STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: September 27, 28, 29, and October 2, and 3, 2017. Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 01 Medicaid: 36 Other: 11 Total: 48 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 6, 2017.	F 0000		
F 0460 SS=E Bldg. 00	483.90(e)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; (e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains Based on observation and interview, the facility failed to ensure the provision of full privacy between resident's beds for 6 of 20 rooms reviewed on the 200 Hall related to the privacy curtains. (Rooms 204, 205, 206, 208, 209, and 211) Findings include: During a tour of the 200 Hall with the Maintenance Director on 10/02/17 at 9:27 a.m., the following measurements were obtained: Room 204's privacy curtains were observed with five eyelets unhooked from the track and hanging loosely. The track between the resident's beds did not meet by 10 inches at the foot of the bed. Room 205's privacy curtain track between the resident's beds did not meet by 5 inches at the foot of the bed. Room 206's privacy curtain track between the resident's beds did not meet by 9 inches at the foot of the bed.	F 0460	The deficient practice of not providing full privacy due to the privacy curtains will be corrected by November 2, 2107 by the Maintenance Department. A piece of track will be added to each curtain that did not meet the track of the other curtain in the rooms mentioned in our 2567. The Administrator or his designee will make sure those extensions are added by the November 2 date. The deficient practice of having loose hooks where the curtains should be hooked in room 204 has been fixed. I have attached a form that each housekeeper will have on their carts daily to make sure that the privacy curtains are attached to the hooks. The housekeeping department head or her designee will make sure that this is being done daily.	11/02/2017

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Room 208's privacy curtain track between the resident's beds did not meet by 10 inches at the foot of the bed.

Room 209's privacy curtain track between the resident's beds did not meet by 11 inches at the foot of the bed.

Room 211's privacy curtain track between the resident's beds did not meet by 11 inches at the foot of the bed.

The Maintenance Director indicated the 200 Hall was an older section than the 300 Hall. The tracking was assembled to meet on the 300 Hall rooms and not the 200 Hall rooms. Housekeeping should check the privacy curtains for loose hooks each time they clean.

During an interview on 10/2/17 at 9:40 a.m., the Administrator acknowledged the tracks did not meet and they could have been moved away from the wall, to the junction of the tracking, to provide full privacy.

During an interview on 10/03/17 at 9:04 a.m., the Housekeeping Assistant Supervisor indicated the rooms were checked daily and if the privacy curtain hook eyelets were observed off of the hooks, on the tracks, then they would be

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	fixed. During an observation on 10/03/17 at 9:20 a.m. Room 204's privacy curtains were still hanging, unhooked from the tracking, between the two resident's beds. The Administrator provided a copy of the Resident Rights Privacy and Confidentiality policy on 10/02/17 at 10:07 a.m. which indicated, but was not limited to, the following: "It is the intent of this facility that the resident has personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations...PROCEDURE...Staff are oriented and in serviced at least annually on the right to privacy for the resident in all aspects of their life during their stay at the facility..." The Administrator indicated he had no other policy for the privacy curtains providing full privacy for the resident's living area. 3.1-19(6)			
F 9999 Bldg. 00				

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	3.1-14 (u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within (6) months of initial employment , or within thirty (30) days of personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule is not met as evidenced by: Based on record review and interview the facility failed to ensure each employee had completed the appropriate number of dementia training hours in a timely manner. This affected 5 of 10 staff members reviewed for employee records. (LPN1, Activities Director, Cook, CNA1, and the Maintenance Director). Findings include: Employee records were provided by the Administrator on 10/03/17 at 8:30 a.m. and indicated the following: a. LPN (Licensed Practical Nurse) 1 - Hire date 04/13/10	F 9999	The corrective action is to ensure the completion of in-service for all MMCH staff/employees regarding Dementia for the initial 6 hours within 6 months and then 3 hours annually thereafter. There were no residents affected by all 3 hours of the dementia training for those staff noted in 2567 not being completed. In-service education provided will meet the needs or preferences or both of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. In-service titled Alzheimers Behaviors & Pain Management was completed on 8/22/17 with all staff employed at that time (see attached signature sheet and in-service material) this in-service was 1 hour in length. In-service titled Dementia-Follow up to State Survey was completed on 10/13/17 (see attached signature sheet and in-service material) this in-service was 2 hours in length. These 2 in-services together total 3 hours. Quarterly audits of staff/employee in-service education to be performed on spreadsheet form (see attached) for tracking of all required in-service education by DON or designee.	11/02/2017

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	b. Activities Director - Hire date 07/21/1991 c. Cook - Hire date 03/24/10 d. CNA (Certified Nurse Aide) 1 - Hire date 04/16/15 e. Maintenance Director - Hire date 08/18/1995 During an interview 10/03/17 at 10:10 a.m. with the DON (Director of Nursing), she indicated "The dementia training on the employees that you asked for did not have any in-services. I could not find any record for dementia training for 2016 or 2017 for these employees. I go by the Licensing and Operational Standards that the state goes by. I did not know they were not done and no one told me. I wasn't responsible for the dementia training at the time."			