CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155719	B. WING		10/18/2024	
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623	T ADDRESS, CITY, STATE, ZIP COD EAST STATE RD 16 OK, IN 47922		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	`	LISC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 0000	REGELITORI GI	LEGO IDENTIL TINO IN ORGANITATION	Ind		BATE	
F 0000 Bldg. 00	IN00444647 and IN Complaint IN00444 related to the allega Complaint IN00444 the allegations are complaint IN00444 the allegations are complaint IN00444 the allegations are completed to the allegation are completed t	1647 - Federal/State deficiencies tions are cited at F677.  1828 - No deficiencies related to cited.  1828 - Response related to cited.  1828 - Response related to cited.  1829 - Response related to cited.  1829 - Response related to cited.  1820 - Response related to cited.  1821 - Response related to cited.  1821 - Response related to cited.  1822 - Response related to cited.  1823 - Response related to cited.  1824 - Response related to cited.  1825 - Response related to cited.  1826 - Response related to cited.  1827 - Response related to cited.  1828 - Response related to cited.  1829 - Response related to cited.  1820 - Response rel	F 0000	The preparation and execution this Plan of Correction does a constitute admission or agreed by the provider of the truth of facts alleged or the conclusion forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the all deficiencies do not individual collectively jeopardize the he and safety of its residents, not they of such character as to I this provider's capacity to renadequate resident care. Furthermore, the operation a 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 the procedural preceding pur to comply with state and federegulations, and correlate with most recent contemplated or accomplished corrective action. These dates do not necessar correspond chronologically to date the provider is under the opinion it was in with require of participation or that the corrective action was necess	ement in the conset of the con	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Scott James HFA 11/18/2024

Any defiency statement 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 disclodays 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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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155719		(X2) MULTI A. BUILD B. WING	survey eted /2024				
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	36	623 EA	DDRESS, CITY, STATE, ZIP COD AST STATE RD 16 , IN 47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0557	483 10(a)(2)				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 Mem Health Care Center, Brook IN. Dear Brenda This is the plan of correction for the above-mentioned complain survey that was conducted on October 18,2024. This plan of correction is being submitted a 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, are requesting the Indiana Sta Department of Health conduct tabletop review to clear the findings and stop all proposed or implemented remedies that have been presented at this til If you have any questions or in further information, please call (219)275-2531, and we will be to assist. Thank you, Scott James, HFA GAMHCC cc:	or nt as t al we te a and me. eed	
SS=D	483.10(e)(2) Respect, Dignity/R	ight to have Prsnl Property					

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Event ID:

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Facility ID: 000559

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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  Findings include:  CROSS-REFERENCED TO HEAPPROPRIATE DATE  TAG  PAGENCIENCY)  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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155719		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  10/18/2024						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  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  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  PREFIX TAG REGULATORY OF LSC IDENTIFY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETRICTION TO THE APPROPRIATE DETR				3623 EAST STATE RD 16					
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  Findings include:  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	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
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.  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.	Bldg. 00	interview, the facilia were treated with durainage bags not conversed for dignit.  Findings include:  1. Resident C was a a.m., 4:34 a.m., and urinary drainage bathe bed closest to the bag was uncovered in the bag.  Resident C's record 1:31 p.m. The diag limited to, cerebral disabilities.  A Quarterly Minimal assessment, dated 9 impaired cognitive activities of daily limited to the bed and was uncovered in the bag.  2. Resident D was a.m. The urinary cattached to the bed and was uncovered in the bag.  During an observat Resident D was aw the bed. The urinary cattached to the urinary cattached.	ity failed to ensure residents lignity, related to urinary covered, for 2 or 4 residents by. (Residents C and D)  observed on 10/18/24 at 4:19 dd 5:49 a.m. lying in bed. The ag was attached to the side of the door. The urinary drainage with urine present and visible dd was reviewed on 10/18/24 at moses included, but were not palsy and moderate intellectual for including and had an indwelling observed asleep in bed at 4:30 attheter drainage bag was frame on the side of the bed with urine present and visible dividing on the side of the bed with urine present and visible dividing on the side of the side of y drainage bag remained	F 03	557	this citing.  The catheter bag for residents D have been covered and place properly so as to prevent furth concern. No other residents we found to be affected by this act All nursing staff have been provided with re-education materials, regarding how to proper catheter placement and care. (See attached) Audits will be performed on five residents with similar needs wiresults presented to the QA committee at the regular quarte meeting. The audits will be thr times a week for first month, the two times a week for first month, the two times a week for second month and then once a week for the third month.  DON or designee to observe a audit, so as to maintain compliance.  This will be done as of November 11, 2024  Addendum: On the forth, fifth a 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 meeting.	C & ced leer vere tion.  Divide I e ith erly ree leen leer leen leer leer leer leer	11/11/2024	

CNA 1 entered the room and asked the resident if

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155719		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/18/2024	
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	he would like to get Resident D opted to morning care had be placed the urinary d wheelchair seat nex	out of bed or lie back down. o get up for the day. After een completed by CNA 1, She drainage bag under the t to the urinary drainage bag the resident to the common			
	indicated the urinar	y on 10/18/24 at 5:15 a.m., LPN 2 y drainage bag was to be y drainage bag cover.			
	2:10 p.m. The diagr	was reviewed on 10/18/24 at noses included, but were not a, history of urinary tract ary retention.			
	indicated a moderat supervision was req hygiene and modera	S assessment, dated 9/27/24, ely impaired cognitive status, uired for oral hygiene and ate assistance was required for ling urinary catheter was			
	January 2013 and re Nursing as current,	were to be used to preserve			
	3.1-3(t)				
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provide	d for Dependent Residents			
	interview, the facili who required assista living (ADL's) rece	on, record review, and ty failed to ensure residents ance with activities of daily ived oral care and assistance yeglasses for 2 of 3 residents	F 0677	A desktop review Is requested this citing.  Appropriate AM care was proto residents B & D per nursing	vided

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155719	B. W	ING		10/18	/2024
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			AST STATE RD 16		
GEORGE	ADE MEMORIAL	HEALTH CARE CENTER			(, IN 47922		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reviewed for ADL's. (Residents B and D)				staff. No other residents were	<b>;</b>	
	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.				found to be affected by this		
					practice.		
					All nursing staff were re-educa		
					on AM care to include oral car		
					(dentures) and eyewear. Res		
		resident's face and checked to			care cards have been reviewe		
		been incontinent of urine or al lift was used to transfer the			and updated. This will help to		
					provide oral hygiene and morr	•	
	resident from the bed to the Broda Chair (reclining chair). Her hair was brushed and the glasses were				care practices. Care plans ha also been updated to reflect a		
	cleaned and applied. Oral care had not been				changes for this.	ii uie	
	completed.				DON or designee to observe a	and	
	completed.				audit care provided (see attac		
	Resident B's record was reviewed on 10/18/24 at				audit) with findings provided to		
	9:07 a.m. The diagnoses included, but were not				QA committee for compliance		
	limited to, Alzheim				adjustments will be made as	unu	
					needed to maintain ongoing		
	An Annual Minimu	ım Data Set (MDS) assessment,			compliance. Audit as follows,		
		cated long and short term			three times a week for first mo		
		and was dependent on staff for			then two times a week for the	,	
	hygiene and oral hy	-			second month, and one time a	a	
					week for the 3rd month.		
	A Care Plan, dated	10/9/24, indicated a deficit in			This will be done as of Novem	ber	
	self care. The interv	ventions indicated the staff			11, 2024		
	were to assist with	oral care twice daily.			Addendum: On the forth, fifth	and	
					sixth months will be done on a	ı	
					monthly basis. A review of five	)	
		vation on 10/18/24 at 4:52 a.m.,			residents per month, to assure	e	
	_	orning care to Resident D. The			compliance. Results to be		
		underarms were washed and			presented at regular QA meet	ings	
		d been provided. He was			for review.		
		othing and assisted out to the					
		NA 1. Oral care had not been					
		glasses were not placed on the					
		ent was observed with natural					
	bottom teeth.						
	Resident D's record	was reviewed on 10/18/24 at					
		noses included but were not					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		155719	B. W	ING		10/18/	2024	
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
GEORGE	ADE MEMORIAL	HEALTH CARE CENTER			AST STATE RD 16 (, IN 47922			
					X, IIV 47 922		Ī	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
		a, history of urinary tract						
	infections, and urin	ary retention.						
	indicated a moderate supervision was rec hygiene and moder	S assessment, dated 9/27/24, tely impaired cognitive status, quired for oral hygiene and ate assistance was required for was adequate with corrective						
	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.							
	-	y on 10/18/24 at 10:36 a.m., the g indicated oral care was to be a morning care.						
	_	v on 10/18/24 at 3:29 p.m., CNA dent would sometimes refuse						
	Director of Nursing p.m., indicated oral for the teeth, gums, an essential part of	giene policy, received from the g as current on 10/18/24 at 1:17 hygiene was to be completed and mouth. Oral hygiene was the morning and evening care.						
	the Director of Nur 1:17 p.m., indicated	sing as current on 10/18/24 at If the resident was to be assisted and eyeglasses were to be						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155719		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       10/18/2024				LETED	
	PROVIDER OR SUPPLIER		1	STREET 2	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922	1 .37.10	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		to Complaint IN00444647.		TAG			DATE
F 0690	3.1-38(a)(3) 3.1-38(a)(3)(C) 483.25(e)(1)-(3)						
SS=D	Bowel/Bladder Inc	continence, Catheter, UTI					
Bldg. 00	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		F 06	590	A desktop review Is requested this citing. The catheter bag was cleaned placed appropriately for reside D. No other residents were for to be affected by this practice. All nursing staff have been re-educated on proper cathete bag and tubing placement as as catheter care and proper emptying of bag, etc. Audits will be performed on five residents with similar needs we results presented to the QA committee at the regular quark meeting. The audits will be the times a week for the first month then two times a week for the second month and then once week for the third month. DON or designee to observe a audit, so as to maintain compliance. This will be done as of Novernia.	d and ent sund ent sund er well ve rith terly ree th, a	11/11/2024
	floor. The urinary d throughout the morn stepped over the uri several times during catheter tubing was resident was observ	age bag was placed on the rainage bag laid on the floor ning care and CNA 1 had nary drainage bag on the floor at the morning care. The also on the floor and the ed rolling the tubing with his aced the plastic urine			11, 2024 Addendum: On the forth, fifth 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 meet for review.	a e e	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	
		155719	B. W	ING		10/18/	2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L		3623 EA	AST STATE RD 16		
GEORGE	ADE MEMORIAL	HEALTH CARE CENTER		BROOK	X, IN 47922		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	-	r on the floor and opened the					
		ned the urine from the bag.					
		timeters of urine was drained,					
	the outlet tubing was clamped and returned to the holder on the drainage bag without being						
		ident stood up on the side of vas soiled with bowel					
		washed the buttocks and					
		ntinent brief on the resident					
	*	sing 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 o	bservation, CNA 1 indicated					
	she was unsure if th	e catheter tubing could be					
	touching the floor a	nd stated, "it usually is". She					
	then assisted the res	sident in the wheelchair to the					
	Nurses' Station, with	h the catheter tubing still on					
	the floor.						
	During an interview	on 10/18/24 at 5:15 a.m., LPN 2					
	_	er tubing was not to be					
	touching the floor.						
	<i>5 91</i>						
	Resident D's record	was reviewed on 10/18/24 at					
	2:10 p.m. The diagr	noses included, but were not					
	limited to, dementia	a, history of urinary tract					
	infections, and uring	ary retention.					
	 	D					
		imum Data Set assessment,					
		cated a moderately impaired					
		pervision was required for oral					
		e and moderate assistance					
	_	thing. An indwelling urinary					
	catheter was presen	ī.					
	A Care Plan, dated	9/20/24, indicated a there was a					
			1				

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		00	COMPL	LETED		
		155719	B. Wl	NG		10/18	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			AST STATE RD 16		
GEORGI	E ADE MEMORIAL	HEALTH CARE CENTER		BROOK, IN 47922			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	-	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	DATE
mo		related to an indwelling		mo			DATE
		ventions indicated, the urinary					
		o be stored in a protective bag,					
		n was not to touch the floor,					
		ras to be completed every shift					
	and as needed.	as to be completed every sinit					
	A facility urinary c	atheter 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						
		or. The outlet tubes were to be					
		antiseptic after emptying the					
		resident was to receive					
		er care with soap and water at					
	least twice daily.	•					
	3.1-41(a)(2)						
F 0880	483.80(a)(1)(2)(4)	)(e)(f)					
SS=D Bldg. 00	Infection Preventi	on & Control					
	Based on observation	on, interview, and record	F 08	380	A desktop review Is requested	l for	11/11/2024
	review, the facility	failed to ensure correct			this citing.		
	Personal Protective	Equipment (PPE) was used by			Resident C & D were provided	d with	
		NA 1 and CNA 6) when			appropriate care, with no othe	:r	
	providing care to re	esidents (Residents D and C)			resident are found to be affect	ted	
		ced Barrier Precautions (EBP)			by this practice.		
	for two random obs	servations for infection control.			Nursing staff have been		
					re-educated on proper (EBP)	and	
	Findings include:				(PPE) procedures. (See		
					attached). Handwashing hygi	ene	
		vation on 10/18/24 at 4:52 a.m.,			has also been provided.		
		sident D's room and prepared to			The DON or designee will obs		
		are without any PPE being			and audit proper procedures a	and	
		stopped before care was			utilization of PPE and EBP.		
		icated if the resident was on			Results will be presented at the		
	EBP, there was usu	ally a cart outside of the room.			QA committee for review in or	der	

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She acknowledged a sign above the bed, which

indicated the resident was on EBP. CNA 1 then

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be ongoing.

to maintain compliance. This will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/18/2024 155719 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3623 EAST STATE RD 16 GEORGE ADE MEMORIAL HEALTH CARE CENTER BROOK. IN 47922 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE donned the PPE and began the morning care. Audits will be performed on five residents with similar needs with Resident D's record was reviewed on 10/18/24 at results presented to the QA 2:10 p.m. The diagnoses included, but were not committee at the regular quarterly limited to, dementia, history of urinary tract meeting. The audits will be three infections, and urinary retention. times a week for the first month, then two times a week for the An Admission Minimum Data Set (MDS) second month and then once a assessment, dated 9/27/24, indicated a moderately week for the third month. impaired cognitive status, supervision was DON or designee to observe and required for oral hygiene and hygiene and audit, so as to maintain moderate assistance was required for bathing. An compliance. indwelling urinary catheter was present. This will be done as of November 11. 2024 A Care Plan, dated 10/4/24, indicated EBP was Addendum: The audits will be required. The interventions included PPE would three times a week for the first be used when care was provided. A sign would be month, then two times a week for placed outside the door that indicated EBP was the second month and then once required. The staff were to wear gown and gloves a week for the third month. while care was provided and a face shield was to On the forth, fifth and sixth months be worn if needed. will be done on a monthly basis. A review of five residents per month, A Physician's Order, dated 10/1/24, indicated to assure compliance. Results to enhanced barrier precautions were ordered. be presented at regular QA meetings for review. 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,

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Event ID:

RLIC11

Facility ID: 000559

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155719	B. WI	B. WING		10/18	10/18/2024	
	PROVIDER OR SUPPLIER		<u> </u>	3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16	1		
GEORGE	E ADE MEMORIAL	HEALTH CARE CENTER		BROOK	K, IN 47922			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		tely impaired cognitive status, all activities of daily living, and ter 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.							
	-	r, dated 10/1/24, indicated ecautions were ordered.						
	During an interview	v on 10/18/24 at 2:20 p.m., the						
	_	indicated the signs for EBP						
	had been moved to	above the residents' beds to						
	make it a little more	e confidential.						
	received from the E indicated EBP was activities, which inductivities. EBP was an indwelling devicurinary catheters. G	cy, dated August 2024, and Director of Nursing as current, to be used during high contact cluded hygiene and bathing to be used if the resident had be, which included indwelling flowns and gloves would be attaide the resident's room.						
	3.1-18(b)							

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