STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155719	A. BUILDING 00 B. WING	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 EAST STATE RD 16 BROOK, IN 47922

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00444647 and IN00444828. Complaint IN00444647 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00444828 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: October 18, 2024 Facility number: 000559 Provider number: 155719 AIM number: 100267170 Census Bed Type: SNF/NF: 58 SNF: 3 Total: 61 Census Payor Type: Medicare: 7 Medicaid: 44 Other: 10 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/24/24.	F 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective action was necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott James	HFA	11/18/2024

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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			November 6,2024 Brenda Buroker Director, Long Term care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: POC for Survey Event ID RLIC11, for George Ade Memorial Health Care Center, Brook IN. Dear Brenda This is the plan of correction for the above-mentioned complaint survey that was conducted on October 18,2024. This plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 11th of November,2024. At this time, we are requesting the Indiana State Department of Health conduct a tabletop review to clear the findings and stop all proposed and or implemented remedies that have been presented at this time. If you have any questions or need further information, please call (219)275-2531, and we will be glad to assist. Thank you, Scott James, HFA GAMHCC cc:	
F 0557 SS=D	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property			

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Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure residents were treated with dignity, related to urinary drainage bags not covered, for 2 or 4 residents reviewed for dignity. (Residents C and D) Findings include: 1. Resident C was observed on 10/18/24 at 4:19 a.m., 4:34 a.m., and 5:49 a.m. lying in bed. The urinary drainage bag was attached to the side of the bed closest to the door. The urinary drainage bag was uncovered with urine present and visible in the bag. Resident C's record was reviewed on 10/18/24 at 1:31 p.m. The diagnoses included, but were not limited to, cerebral palsy and moderate intellectual disabilities. A Quarterly Minimum Data Set (MDS) assessment, dated 9/29/24, indicated a moderately impaired cognitive status, was dependent for activities of daily living, and had an indwelling urinary catheter. 2. Resident D was observed asleep in bed at 4:30 a.m. The urinary catheter drainage bag was attached to the bed frame on the side of the bed and was uncovered with urine present and visible in the bag. During an observation on 10/18/24 at 4:52 a.m., Resident D was awake and sitting on the side of the bed. The urinary drainage bag remained attached and uncovered on the side of the bed. There was urine present and visible in the bag. CNA 1 entered the room and asked the resident if	F 0557	A desktop review Is requested for this citing. The catheter bag for residents C & D have been covered and placed properly so as to prevent further concern. No other residents were found to be affected by this action. All nursing staff have been provided with re-education materials, regarding how to provide proper catheter placement and care. (See attached) Audits will be performed on five residents with similar needs with results presented to the QA committee at the regular quarterly meeting. The audits will be three times a week for first month, then two times a week for second month and then once a week for the third month. DON or designee to observe and audit, so as to maintain compliance. This will be done as of November 11, 2024 Addendum: On the forth, fifth and sixth months will be done on a monthly basis. A review of five residents per month, to assure compliance. Results to be presented at regular QA meetings for review.	11/11/2024

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	he would like to get out of bed or lie back down. Resident D opted to get up for the day. After morning care had been completed by CNA 1, She placed the urinary drainage bag under the wheelchair seat next to the urinary drainage bag cover and assisted the resident to the common area across from the Nurses' Station. During an interview on 10/18/24 at 5:15 a.m., LPN 2 indicated the urinary drainage bag was to be placed in the urinary drainage bag cover. Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention. An Admission MDS assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. An indwelling urinary catheter was present. A facility urinary catheter care policy, dated January 2013 and received from the Director of Nursing as current, indicated catheter covers/dignity bags were to be used to preserve the resident's dignity and privacy. 3.1-3(t)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with activities of daily living (ADL's) received oral care and assistance with placement of eyeglasses for 2 of 3 residents	F 0677	A desktop review Is requested for this citing. Appropriate AM care was provided to residents B & D per nursing	11/11/2024

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	reviewed for ADL's. (Residents B and D) Findings include: 1. During an observation on 10/18/24 at 6:30 a.m., CNA 3 and CNA 4 entered Resident B's room. CNA 3 washed the resident's face and checked to ensure she had not been incontinent of urine or bowel. A mechanical lift was used to transfer the resident from the bed to the Broda Chair (reclining chair). Her hair was brushed and the glasses were cleaned and applied. Oral care had not been completed. Resident B's record was reviewed on 10/18/24 at 9:07 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. An Annual Minimum Data Set (MDS) assessment, dated 10/8/24, indicated long and short term memory problems and was dependent on staff for hygiene and oral hygiene. A Care Plan, dated 10/9/24, indicated a deficit in self care. The interventions indicated the staff were to assist with oral care twice daily. 2. During an observation on 10/18/24 at 4:52 a.m., CNA 1 provided morning care to Resident D. The resident's face and underarms were washed and incontinent care had been provided. He was dressed in clean clothing and assisted out to the common area by CNA 1. Oral care had not been completed and eyeglasses were not placed on the resident. The resident was observed with natural bottom teeth. Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not		staff. No other residents were found to be affected by this practice. All nursing staff were re-educated on AM care to include oral care (dentures) and eyewear. Resident care cards have been reviewed and updated. This will help to provide oral hygiene and morning care practices. Care plans have also been updated to reflect all the changes for this. DON or designee to observe and audit care provided (see attached audit) with findings provided to the QA committee for compliance and adjustments will be made as needed to maintain ongoing compliance. Audit as follows, three times a week for first month, then two times a week for the second month, and one time a week for the 3rd month. This will be done as of November 11, 2024 Addendum: On the forth, fifth and sixth months will be done on a monthly basis. A review of five residents per month, to assure compliance. Results to be presented at regular QA meetings for review.	

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	limited to, dementia, history of urinary tract infections, and urinary retention. An Admission MDS assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. The vision was adequate with corrective lenses. The Resident Care Card, identified as current by CNA 1 on 10/18/24 at 5:15 a.m., indicated the resident was to wear glasses. A Care Plan, dated 9/20/24, indicated a deficit in self-care. The interventions indicated assistance would be provided for oral care for his upper denture and lower natural teeth twice a day and as needed. During an interview on 10/18/24 at 10:36 a.m., the Director of Nursing indicated oral care was to be provided daily with morning care. During an interview on 10/18/24 at 3:29 p.m., CNA 5 indicated the resident would sometimes refuse to wear his glasses. An undated oral hygiene policy, received from the Director of Nursing as current on 10/18/24 at 1:17 p.m., indicated oral hygiene was to be completed for the teeth, gums, and mouth. Oral hygiene was an essential part of the morning and evening care. An undated morning care policy, received from the Director of Nursing as current on 10/18/24 at 1:17 p.m., indicated the resident was to be assisted with oral hygiene and eyeglasses were to be cleaned and placed on the resident.			

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	This citation relates to Complaint IN00444647. 3.1-38(a)(3) 3.1-38(a)(3)(C)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary catheter and history of urinary tract infections received proper care and services related to improper placement of the urinary catheter drainage bag and tubing, catheter care not completed, and the outlet tube was not disinfected after emptying the urinary drainage bag, for 1 of 2 residents reviewed for urinary catheters. (Resident D) Finding includes: During an observation on 10/18/24 at 4:52 a.m., Resident D was awake and sitting on the side of the bed. CNA 1 entered the room and asked the resident if he would like to get out of bed or lie back down. Resident D opted to get up for the day. The urinary drainage bag on the side of the bed contained a large amount of clear yellow urine. CNA 1 unattached the urinary drainage bag from the side of the bed and placed the bag on the floor. She changed the resident's pants and each time after threading the catheter through the leg of the pants, the drainage bag was placed on the floor. The urinary drainage bag laid on the floor throughout the morning care and CNA 1 had stepped over the urinary drainage bag on the floor several times during the morning care. The catheter tubing was also on the floor and the resident was observed rolling the tubing with his foot. CNA 1 then placed the plastic urine	F 0690	A desktop review Is requested for this citing. The catheter bag was cleaned and placed appropriately for resident D. No other residents were found to be affected by this practice. All nursing staff have been re-educated on proper catheter bag and tubing placement as well as catheter care and proper emptying of bag, etc. Audits will be performed on five residents with similar needs with results presented to the QA committee at the regular quarterly meeting. The audits will be three times a week for the first month, then two times a week for the second month and then once a week for the third month. DON or designee to observe and audit, so as to maintain compliance. This will be done as of November 11, 2024 Addendum: On the forth, fifth and sixth months will be done on a monthly basis. A review of five residents per month, to assure compliance. Results to be presented at regular QA meetings for review.	11/11/2024

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	measuring container on the floor and opened the outlet tube and drained the urine from the bag. After 850 cubic centimeters of urine was drained, the outlet tubing was clamped and returned to the holder on the drainage bag without being disinfected. The resident stood up on the side of the bed. The brief was soiled with bowel movement. CNA 1 washed the buttocks and placed a clean incontinent brief on the resident and completed dressing the lower part of his body. The urinary catheter was not washed. The resident was then assisted to the wheelchair. CNA 1 placed the urinary drainage bag under the wheelchair seat. The catheter tubing was on the floor. At the time of the observation, CNA 1 indicated she was unsure if the catheter tubing could be touching the floor and stated, "it usually is". She then assisted the resident in the wheelchair to the Nurses' Station, with the catheter tubing still on the floor. During an interview on 10/18/24 at 5:15 a.m., LPN 2 indicated the catheter tubing was not to be touching the floor. Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention. An Admission Minimum Data Set assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. An indwelling urinary catheter was present. A Care Plan, dated 9/20/24, indicated a there was a			

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	risk for infections related to an indwelling catheter. The interventions indicated, the urinary drainage bag was to be stored in a protective bag, the drainage system was not to touch the floor, and catheter care was to be completed every shift and as needed. A facility urinary catheter care policy, dated January 2013 and received from the Director of Nursing as current, indicated the urinary drainage bags and tubing were to be positioned to prevent touching of the floor. The outlet tubes were to be disinfected with an antiseptic after emptying the drainage tube. The resident was to receive perineal and catheter care with soap and water at least twice daily. 3.1-41(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff members (CNA 1 and CNA 6) when providing care to residents (Residents D and C) who were in Enhanced Barrier Precautions (EBP) for two random observations for infection control. Findings include: 1. During an observation on 10/18/24 at 4:52 a.m., CNA 1 entered Resident D's room and prepared to start the morning care without any PPE being worn. CNA 1 was stopped before care was started. CNA 1 indicated if the resident was on EBP, there was usually a cart outside of the room. She acknowledged a sign above the bed, which indicated the resident was on EBP. CNA 1 then	F 0880	A desktop review Is requested for this citing. Resident C & D were provided with appropriate care, with no other resident are found to be affected by this practice. Nursing staff have been re-educated on proper (EBP) and (PPE) procedures. (See attached). Handwashing hygiene has also been provided. The DON or designee will observe and audit proper procedures and utilization of PPE and EBP. Results will be presented at the QA committee for review in order to maintain compliance. This will be ongoing.	11/11/2024

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	donned the PPE and began the morning care. Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention. An Admission Minimum Data Set (MDS) assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. An indwelling urinary catheter was present. A Care Plan, dated 10/4/24, indicated EBP was required. The interventions included PPE would be used when care was provided. A sign would be placed outside the door that indicated EBP was required. The staff were to wear gown and gloves while care was provided and a face shield was to be worn if needed. A Physician's Order, dated 10/1/24, indicated enhanced barrier precautions were ordered. 2. During an observation on 10/18/24 at 5:49 a.m., CNA 6 prepared to complete morning care for Resident C without any PPE being worn. CNA 6 was stopped prior to the start of the care. She acknowledged a sign on the wall above the bed that indicated the resident was on EBP. She then donned a gown and gloves. Resident C's record was reviewed on 10/18/24 at 1:31 p.m. The diagnoses included, but were not limited to, cerebral palsy, moderate intellectual disabilities. A Quarterly MDS assessment, dated 9/292/4,		Audits will be performed on five residents with similar needs with results presented to the QA committee at the regular quarterly meeting. The audits will be three times a week for the first month, then two times a week for the second month and then once a week for the third month. DON or designee to observe and audit, so as to maintain compliance. This will be done as of November 11, 2024 Addendum: The audits will be three times a week for the first month, then two times a week for the second month and then once a week for the third month. On the forth, fifth and sixth months will be done on a monthly basis. A review of five residents per month, to assure compliance. Results to be presented at regular QA meetings for review.	

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	indicated a moderately impaired cognitive status, was dependent for all activities of daily living, and an indwelling catheter was present. A Care Plan, dated 10/4/24, indicated EBP was required. The interventions included PPE would be used when care was provided. A sign would be placed outside the door that indicated EBP was required. The staff were to wear gown and gloves while care was provided and a face shield was to be worn if needed. A Physician's Order, dated 10/1/24, indicated enhanced barrier precautions were ordered. During an interview on 10/18/24 at 2:20 p.m., the Director of Nursing indicated the signs for EBP had been moved to above the residents' beds to make it a little more confidential. A facility EBP policy, dated August 2024, and received from the Director of Nursing as current, indicated EBP was to be used during high contact activities, which included hygiene and bathing activities. EBP was to be used if the resident had an indwelling device, which included indwelling urinary catheters. Gowns and gloves would be available near or outside the resident's room. 3.1-18(b)			