooler had a puddle of liquid		department for the next six months to ensure compliance and document as such. *If compliance is not maintained during the six month monitoring period, the monitoring will extend until the Community is found to be in compliant for a three month period.	

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	surrounding the drain approximately 15 inches in diameter that had a gray/brown matter floating in the liquid. The Maintenance Director indicated something had leaked in the cooler recently and the cooler was cleaned monthly. The October 2022 cleaning schedule posted in the kitchen was provided by the Maintenance Director on 10/25/2022 at 10:49 A.M. The schedule indicated the following: - The rack the clean dishes were on was to be cleaned once per week. The schedule indicated the rack had not been cleaned in October. - Staff were to clean the bottom of the refrigerator daily on day shift. The schedule indicated the task was completed on 10/24/22. The current Equipment Maintenance, Sanitation, and Safety policy, with a revised date of 03/31/16, was provided by the Maintenance Director on 10/26/22 at 10:50 A.M. The policy indicated, "...The Dining Services Staff shall be responsible for all food service areas...Cleaning schedules shall be posted in the kitchen. Completed tasks shall be initialed by staff completing task...shelves, and equipment shall be kept clean...The lead Dining Services Staff shall prepare and post a cleaning schedule and is responsible for insuring that the schedule is followed in a satisfactory manner..."			