STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155611	A. BUILDING 00 B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

(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. Survey dates: August 24, 25, 26, 29, and 30, 2022 Facility number: 000277 Provider number: 155611 AIM number: 100290530 Census Bed Type: SNF/NF: 78 SNF: 9 Total: 87 Census Payor Type: Medicare: 6 Medicaid: 66 Other: 15 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 7, 2022.	F 0000	Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure survey event ID SCQN11.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

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

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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	Based on observation and interview, the facility failed to follow manufacturer's guidelines related to insulin pen usage for 2 of 10 residents reviewed for medication administration. (Residents 24 and 21) Findings include: 1. Medication administration was observed on 08/29/22 at 10:26 A.M., with LPN (Licensed Practical Nurse) 2. Resident 24 had a blood glucose value of 260 and required 13 units of Humalog insulin. The LPN removed the resident's insulin pen from the treatment cart, removed the pen cap, applied a new needle, and primed the pen with two units of insulin leaving the cap on the needle and being unable to visibly see the tip of the needle. She did not clean the end of the pen before applying the needle. 2. Medication administration was observed on 08/29/22 at 10:29 A.M., with LPN 2. Resident 21 had a blood glucose value of 147 and required 6 units of Humalog insulin. The LPN removed the resident's insulin pen from the treatment cart, removed the pen cap, applied a new needle, and primed the pen with two units of insulin leaving the cap on the needle and being unable to visibly see the tip of the needle. She did not clean the end of the pen before applying the needle. During an interview on 08/29/22 at 10:31 A.M., LPN 2 indicated she did not know why she had not cleaned the end of the insulin pen before applying the needle. She would have cleaned the top of a vial of insulin. She primed the pen per the manufacturer's instructions. She primed the pen to make sure there was no air in the pen.	F 0684	- Hoosier Christian Village does ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan, and resident's choices. On August 29, 2022, residents number 24 and 21 were assessed for any side effect of insulin injections, no side effects observed. No other residents were found to be affected by this alleged deficient practice. - The DON and ADON completed a physician order review to identify any other residents having the potential to be affected by the alleged deficient practice. Residents receiving insulin via insulin pen injections have the potential to be affected by this alleged deficient practice. - On August 29, 2022, the DON and ADON provided one:one re-education to LPN 2, which included review of policy and procedure for insulin administration. LPN 2 accurately demonstrated insulin administration per the insulin administration skills competency. - On August 29, 2022, the DON and ADON provided re-education for nurses on proper insulin administration procedures, including procedures for insulin pens. The re-education included being able to visibly see the tip of the needle when priming, and	09/16/2022

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	During an interview on 08/30/22 at 3:21 P.M., the ADON (Assistant Director of Nursing) indicated no residents had recently had any acute concerns related to blood glucose levels. The Humalog package insert, with a revised date of 02/2020, was provided by the ADON on 08/30/22 at 9:14 A.M. The insert indicated, "...Preparing your Pen...Pull the Pen Cap straight off...wipe the Rubber Seal with an alcohol swab...push the capped Needle...onto the pen...Pull off the Outer Needle Shield...If you do not prime before each injection, you may get too much or too little insulin...To prime your pen, turn the Dose Knob to select 2 units...Hold your pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding your Pen with the Needle pointing up. Push the Dose Knob in until it stops...You should see insulin at the tip of the needle...If you do not see insulin, repeat priming steps..." The current Insulin Pen policy, dated 2022, was provided by the ADON on 08/30/22 at 9:14 A.M. The policy indicated, "...Remove the pen cap from the insulin pen...Wipe the rubber seal with an alcohol wipe...Screw the pen needle onto the insulin pen...Twist open and remove outer cover from the pen needle...With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears..." 3.1-47(a)(1)		cleaning the end of the insulin pen before applying the needle. - On September 13, 2022, the pharmacy nurse consultant conducted in-service educational training on proper insulin administration techniques, including procedures for insulin pens. - On August 29 and September 13, 2022, re-education was provided to all nursing staff on proper insulin administration techniques, including procedures for insulin pens. The pharmacy nurse consultant, the DON, and the ADON will complete random skills competencies checks weekly for four weeks, then monthly for five months. Any newly hired nurse will complete skills competency on insulin injections during orientation process. Any concerns with insulin injections will immediately be brought to administrator and addressed in QAPI for further review and recommendations. - The DON, ADON, or designee will conduct random insulin administration compliance checks for at least weekly for four weeks, then monthly for five months, ongoing, to ensure compliance with proper techniques for insulin administration. These compliance audits will be continued monthly, ongoing. Any concerns with insulin injections will immediately be brought to	

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			administrator and addressed in QAPI for further review and recommendations. - Completion date 9/16/2022.	
F 0689 SS=G 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, record review, and interview, the facility failed to provide adequate assistance for bed mobility and personal hygiene that resulted in a fall with a fracture (Resident 70) and to follow a resident's care plan intervention for a resident who was at risk for falls (Resident 73) for 2 of 5 residents reviewed for accident hazards. Findings include: 1. During an interview and observation on 08/25/22 at 12:19 P.M., Resident 70 was sitting in her bed that had one side flush against the wall. She indicated she had fallen out of bed and broken her hip about three weeks ago when she was given a bed bath. The clinical record for Resident 70 was reviewed on 08/26/22 at 10:06 A.M. An Admission MDS (Minimum Data Set) assessment, dated 07/30/22,	F 0689	Hoosier Christian Village does ensure that resident environment remain as free from accident hazard as possible and each resident receives adequate supervision and assistance devices to prevent accidents. Hoosier Christian Village does provide adequate assistance for bed mobility and personal hygiene. On August 9, 2022, Resident 70 received one assist per plan of care with rolling side to side and personal hygiene. On August 16, 2022, upon resident 70 return from hospital, therapy screened with recommendation of two assist with bed mobility, plan of care updated accordingly. -. DON and ADON completed resident record reviews to identify	09/16/2022

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	indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, anxiety, respiratory failure, and morbid obesity. She required extensssive assistance of two staff members for bed mobility and personal hygiene. A Progress Note, dated 8/9/2022 at 6:45 P.M., indicated NA (Nurse Aide) 5 was assisting Resident 70 with a bed bath, as NA 5 rolled the resident toward her, the resident rolled out of bed and onto the floor. The resident was assessed for injuries, and placed back in the bed with a manual lift. A Progress Note, dated 8/9/2022 at 8:14 P.M., indicated the resident was having pain in her left leg when she was moved. The resident was transported to the local emergency room for an evaluation. A Progress Note, dated 8/10/2022 at 1:35 A.M., indicated the resident was being admitted to the local hospital with a fractured left hip. A Skilled Progress Note, dated 8/8/2022 at 7:00 P.M., indicated the resident required the use of a manual lift with the assistance of two staff members and required extensive assistance of two staff members for bed mobility. During an interview on 08/26/22 at 1:11 P.M., CNA (Certified Nurse Aide) 3 indicated prior to receiving her broken hip Resident 70 required the assistance of two staff members for all ADLs. During an interview on 08/30/22 at 2:19 P.M., LPN (Licensed Practical Nurse) 22 indicated NA 5 had been giving Resident 70 a bed bath when the resident's foot and leg slid off the bed. The weight		other residents having the potential to be affected by the alleged deficient practice. Residents were reviewed according to their plan of care to ensure all interventions are followed accordingly. No other residents were identified to be affected by this alleged deficient practice. - On August 30, 2022, when surveyor voiced concerns, further discussion and documentation were offered by administrator, adon, and don, but not accepted. Documentation includes therapy evaluation completed July 27, 2022, therapist progress and discharge summary July 27,2022 to August 5, 2022, both which include substantial/max assistance, helper does more than half the effort, helper lifts or holds trunk or limbs, and provides more than half the effort for bed mobility, rolling left and right. See supportive documentation of substantial to max assistance. Per therapy evaluation on July 27,2022 one person assistance was indicated. Per definition of ADL support provided, it is indicated that it measures the most support provided by staff over the last seven days, even if that level of support only occurred once. Upon interview of CNA 3 on September 13, 2022, CNA clarified resident 70 did require assist of two upon pulling upward	

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	of the leg pulled the rest of the resident off the bed and onto the floor. The resident denied any pain at the time of the fall. The resident later complained of left leg pain and was sent to the emergency room. The current facility policy titled "Fall Prevention - Steady Steps Policy", with a revision date of February 17, 2020, was provided by the ADON (Assistant Director of Nursing) on 08/30/22 at 2:51 P.M. The policy indicated "...It is the policy of Christian Horizons to provide each resident with an appropriate assessment and interventions to prevent falls..." 2. On 08/26/22 at 1:25 P.M., Resident 73 was observed lying in her bed. The bed was in a low position and had a scoop mattress. The resident's call light was within reach and a thick pad was on the floor next to the resident's bed. The clinical record was reviewed on 08/29/22 at 2:28 P.M. A Quarterly MDS assessment, dated 08/03/22, indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, psychotic disorder, and repeated falls. The resident had two or more falls since the previous assessment. The progress notes were provided by the ADON on 08/30/22 at 11:23 A.M., and included, but were not limited to, the following: - a note, dated 07/11/22 at 3:30 P.M., indicated staff were called to the resident's room. Through a crack in the door, the resident could be seen lying on her back on the floor in her room cross ways in front of the door. The staff had to enter the resident's room through an adjoining room. The resident was alert but not able to answer		in bed, and assist of one to roll from side to side in bed. On September 13, 2022, interview with LPN 2, she clarified that resident did require two assist to be pulled up in bed, and one assist to be rolled from side to side in bed. See attached interview with CNA 3 and LPN 2. On MDS assessment dated July 30, 2022, section GG, it is indicated substantial to max assistance of one helper for rolling left and right, see supportive documentation. On August 6 ,2022, an MDS discharge/end of therapy assessment was completed to include section GG, in which resident required substantial/maximal assistance of one helper for rolling left and right. Upon further investigation by our Quality assurance team, Hoosier Christian Village will submit an IDR to the alleged deficient practice in regards to Resident 70. All residents plans of care will continue to include therapy recommendations in addition to MDS assessments. Resident 73 did not sustain any injuries or harm in result of fall on July 11, 2022. 1. Upon DON and ADON interviews with staff, regarding intervention implementation, it was noted that resident sleeps through scheduled arousal time and can	

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	questions due to advanced dementia. No apparent injuries were noted. The resident had been incontinent of bowel and had two blankets tangled around her ankles. The staff were educated on getting the resident up between 2:30 P.M. and 3:00 P.M., per the resident's care plan. During an interview on 08/26/22 at 1:27 P.M., CNA 6 indicated the resident usually laid down after meals. The staff got her up by 3:00 P.M., because she was a fall risk. The resident attempted to get out of bed by herself and was unable to stand or walk unassisted anymore. During an interview on 08/30/22 at 9:58 A.M., CNA 9 and CNA 10 indicated they knew what was on a resident's care plan by logging into the Kardex on their tablets. They completed their charting on the tablets. It was a routine that the resident was to be up by 3:00 P.M., daily. The resident's care plan should have her fall preventions listed. They laid the resident down after lunch and she usually took a nap. They often got her up before their shift ended at 2:00 P.M. If she was sleeping really well, they would let the oncoming shift know during the walk through report session to have her up by 2:30 P.M. They laid eyes on each resident during the walk through report. If the resident was awake at that time, they would help the second shift staff transfer her and bring her out to the common room. They tried to keep all fall risk residents in a common community area where a staff member could see them. During an interview on 08/30/22 at 2:13 P.M., CNA 11 indicated she had worked at the facility for over five years. She had been in the building when the resident had fallen at times but could not remember the details of the fall on 07/11/22. The		be difficult to awaken at times. On August 29, 2022, resident 73's plan of care was updated to include when resident does not awaken easily upon touch, to allow resident to sleep longer and nursing to monitor frequently and assist resident out of bed when resident awakens easily upon touch. 2. On August 30, 2022, DON and ADON identified residents who had fallen and reviewed post incident records and plans of care. Residents were assessed and reviewed according to their plan of care to ensure all interventions were being followed accordingly. No other residents were found to be affected by this alleged deficient practice. 3. On September 1, 2022, DON and ADON or nurse designee, met with nurses and CNAs from all shifts to discuss and review falls, to include new interventions and ensure they are being implemented and followed accordingly. During the week of September 26, DON and ADON will remind staff to continue to follow plan of care with bed mobility and transfers for all residents. These meetings will continue bi-weekly, ongoing. Any identified concerns will be addressed immediately with plan of care updated. 4. The DON and ADON will conduct audits weekly, for four	

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	resident currently required extensive assistance of two staff members for mobility and had special instructions to have her up before 3:30 P.M. Today, the staff were to have her up by 2:30 P.M. During an interview on 08/30/22 at 2:20 P.M., CNA 12 and CNA 13 indicated the resident used to get out of bed on her own and had fallen a few times. The intervention to get the resident up by 3:00 P.M., was just put in place in the last couple of months. They had both been working in the facility for about two years. They could not remember the resident's fall on 07/11/22. The Neurological Assessment Flow Sheet for the resident's fall on 07/11/22, was provided by the ADON on 08/30/22 at 11:23 A.M. The assessments began at 3:30 P.M., at the time of the fall. The care plan, provided by the ADON on 8/30/33 at 11:23 A.M., indicated the resident was at risk for falls related to dementia. An intervention, with a start date of 02/17/22, indicated the staff were to assist the resident, following her afternoon nap after lunch, in getting her up between 2:30 P.M., and 3:00 P.M. An intervention, with a start date of 06/17/22, indicated the staff were provided education on assisting the resident in getting up, daily, between 2:30 P.M., and 3:00 P.M. An intervention, with a start date of 07/11/22, indicated the staff were re-educated pertaining to the resident's plan of care. The current Comprehensive Care Plans policy, with a reviewed date of 05/18/17, was provided by the ADON on 08/30/22 at 2:24 P.M. The policy indicated, "... It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...to		weeks, then monthly, ongoing to ensure interventions per plan of care are implemented accurately. The DON, ADON, or designee will conduct random audits weekly for four weeks, then monthly for five months to ensure staff are following plan of care with bed mobility and transfers and number of staff required to provide safe assistance is being followed. These audits will be brought to the quality assurance team fore further review and recommendations, for no concerns or negative incidents, these audits will be discontinued after six months. Any additional concerns from all audits will be brought to the quality assurance team for further review and recommendations. 5. Completion September 16, 2022.	

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	meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...care plan will describe...The services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being...Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions..." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medications appropriately related to signing out narcotics before they were due, labeling and disposing of expired medications for 4 of 8 medication and treatment carts reviewed. (Hall 3 North medication cart, Hall 2 North medication cart, Hall 2 North treatment cart, and Hall 2 South treatment cart) Findings include: 1. The medication and treatment carts for Hall 3 North and Hall 2 North were observed on 08/24/22 at 10:10 A.M., with LPN (Licensed Practical Nurse) 7, and included, but were not limited to, the following: a. The narcotics drawer in the Hall 3 North medication cart contained two bubble cards of the medication Tramadol for Resident 43. One card had 60 tablets and one card had 5 tablets. The Tramadol record in the narcotics count book indicated the resident had 63 tablets remaining. The LPN indicated she was going to be here the entire shift and had already signed out the noon dose and the 4:00 P.M. dose for the resident and she should not have signed the medication out before it was due. b. The medication cart for Hall 2 North contained an inhaler, Symbicort, for Resident 40 that was 3/4 full and had no open date, and c. The treatment cart for Hall 2 North contained a Humulin 70/30 insulin pen for Resident 54 that was 3/4 full. The open date label was unreadable.	F 0761	1. Hoosier Christian Village does label drugs in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. A. On August 24, 2022, ADON provided one:one re-education to LPN 7 indicating narcotic medications are not to be signed out until time of administration. B. On August 24, 2022, the Symbicort for Resident 40 with the unopened date was discarded, and the Humilin 70/30 insulin pen for Resident 54 with unreadable label was discarded. Novolin R Insulin pen for resident 11 was discarded. Novolog insulin pen for resident 15 was discarded. On August 24, 2022, one:one re-education was provided with LPN 7 and LPN 8, and all of nursing staff to include date required when pen opened and when expired, insulin pens must be clearly labeled with dates dispensed and expiration dates and insulin pens should be disposed per manufacturer's guidelines. 2. On August 24, 2022, DON and ADON reviewed orders to identify all residents receiving insulin to ensure accuracy of	09/16/2022

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	A sticker on the pen indicated to discard the pen after 10 days. LPN 7 indicated staff should be able to read the label. 2. A treatment cart for Hall 2 South was observed on 08/24/22 at 10:54 A.M., with LPN 8, and included, but was not limited to, the following: - A Novolin R insulin pen for Resident 11 that was 1/3 full, had an open date of 07/19/22, and a discard date was 09/16/22, and - A Novolog insulin pen for Resident 15 that was 1/3 full, had an open date 07/20/22, and a discard date of 08/17/22. LPN 8 indicated all insulin pens should be dated when opened and have a "do not use after" sticker that was to be completed by the staff member who opened the pen. During an interview on 08/30/22 at 3:21 P.M., the ADON (Assistant Director of Nursing) indicated no residents had recently had any acute concerns related to blood glucose levels. The Novolin R insulin pen package insert was provided by the ADON on 08/30/22 at 3:20 P.M. The insert indicated when a pen was opened, in use, and at room temperature, it expired after 28 days. The current Insulin Pen policy, dated 2022, was provided by the ADON on 08/30/22 at 9:14 A.M. The policy indicated, "...Insulin pens must be clearly labeled with...date dispensed...and expiration date...Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation...Procedure...Check the expiration date on the pen. Discard if expired..."		labeling. No other residents were identified to be affected by this alleged deficient practice. 3. DON, ADON, pharmacist consultant, IP, and ward clerk will complete audits weekly, for four weeks, then monthly for five months of all medication carts to ensure insulin pens and inhalers are labeled correctly per manufacturer's guidelines. Infection Previonist will continue to conduct random rounds daily to include medication storage and labeling with accuracy of labeling insulin pens. 4. Infection Preventionist and ward clerk will conduct random audits, monthly, ongoing, to ensure accuracy of labeling and storage. Any concerns will be brought to the quality assurance committee for further review and recommendations. 5. Completion date September 16, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155611	A. BUILDING 00 B. WING	08/30/2022

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	The current Storage of Medications policy, with a reviewed date of 12/07/11, was provided by the ADON on 08/30/22 at 2:24 P.M. The policy indicated, "...purpose...to ensure that medications are stored in a safe, secure, and orderly manner...Drug containers having soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels will be destroyed...No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed..." 3.1-25(j) 3.1-25(o)			
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 serve food in accordance with professional			

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	standards for food service safety. Based on observation and interview, the facility failed to store food in a sanitary manner for 2 of 3 observations in the kitchen and snack refrigerator related to expired dates, food storage, hand hygiene and mask usage. Findings include: 1. During an initial tour of the kitchen on 08/24/22 at 10:05 A.M., the following was observed: - a reach-in refrigerator near the steam table had 19 pint-sized cartons of nutritional drinks with a use by date of 07/27/22. The Dietary Manager removed the drinks and threw them away. She indicated they should have already been taken out. - in the walk-in refrigerator on the bottom wired shelf was a 5-pound package of sealed turkey deli meat. A box of ground beef was sitting on top of the deli meat thawing. The ground beef box had no leaks, and the turkey was sealed. The meats were not sitting on trays. The Dietary Manager removed the ground beef from atop the deli meat. - in the walk-in freezer there were two boxes sitting on the floor. A box of frozen chicken was removed from the floor and placed in the refrigerator to thaw. A box of bratwurst were removed from the floor. The bratwurst had a delivery date of 10/18/19. The Dietary Manager removed the bratwurst and threw them away, she indicated the boxes should not have been sitting on the floor. - by the dishwasher area was a wired rack with dry dishes. There was a tray that contained a stack of clean red bowls and various other clean dishes. Beside the red bowls was a set of keys on a	F 0812	1. Hoosier Christian Village does ensure food safety requirements with storage preparation and serving. On August 24, 2022 and August 30, 2022, all residents were noted to be free of any food borne illnesses. No residents were affected by this alleged deficient practice. 2. No other residents were identified to be affected by the alleged deficient practice. On August 24, 2022, administrator conducted one:one re-education to Dining Manager including discarding outdated drinks and food, proper storage protocol of meat, proper storage protocol in refrigerator and freezer, and proper storage of scoops near sugar and flour bins. Re-education to all dining staff also included no staff drinks or personal items to be in kitchen area. Re-education was also provided to dining aide 14 including how to properly remove gloves and wash hands after touching mask and other items. For dining aides 15,16, and 17, re-education was provided on appropriate mask usage on August 24, 2022. On August 31, 2022, re-education was provided to all staff, including dining manager, of proper food storage with discarding outdated items appropriately. On September 13, the IDT determined that	09/16/2022

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	lanyard and a plastic fast food restaurant cup without a lid that was half full of a liquid. The Dietary Manager indicated those items were not to be sitting there and instructed a staff member to remove them from the shelf. - the dry storage room contained a sugar and flour bin that was half full. each bin had a scoop inside. The Dietary Manager indicated the scoops should be stored outside of the containers and her staff knew better. During an observation on 08/24/22 at 10:43 A.M., Dietary Aide 14 was standing by the steam table when she touched her face mask with her gloved right hand. She then retrieved a tray of drinks from the reach in refrigerator. She sat the tray down on a cart and removed each glass from the tray with her right hand and sat them in a tub. During an observation on 08/24/22 at 1:41 P.M., Dietary Aide 15 and Dietary Aide 16 were standing at a prep table with their mask under their chin and nose. They were moving a dessert from a pan to cups. Dietary Aide 17 was standing on the opposite side of the prep table with her mask under her chin. During a follow up visit to the kitchen on 08/30/22 at 10:00 A.M., the following was observed: - a reach in refrigerator by the steam table contained 32 power puddings with a date of 08/22/22. The Dietary Manager indicated there were made on 08/22/22 and would need to be used 5-6 days after making them. She removed them and threw them away. - a reach-in refrigerator, located next to the walk-in refrigerator, contained a 5-pound carton of liquid		accessibility to drinks in a central location no longer warrants the need for mini refrigerators in the community's clean utility storage rooms. On September 13, 2022, Environmental Services director removed refrigerators from the areas. 3. On September 7, 2022, our consultant registered dietician provided education to all dining staff pertaining to storage, preparation, and serving of food. The dietician will continue bi-weekly audits of food storage, preparation and serving of food, ongoing. The Infection Preventionist, during her daily environmental round audits, will audit appropriate mask usage of all staff, and educate as necessary. Any findings or concerns will be brought to the quality assurance team for further review and recommendations. On September 13, 2022, Environmental services director removed refrigerators from the clean utility storage areas. 4. On September 7, 2022, our consultant registered dietician provided education to all dining staff pertaining to storage, preparation, and serving of food. The dietician will continue bi-weekly audits of food storage, preparation and serving of food, ongoing. The Infection Preventionist, during her daily environmental round audits,	

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	whole eggs that was ¼ full and had an open date of 08/23/22. The label on the side indicated the eggs should be used within 3 days of opening. 2. During an observation and interview on 08/30/22 at 9:52 A.M., a snack refrigerator on the 300 Hall contained the following: - two energy drinks LPN (Licensed Practical Nurse) 2 indicated the drinks belonged to staff and shouldn't have been in there, - a one quart milk jug that was 1/4 full of a red substance. It was unlabeled and undated. LPN 2 indicated she believed it was tomato juice for a resident, but she was unsure how long it had been in there, - a 1.5-liter container of unopened chocolate milk that had no name. The milk had a use by date of 08/21/22. LPN 2 indicated the resident's snack refrigerators were to be cleaned out by the 3rd shift nursing staff. During an interview on 08/30/22 at 10:40 A.M., the Administrator indicated there had not been any food borne illnesses in the building. During an interview on 08/29/22 at 2:24 P.M., Nurse Aide 18 indicated masks should be covering the nose and mouth. The current facility policy titled, "Infection Prevention and Control Manual Dietary", dated 2017, was provided by the Administrator on 08/30/22 at 11:13 A.M. The policy indicated, "...Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discard...Store raw meat (e.g., beef,		ongoing, will audit appropriate mask usage of all staff, and educate as necessary. Any findings or concerns will be brought to the quality assurance team for further review and recommendations. 5. Completion September 16, 2022.	

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	pork, lamb, poultry, and seafood) separately and in drip-proof containers and in a manner that prevents cross-contamination of other food in the refrigerator..." The current facility policy titled, "Food from Family, Visitors, Community" dated 2016, was provided by the Dietary Manager on 08/23/22 at 12:00 P.M. The policy indicated, "...Food stored for residents should be labeled and dated appropriately, and discarded per safe food storage guidelines. A facility may choose to utilize a specific refrigerator or area of cooler for resident food..." The current facility policy titled, "Masking Technique" dated 2020, was provided by the Administrator on 08/30/22 at 11:13 A.M. The policy indicated, "...Staff, visitors, and family will wear a mask...Place mask over nose and mouth...The mask is intended to fully cover the nose and mouth..." 3.1-21(i)(3)			
F 0880 SS=D 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			

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	elements: §483.80(a)(1) A system for preventing, 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			

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	followed by staff involved in direct resident contact. §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 follow appropriate infection control guidelines related to Transmission Based Precautions and mask usage for 2 random observations (Residents 132 and 13), and indwelling urinary catheters (Residents 38 and 20) for 4 of 15 residents reviewed for Infection Prevention. Findings include: 1. During a random observation on 08/26/22 at 11:11 A.M., CNA (Certified Nurse Aide) 4, was wearing only a surgical mask, walked into room 351, Resident 132's room, that had an isolation cart located in the hallway, next to the door and outside the room. The room had four signs posted on the outside of the door indicating the resident was in TBP (Transmission Based Precautions). The signs indicated the staff were required to use hand hygiene, don a gown, gloves, eyewear, and an N95 mask before entering the room. CNA 4 and CNA 3 exited the room wearing their scrubs and a	F 0880	1. Hoosier Christian Village does establish and maintain and 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. On August 26, 2022, CNA 3 and CNA 4 washed hands upon completion of care and placed an N95 mask for duration of their shift. DON and ADON provided re-education to CNA 3 and CNA 4 regarding donning and doffing of PPE with return demonstration, and isolation protocols. Both CNAs were provided a rapid POC COVID-19 test, in which both resulted negative. Resident 132 did receive a negative PCR COVID-19 test result on August 26, 2022.	09/16/2022

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	155611	A. BUILDING 00 B. WING	08/30/2022

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	surgical mask. During an interview CNA 3 indicated she should have donned a gown before entering the resident's room. The resident was in isolation. During an observation and interview on 08/26/22 at 11:14 A.M., the ADON (Assistant Director of Nursing) indicated Resident 132 was in TBP due to having a cough. She was tested for COVID-19, with a rapid test, on 08/24/22. The test was negative. She had a chest X-ray, that was completed on 08/24/22, and it was negative. She had a pending PCR (Polymerase Chain Reaction) COVID-19 test. Staff were to wear a gown, gloves, face shield, and an N95 mask when entering the resident's room. The resident's room had an isolation cart stocked with PPE (Personal Protective Equipment) in the hallway next to the door. During an interview on 08/29/22 at 3:01 P.M., the DON (Director of Nursing) indicated the facility had a COVID-19 positive resident in the building who tested positive on 8/15/22 and was removed from isolation on 08/25/22. The clinical record for Resident 132 was reviewed on 08/30/22 11:41 AM. The resident was readmitted on 08/19/22. The diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and cognitive communication deficit. The PCR test result was provided by the ADON on 08/30/22 at 9:14 A.M., and were negative. Signage posted on the resident's room door was provided by the ADON on 08/30/22 at 9:14 A.M. The "Contact Precautions" sign indicated providers and staff must clean their hands before		2. On August 26, 2022 and August 31,2022, DON and ADON provided to staff education on the need to maintain face covering, over the mouth and nose, as well as the appropriate covering to be used, at all times when in use. 3. On August 30, 2022, DON and ADON identified residents with catheters and immediately placed catheter bags inside of dignity cover bags so that the bag and tubing would not touch the floor. No other residents were identified to be affected by this alleged deficient practice. On August 30, 2022, nursing staff were re-educated on indwelling catheter infection control practices. Infection Preventionist, or designee, will conduct daily audits for six weeks, then monthly, ongoing, to ensure catheter bags and tubing are kept off of the floor and below the level of the bladder with any findings reported to administrator and brought to the quality assurance team for further review and recommendations. 4. On August 30, 2022, a Root cause analysis was initiated with IP, Medical Director, DON, ADON, and administrator. The root cause of donning and doffing PPE was identified as signage being similar in format and color pertaining to aerosol precaution signage and Transmission based precautions signage. B. IP	

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	155611	A. BUILDING 00 B. WING	08/30/2022

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	entering and when leaving the room, don gloves, and a gown before entering the room. The "Droplet Precautions" sign indicated staff were to make sure their eyes, nose, and mouth were fully covered before entering the resident's room and to remove their face protection before exiting the room. The "Aerosol-Generation Procedure in Progress" sign indicated the PPE required to enter the resident's room included an N95 mask, eye wear, a gown, and gloves. The "PERSONAL PROTECTIVE EQUIPMENT" sign indicated staff were to don a gown, mask, face shield or goggles, and gloves. The current "Novel Coronavirus Prevention and Response Policy, with an effective date of 02/14/22, was provided by the ADON on 08/30/22 at 9:14 A.M. The policy indicated, "...The community will promote appropriate use of personal protective equipment (PPE) by...Posting signs on the door...of the resident room that clearly describe the type of precautions needed and required PPE..." 2. During a random observation on 08/29/22 at 2:24 P.M., Nurse Aide 18 was propelling Resident 13 out of the dining room and down the hallway. Nurse Aide 18 had her mask under her chin. She indicated masks should be covering the nose and mouth. The current facility policy titled, "Masking Technique" dated 2020, was provided by the Administrator on 08/30/22 at 11:13 A.M. The policy indicated, "...Staff, visitors, and family will wear a mask...Place mask over nose and mouth...The mask is intended to fully cover the nose and mouth..." 3. During an observation and interview on 08/26/22 at 9:03 A.M., Resident 38 was sitting in		re-formatted signage in order for staff to be able to differentiate proper precautions in place for residents. See supportive documentation. On August 31, 2022, staff were educated on new signage protocol for isolation and aerosol usage. On August 30, 2022, a root cause analysis was initiated with IP, Medical Director, DON, ADON, and administrator in reference to catheter bags and tubing touching the floor. The root cause of catheter bags touching the floor was determined to be that the dignity bags allowed catheter bags and tubing to continue to touch flooring. On August 30, 2022, DON and ADON identified residents with catheters and immediately placed catheter bags inside of dignity cover bags so that the bag and tubing would not touch the floor. On August 31, 2022, all staff were re-educated on catheter bags being placed in proper dignity bags that do now allow catheter bags to not touch the floor and to ensure the tubing and catheter drainage bag are below the level of the bladder. The catheter bags with an open bottom were discontinued for use within the facility. Infection Preventionist, or designee, will conduct daily audits for six week, then monthly ongoing to ensure catheter bags and tubing are kept off of the floor and below the level of the bladder with any findings	

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	155611	A. BUILDING 00 B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	her room in a recliner. Her urinary catheter drainage bag was hanging on a garbage can sitting between the recliner and the bed, the resident indicated she had not placed her catheter bag on the garbage can. During an observation on 08/26/22 at 1:20 P.M., Resident 38 was sitting in her room in a recliner. Her urinary catheter drainage bag was hanging on a garbage can sitting between the recliner and the bed. During an observation on 08/29/22 at 10:37 A.M., Resident 38 was sitting in her room in a recliner. Her urinary catheter drainage bag was hanging on a garbage can sitting between the recliner and the bed. During an observation on 08/30/22 at 10:10 A.M., Resident 38 was sitting in her room in a recliner. Her urinary catheter drainage bag was hanging on a garbage can sitting between the recliner and the bed. The clinical record for Resident 38 was reviewed on 08/26/22 at 9:44 A.M. An Admission MDS (Minimum Data Set) assessment, dated 07/06/22, indicated the resident was cognitively intact. The diagnosis included, but was not limited to, malignant neoplasm of central portion of right female breast. 4. On 08/24/22 at 12:37 P.M., Resident 20 was observed in her room in bed. The resident's indwelling urinary catheter drainage bag was hanging off the side of the bed. The bed was in a lower position, and 2 to 3 inches of the drainage bag was folded and resting on the floor. On 08/26/22 at 9:02 A.M., the resident was observed lying in bed eating breakfast. Her		reported to administrator and brought to the quality assurance team for further review and recommendations. 5. IP will bring daily, ongoing audits to monthly QAPI meetings for IDT team to review and off further recommendations as needed. 6. Completion September 16, 2022.	

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	155611	A. BUILDING 00 B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	catheter drainage bag was touching the floor with 5 inches of the bag lying flat against the floor. On 08/26/22 at 1:29 P.M., the resident was observed in her room sitting in her wheelchair in front of the television. The catheter drainage bag and tubing were hanging below the wheelchair, touching the floor. On 08/29/22 at 10:47 A.M., the resident was observed in her room, sitting in her recliner. The resident's feet were elevated, and an overbed table was in place in front of the resident. The catheter drainage bag was hanging from the recliner and the drainage bag was resting on the base of the over bed table. The resident's clinical record was reviewed on 08/29/22 at 2:18 P.M. A Quarterly MDS assessment, dated 06/01/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia, diabetes, chronic kidney disease, neurogenic bladder, and obstructive neuropathy. The resident had an indwelling urinary catheter. During an interview on 08/30/22 at 10:12 A.M., CNA 21 indicated catheter bags shouldn't touch the floor and should be placed below the bladder and should never be hanging from a garbage can. The current facility policy, titled "Incontinence and Catheter Management", with a revision date of 09/27/21, was provided by the ADON on 08/30/22 at 2:51 P.M. The policy indicated, "...A resident, with a catheter, will receive the appropriate care and services to prevent urinary tract infections...proper storage of collection bag when not in use..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155611	A. BUILDING 00 B. WING	08/30/2022

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	3.1-18(b) 3.1-41(a)(2)			
F 9999 Bldg. 00	410 IAC 16.2-3.1-14 Personnel Sec. 14. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to complete criminal background checks on minors hired to work in the facility (Employee 23, 24, 25, 26, 27, and 28) and to have complete CNA (Certified Nurse Aide) student files related to Pre-Enrollment math and reading comprehension tests for 2 of 2 student files reviewed. (Student 5 and Student 19) Findings include: 1. The following employees were hired and lacked a criminal background in their employee files: - Employee 23 had a start date of 05/12/22, - Employee 24 had a start date of 05/25/22, - Employee 25 had a start date of 11/30/21, - Employee 26 had a start date of 11/23/21, - Employee 27 had a start date of 04/20/22, and - Employee 28 had a start date of 06/01/22. During an interview on 08/30/22 at 12:04 P.M., the Human Resource Director indicated the system she used for background checks doesn't allow her request a background check if the employee was	F 9999	Hoosier Christian Village does have specific procedures written and implemented for the screening of prospective employees. On August 30, 2022, minors employed at Hoosier Christian Village were contacted by Human Resources to obtain a background check. On August 30, 2022, administrator provided one:one education to HR and Nurse educator on background check policy and the requirement for a pre-enrollment math and reading comprehension test for CNA classes. The HR Director completed an audit review to identify any employees who may need to complete the pre-enrollment math and reading comprehension test and obtain a background check. Any employee applying for the CNA class at Hoosier Christian Village will complete a pre-enrollment math and reading comprehension test. Hoosier Christian Village will conduct background checks on finalists for all positions within the community and in accordance with state and federal laws.	09/16/2022

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	under the age of 18. She doesn't do a background check on the minors, she calls the school and speaks to the guidance counselor. The current facility policy titled "Backgrounnd Checks Policy" with a revised date of February 27, 2019, was provided by the Administrator on 08/30/22 at 2:28 P.M. The policy indicated "...It is the policy of Christian Horizons as part of its hiring procedures, to conduct background checks on finalist(s) for all positions within the organization and in accordance with applicable state and federal laws..." 2. Standard 3 Classroom Instruction. Students must meet the following requirements: - Be able to add and subtract simple equations and Be able to read and write English Standard 5 Student Files each student trained as a Nurse Aide by an approved training entity will have and organized individualized student file. These files will contain a minimum of any and all assessment tools utilized during the classroom portion of the course. This standard was not met based on record review and the training entity lacked documentation of a pre-enrollment test. Student 5 file was reviewed on 08/30/22 at 2:20 P.M. The file lacked a pre-enrollment math and reading comprehension test. Student 19 file was reviewed on 08/30/22 at 2:25 P.M. The file lacked a pre-enrollment math and reading comprehension test. During an interview on 08/30/22 at 2:30 P.M., LPN 20 and Human Resources had indicated the files had not contained pre-tests for the students. They were under the impression the tests didn't		The HR Director will continue to do monthly audits for employee files, ongoing, to ensure background checks for minors and pre-enrollment meth and reading comprehension tests for CNA classes are complete in necessary files. Any concerns will be brought to the administrator and the quality assurance team for further review and recommendations.	

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	need to be done. During an interview on 08/30/22 at 3:41 P.M., Human Resources indicated there was not a facility policy related to the math and reading comprehension tests for students.			