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

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 02/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| DIGBY PLACE | 167 CR W 240 S<br>LAFAYETTE, IN 47905 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00452896.<br><br>Complaint IN00452896 - No deficiencies related to the allegations are cited.<br><br>Survey dates: February 19, 20, 21 and 24, 2025.<br><br>Facility number: 004392<br><br>Residential Census: 36<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on March 3, 2025. | R 0000 | | |
| R 0116<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(a)<br>Personnel - Noncompliance<br><br>Based on record review and interview, the facility failed to ensure reference checks were obtained for prospective employees prior to employment for 6 of 10 employees reviewed for references. (CNA 2, LPN 3, CNA 4, LPN 5, CNA 6 and CNA 7)<br><br>Findings include:<br><br>1. The employee record for CNA 2 was reviewed on 2/21/25 at 1:10 p.m. The employee reference checks for CNA 2 were not in the employee's file.<br><br>2. The employee record for LPN 3 was reviewed on 2/21/25 at 1:12 p.m. The employee reference checks for LPN 3 were not in the employee's file. | R 0116 | Deficiency ID: R _0116<br>Completion Date 03/15/2025 12:00AM<br>On 2/25/2025 the Executive Director (ED) and Director of Health and Wellness (DHW) audited current staff files for completion of reference check verifications. Staff identified as not having references on file were asked to provide a minimum of 2 professional references for their files.<br>The ED and/or designee will complete reference checks for any new hire prospects to ensure | 03/20/2025 |

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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| | 3. The employee record for CNA 4 was reviewed on 2/21/25 at 1:14 p.m. The employee reference checks for CNA 4 were not in the employee's file.<br><br>4. The employee record for LPN 5 was reviewed on 2/21/25 at 1:18 p.m. The employee reference checks for LPN 5 were not in the employee's file.<br><br>5. The employee record for CNA 6 was reviewed on 2/21/25 at 1:20 p.m. The employee reference checks for CNA 6 were not in the employee's file.<br><br>6. The employee record for CNA 7 was reviewed on 2/21/25 at 1:23 p.m. The employee reference checks for CNA 7 were not in the employee's file.<br><br>During an interview, on 2/21/25 at 1:25 p.m., the Executive Director indicated CNA 2, LPN 3, CNA 4, LPN 5, CNA 6 and CNA 7 did not have any employee reference checks completed or placed in their employee file.<br><br>A policy and procedure for reference checks was not provided. | | compliance. New hire folders with all required documents and checklists were prepared and will be followed to ensure completion. On 2/24/2025, the Regional Care Specialist (RCS) in-service the ED and DHW on personnel compliance by ensuring that each community will have specific procedures written and implemented for the screening of prospective employees, including personal/professional references and criminal background checks. ED and/or designee is responsible for compliance. ED and/or designee will audit 5 staff personnel records weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure compliance of staff references and screening. Results will be reviewed monthly in QI meeting. The QI committee will determine if continued auditing will be necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br><br>Based on record review and interview, the facility failed to ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws for 10 of 21 shifts reviewed for valid CPR certifications. (10 of 21 shifts) | R 0117 | Deficiency ID: R_0117<br>On 2/24/2025, the ED and DHW audited current staff files for CPR certification and basic first aid training certificates. All staff were noted to have current CPR and First Aid certification in their files. | 03/20/2025 |

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| | Findings include:<br><br>A review of the employees' as-worked schedule, on 2/20/25 at 4:15 p.m., indicated during the week of 2/9/25 through 2/15/25, the facility had 10 out of 21 shifts without documentation of a certified staff member with skills validation training for CPR.<br><br>During an interview, on 2/20/25 at 4:28 p.m., the Executive Director indicated the staff members had completed their CPR training online and she was not aware CPR training required skills validation training to certified staff members. She indicated the facility did not have a policy and procedure related to CPR certifications. | | Per the state inspector during the most recent survey, the ED was notified that the current company used for CPR and First Aid certification was no longer sufficient for compliance based on the absence of an in-person instructor to observe return demonstration of CPR. This ED was unaware of this stipulation of the regulation. The regulation states “(1) awake person with current CPR and first aid certification on site”. The regulation does not specify whether a return demonstration is required. The ED and DHW have also not been notified of any specifics requirement of return demonstration being added to the regulation by the ISDH. The community is in compliance based on the regulations as written.<br>On 2/24/2025 the ED, RCS, Divisional Care Specialist and Regional Director of Operations discussed this reported deficiency. None of the above have been notified of any addition or change to the regulation based on CPR certification.<br>The ED has contacted the local Fire Department and other health organizations to request an in-person CPR certification class and will have all staff attend for the desired return demonstration.<br>Due to the regulation written not specifying a return demonstration | |

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| | | | and all employees reviewed are CPR and First Aid certified, We formally request an IDR. | |
| R 0120<br>Bldg. 00 | 410 IAC 16.2-5-1.4(e)(1-3)<br>Personnel - Noncompliance | | | |
| | Based on record review and interview, the facility failed to ensure staff members had completed annual in-service education for 3 of 10 staff members reviewed for annual training. (CNA 2, LPN 3 and CNA 8)<br><br>Findings include:<br><br>1. The employee record for CNA 2 was reviewed on 2/21/25 at 3:33 p.m. The employee did not have dementia training documented in the employee's file.<br><br>2. The employee record for LPN 3 was reviewed on 2/21/25 at 3:35 p.m. The employee did not have resident's rights and abuse training documented in the employee's file.<br><br>3. The employee record for CNA 8 was reviewed on 2/21/25 at 3:38 p.m. The employee did not have resident's rights training documented in the employee's file.<br><br>During an interview, on 2/24/25 at 12:02 p.m., the Executive Director indicated CNA 2, LPN 3 and CNA 8 did not have the annual in-service education documented in their files. She indicated the facility did not have a policy and procedure related to annual in-service education. | R 0120 | Deficiency ID: R_0120<br>On 2/24/25 the ED audited all current employee files to identify those not in compliance with state required in-services on abuse and neglect, resident rights and dementia. Those employees found out of compliance will complete the required in-services no later than 3/20/25.<br>All newly onboarding employees will complete Resident Rights, Abuse and dementia training with the DHW while in orientation.<br>Current employee files will be audited by the ED or designee, monthly to maintain compliance.<br>On 2/25/2025, the ED and DHW were re-trained by the Regional Care Specialist on the requirements for staff in-service.<br>The ED is responsible for maintaining compliance.<br>Employee files will be audited monthly and discussed in monthly QI.<br>Monitoring will be ongoing. | 03/20/2025 |
| R 0272<br>Bldg. 00 | 410 IAC 16.2-5-5.1(e)<br>Food and Nutritional Services - Deficiency | | | |

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| | Based on interview and record review, the facility failed to ensure food temperatures were documented as being checked prior to serving the meal during 10 of the 12 months reviewed for safe and appropriate temperatures. (March 2024, April 2024, May 2024, June 2024, July 2024, August 2024, September 2024, November 2024, December 2024 and January 2025)<br><br>Findings include:<br><br>During a record review, on 3/24/25 at 2:30 p.m., the serving temperature logs for the facility meals had the following missing dates:<br>a. There were missing or no records for meals on 7 days in March 2024.<br>b. There were missing or no records for meals on 2 days in April 2024.<br>c. There were missing or no records for meals on 3 days in May 2024.<br>d. There were missing or no records for meals on 13 days in June 2024.<br>e. There were missing or no records for meals on 8 days in July 2024.<br>f. There were missing or no records for meals on 5 days in August 2024.<br>g. There were missing or no records for meals on 1 day in September 2024.<br>h. There were missing or no records for meals November 16 through November 30, 2024.<br>i. There were no records for meals in December 2024.<br>j. There were no records for meals in January 2025.<br><br>During an interview, on 2/24/25 at 4:50 p.m., the Executive Director indicated the temperature records should have been completed prior to serving the meals. She did not know why the documentation was incomplete and missing. She indicated the facility did not have a policy and | R 0272 | Deficiency ID: R_0272<br>On 2/25/2025 the ED audited the food temp log for compliance. All log sheets placed in an organized binder to promote efficiency and organization for all food related temperatures (i.e cooked food temp, fridge/freezer)<br>Chef and cook both inserviced on proper food temp checks and logging of results.<br>All food temperature log sheets and fridge/freezer temps will be provided to the ED each morning during Stand-up Meeting to ensure completion. Effective 2/26/2025 audits will be completed of the food temperature logs by the ED or designee 3x a week for 4 weeks, then 2x/week for four weeks, then weekly x 4 weeks.<br>Findings will be discussed in the monthly QI meeting and the committee will determine frequency or need for continued audits based on 3 months of compliance.<br>Monitoring will be ongoing. Temp logs will be brought to each daily Stand-Up meeting ongoing. | 02/26/2025 |

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| | procedure related to recording food temperatures.<br><br>During an interview, on 2/24/25 at 4:58 p.m., the Cook indicated the temperature records should have been completed prior to serving the meals. He did not know why the documentation was incomplete and missing. | | | |