STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KEYSTONE WOODS	2335 N MADISON AVE ANDERSON, IN 46011

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00423216. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00423216 - State deficiencies related to the allegations are cited at R407. Survey dates: January 31, 2024 Facility number: 010409 Residential Census: 56 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 5, 2024.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Keystone Woods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindi Cooper	Executive Director	02/16/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on interview and record review, the facility failed to maintain COVID-19 testing documentation regarding staff testing and positive infections. This had the ability to effect 56 of 56 residents residing in the facility. Findings include: During an interview on 1/31/24 at 11:24 a.m., the DON indicated she had no documentation or a surveillance list of staff who were tested for COVID-19 or of staff who had tested positive for COVID-19. During an interview on 1/31/24 at 2:31 p.m., the Administrator indicated she was not sure where the staff testing documentation was kept. She had not been able to find any documentation regarding the staff testing in November and December when the facility had a COVID-19 outbreak. She had no documentation regarding staff who had tested positive during that time but indicated there were three staff members involved. A current facility policy, revised 9/28/23, titled, "Novel Coronavirus (2019-nCoV) (COVID-19)," provided by the Administrator on 1/31/24 at 10:25 a.m., indicated the following: "...Monitoring and Surveillance:...All surveillance documents will be maintained by the facility Wellness Director and will be reviewed by the Executive Director...." This citation relates to Complaint IN00423216.	R 0407	1 The facility has implemented and will maintain a COVID-19 testing log for all staff and residents. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Executive Director and Wellness Director received in-service training on COVID-19 procedures, including how to maintain a COVID-19 testing log for all staff and residents. The facility is now using the COVID-19 testing log to ensure the deficient practice does not recur. 4 The Wellness Director or designee will audit once per week for six weeks to ensure that the COVID-19 testing log is ready and available to use. During the next COVID-19 outbreak, the Wellness Director or designee will be responsible for ensuring that the COVID-19 testing log is being used for all staff and residents. 5 This systemic change will be completed by 02/16/24	02/14/2024