

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2023
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NAME OF PROVIDER OR SUPPLIER SWEET GALILEE AT THE WIGWAM	STREET ADDRESS, CITY, STATE, ZIP COD 1315 JOHN STREET ANDERSON, IN 46016
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00395485, IN00396376, and IN00395977.</p> <p>Complaint IN00395485 - Substantiated. State deficiencies related to the allegations are cited at R0039.</p> <p>Complaint IN00396376 - Substantiated. State deficiencies related to the allegations are cited at R0039.</p> <p>Complaint IN00395977 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: February 1 and 2, 2023.</p> <p>Facility number: 014706</p> <p>Residential Census: 75</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed February 7, 2023.</p>	R 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Sweet Galilee at the Wigwam desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective: 3/1/2023 Sweet Galilee respectfully requests paper compliance</p>	
R 0039 Bldg. 00	<p>410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference.</p> <p>Based on interview and record review, the facility</p>	R 0039	<p>What corrective action will</p>	02/24/2023

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

TITLE

(X6) DATE

Daphne New

Administrator

02/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>failed to investigate and provide a response to the resident for grievances filed for 9 of 18 resident grievances reviewed.</p> <p>Findings include:</p> <p>Grievances for November 2022, December 2022, and January 2023, provided by the administrator on 2/1/23 at 11:06 a.m., were reviewed on 2/1/23 at 11:12 a.m. Nine grievances from November contained the resident's written concern and signature, with no additional documentation.</p> <p>During an interview, on 2/1/23 at 4:26 p.m., the Administrator indicated she was unable to locate additional documentation for the grievances lacking investigations. She was uncertain if anyone had looked at the grievances, or if they had been ignored by the previous management team.</p> <p>A current facility policy, dated 1/6/22, provided by the Administrator on 2/1/23 at 4:26 p.m., and titled "Resident Grievance Policy and Procedure," indicated the following: "...Once the Resident Grievance Form has been completed, it will be forwarded to the Administrator. The Administrator shall oversee and ensure that a comprehensive investigation of the matter is conducted, corrective action is taken, if necessary, and a report is provided to the Resident within 10 days of filing the complaint"</p> <p>This Residential Tag relates to Complaints IN00395485 and IN00396376.</p>		<p>be accomplished for those residents found to have been affected by this deficient practice: 9 grievances identified will be overseen by the Administrator and will follow the grievance policy/procedure, reviewed and investigated by the responsible department with findings reported to the resident within 10 days of reporting.</p> <ul style="list-style-type: none"> How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken <p>All residents have the potential to be affected by this deficient practice. No other outstanding grievances identified.</p> <ul style="list-style-type: none"> What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur <p>A resident council was held initially upon identifying the deficiency. Administrator shared with Resident Council of the process and where/how to file a grievance. Education will be provided for all staff, ongoing in monthly staff meeting or other monthly inservice. Grievance forms will be easily accessible in identified areas.</p> <ul style="list-style-type: none"> How the corrective action will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program 	

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R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for		will be put into place The Administrator will request new or outstanding Grievances upon daily meeting at least 5 days a week, for review, as well as ensure that grievance forms are available and accessible in identified areas. Administrator or designee will interview 10 Residents per week for 1 month and then monthly for 6 months to ensure Grievances are heard and Policy is followed. In addition to daily meeting requests for new or outstanding Grievances from Department Heads, Grievance process concerns and audits will be brought to monthly QA meeting, ongoing.	

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	<p>employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interview, the facility failed to ensure newly hired employees had a completed and signed job-specific orientation for 3 of 5 employee records reviewed (DON (Director of Nursing), LPN (Licensed Practical Nurse) 3, QMA (Qualified Medication Aide) 5).</p> <p>Findings include:</p> <p>An employee record review, on 2/2/23 at 12:40 p.m., indicated LPN 3 and QMA 5 lacked job-specific orientations. The DON's job-specific orientation was signed by herself with no supervisor initials or supervisor signatures.</p> <p>During an interview, on 2/2/23 at 1:02 p.m., the Business Office Manager (BOM) indicated she had no additional employee records.</p> <p>A current facility policy, dated 4/24/21, provided by the Administrator on 2/2/23 at 1:40 p.m., and titled "General Orientation," indicated " ...All new employees will receive general orientation within their first 30 days of employment ...Specific job orientation will also begin on the first day of work</p>	R 0119	<p>What corrective action will be accomplished for those residents found to have been affected by this deficient practice:</p> <ul style="list-style-type: none"> · Employee personnel files for DON, LPN 3, and QMA 5 identified will be updated with job-specific orientation. <p>/p></p> <ul style="list-style-type: none"> · All personnel files will be audited for completeness. Any missing job specific orientation forms will be corrected and brought up to date. <p>/p></p> <ul style="list-style-type: none"> · Administrator will inservice BOM and Department Directors on required job specific orientation. All new hire file check list will be audited daily x 5 days a week until complete. New hires will not start 	03/01/2023
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R 0121 Bldg. 00	<p>...Each new employee will be scheduled by the Department Head/Supervisor to receive orientation beginning on the first day of employment which is to be completed no later than by the 30th day of employment"</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting</p>		<p>work until required information/documentation is received and all other required information/documentation received within 30 days of hire.</p> <p>/p> /p></p> <p>· Business Office Manager or Designee will ensure that employee file audit is completed, collecting any missing information found. In addition, BOM will utilize a checklist to ensure all needed items are complete before new hires' start of work. In addition, New Hire file audits will be brought to monthly QA meeting and monitored ongoing until 100% compliance is met for 6 months</p>		

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	<p>work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to complete health screenings for tuberculosis (TB) upon hire for 5 of 5 newly hired employees (QMA (Qualified Medication Aide) 5, CNA (Certified Nurse Aide) 7, LPN (Licensed Practical Nurse) 3, the DON (Director of Nursing), and the Activity Director).</p> <p>Findings include:</p> <p>An employee record review, on 2/2/23 at 12:40 p.m., indicated QMA 5, CNA 7, LPN 3, the DON, and the Activity Director lacked a second step TB test required for health screenings for tuberculosis.</p>	R 0121	<p>What corrective action will be accomplished for those residents found to have been affected by this deficient practice/div> </div> sup>st day worked and utilize Calendar to track 2nd step to ensure completed within 7 -21 days after 1st step New Hire file audits will be brought to monthly QA meeting and monitored ongoing until 100% compliance is met for 6 months</p>	03/01/2023

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

PRINTED: 02/28/2023

FORM APPROVED

OMB NO. 0938-039

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	<p>During an interview, on 2/2/23 at 1:02 p.m., the Business Office Manager (BOM) indicated the employees had not received a second step TB test, as she did not know a second step TB test was required.</p> <p>A current facility policy, dated 1/6/22, provided by the Administrator on 2/2/23 at 1:40 p.m., and titled "Personnel Records" indicated " ...The following documents will be retained in the personnel file or separate file as appropriate ...TB testing results"</p>			