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	01/04/2023

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: January 3 and 4, 2023 Facility number: 004017 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 6, 2023.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Fields	Executive Director	01/30/2023

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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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure monthly fire drills were conducted for 8 of 12 calendar months reviewed for fire drills. Findings include: On 1/3/23 at 11:15 a.m., the Administrator provided documentation of the 2022 facility fire drills that were conducted. A review of the record indicated the following months lacked documentation that fire drills were conducted: - January 2022 - February 2022 - March 2022 - May 2022 - August 2022 - October 2022 - November 2022 - December 2022 During an interview on 1/3/23 at 11:30 a.m., the Administrator indicated fire drills were to be conducted monthly. Each shift was to have had quarterly fire drills conducted. During 2022 calendar year, there were eight months where no fire drills were conducted.	R 0092	R092-Administration and Management - Noncompliance **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Executive Director (ED) observed the Maintenance Director (MD) conduct a fire drill on 1/18/2023 with no concerns identified. At this time no residents have been identified as having been affected. This community will adhere to the requirements of completing one fire drill per month ensuring each shift is completed on a quarterly basis to mitigate the potential for additional residents to be affected. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of 2022 fire drill logs were completed on 1/5/2023 by ED with no additional fire drills	02/15/2023

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	During an interview on 1/4/23 at 9:15 a.m., the Maintenance Director indicated no fire drill were conducted during the month of December 2022 and fire drills were to be conducted monthly. During an interview on 1/4/23 at 10:45 a.m., the Dietary Manager indicated it had "been a while" since there was a fire drill conducted. Fire drills were to be conducted monthly. On 1/3/23 at 12:11 p.m., the Administrator provided an undated copy of the Guidelines for Life Safety Drills. A review of the document indicated , "...The following information is a guide to complying with policies in the Life Safety Resource Guide regarding various drills that should be completed...All residences must conduct Fire...Drills as indicated...monthly..."		omitted (Attachment 1). **1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by Regional Director of Clinical Services (RDCS) on 1/5/2023 regarding fire drill regulation requirement (Attachment 2). The (MD) was re-trained by ED on 1/18/2023 regarding fire drill regulation requirement (Attachment 3). **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director is responsible for sustained compliance. The Executive Director or designee will audit the fire drill log monthly for 3 months, then bi-monthly for 2 months to ensure fire drills are completed per regulatory requirement. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 1. **By what date the systemic**	

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			changes will be completed:	
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 interview and record review, the facility failed to ensure a staff member with CPR and First Aid certification was working for 4 of 7 days reviewed. Findings include: On 1/4/23 at 8:45 a.m., the staffing schedule, for 1/1/23 through 1/7/23, was reviewed. A review of	R 0117	R117 – Personnel – Deficiency **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Executive Director (ED) audited current staff files for CPR	02/15/2023

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	the schedule identified, per shift - per day, staff who were CPR certified and First Aid certified. The following shifts lacked at least one working staff member who was CPR and First Aid certified: 1/1/23 - third shift (10:00 p.m. to 6 :00 a.m.) 1/2/23 - third shift 1/6/23 - third shift 1/7/23 - third shift During an interview on 1/4/23 at 1:50 p.m., the Administrator the third shift on 1/1/23, 1/2/23, 1/6/23, and 1/7/23 lacked an employee who was CPR and First Aid certified. On 1/4/23 at 2:00 p.m., the Administrator provided a copy of the First Aid policy, dated 3/1/22, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...staff members will be required to be first aid certified in states which require employees to obtain and maintain certification based on the state regulatory requirements..." On 1/4/23 at 2:00 p.m., the Administrator provided a copy of the CPR policy, dated 7/20/18, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...staff and volunteers are required to obtain and provide current documentation of cardiopulmonary resuscitation training specific to adults...for those states that require a CPR certified staff member to be on duty at all times, initiate CPR and continue CPR until emergency personnel arrive..."		and basic first aid certificates (Attachment 4). Current staff not certified will be by 2/15/2023. At this time no residents have been identified as having been affected. **1.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The ED or designee will ensure that new clinical staff have completed CPR and basic first aid training during basic orientation, prior to working the floor. Additionally, with ongoing monitoring of the schedule to ensure each shift is staffed with at least one CPR and First Aid certified team member, this will mitigate the risk of residents being negatively impacted. **1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED or designee will provide twice a year CPR and first aid certification opportunities. The ED or designee will review staff schedules before posting to ensure at least 1 person on shift has current CPR and first aid certifications.	

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			The ED or designee will ensure that new clinical staff have completed CPR and basic first aid training during basic orientation, prior to working floor. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The ED is responsible for compliance. The ED and/or designee will audit 5 staff training records weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure appropriate CPR and first training. 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. Monitoring will be ongoing. **1.By what date the systemic changes will be completed:** 2/15/2023	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of			

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	induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure that a resident received an admission tuberculin skin test in a timely manner, as indicated by State guidelines for all residents upon admission, for 1 of 7 residents reviewed for tuberculin skin tests. (Resident 62) Finding includes: On 1/3/23 at 1:15 p.m., the medical record was reviewed for Resident 62. The record indicated that Resident 62 admitted to the facility on 10/28/22 and lacked documentation of a two-step tuberculin skin test (a test required for all admitting residents to assess for the presence of tuberculosis; a contagious and potentially serious bacterial disease that mainly affects the lungs). During an interview on 1/4/23 at 10:46 a.m., the ED indicated that a record of Resident 62's admission tuberculin skin test could not be found and that Resident 62 should have received one upon admission.	R 0410	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 62 received a first step tuberculin skin test (TST) on 1/6/2023 administered by the Regional Care Specialist (RCS). The second step TST will be administered by the RCS or designee on 1/20/2023. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit of resident TST's was completed on 1/10/2023 by the RCS to ensure current residents have received a TST within 3 months prior to admission or upon admission and if negative, a second step TST if no	02/15/2023

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	On 1/4/23 at 8:50 a.m., the Executive Director (ED) provided a policy, dated 3/1/22, titled Tuberculosis (TB) Testing Policy, and indicated it was the policy currently in use by the facility. A review of the policy indicated, "Tuberculosis testing will be completing per state regulations for residents, staff, and volunteers ...", and it specified that for Indiana, under the Residents column of the state-specific TB Testing Requirements Appendix, "2-step required upon movie-in. If TB test documented within past year prior to move-in, only 1-Step is needed ..."		documented negative TST in the preceding twelve months. No other residents were identified as being affected during this audit. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur? The RCS was retrained on 1/5/2023 by the Regional Director of Care Services (RDCS) on the need to ensure residents receive a TST within 3 months prior to admission or upon admission and if negative, a second step TST if no documented negative TST in the preceding twelve months (attachment 6). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Effective 1/18/2023, the RCS or designee will audit 5 resident tuberculin skin test records weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure residents receive a TST within 3 months prior to admission or upon admission and if negative, a second step TST if no documented negative TST in the preceding twelve months. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of	

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			compliance. Monitoring will be on-going. 5. By what date the systemic changes will be completed: 2/15/23 !--[if="" !supportannotations]--="">	